

Special Committee on Criminal Justice Reform
May 23, 2016

COUNCIL OF THE CITY OF PHILADELPHIA
SPECIAL COMMITTEE ON CRIMINAL JUSTICE REFORM

Room 400, City Hall
Philadelphia, Pennsylvania
Monday, May 23, 2016
1:13 p.m.

PRESENT:

COUNCILMAN CURTIS JONES, JR. - CHAIR
COUNCILMAN KENYATTA JOHNSON

PANEL MEMBERS:

KEIR BRADFORD-GREY
KEVIN BETHEL
WILLIAM COBB
TARIQ EL-SHABAZZ
JOHN F. HOLLWAY
RICHARD MCSORLEY
RICHARD PODJUSKI
WILFREDO ROJAS
ANN SCHWARTZMAN
JULIE WERTHEIMER

RESOLUTIONS: 160101

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2 COUNCILMAN JONES: Good afternoon,
3 everyone. We are reconvening the Special
4 Criminal Justice Reform Committee Hearing.
5 And will the clerk please read the title of
6 the Resolution.

7 THE CLERK: Resolution 160101:
8 Resolution appointing members to the
9 "Special Committee on Criminal Justice
10 Reform," who will conduct public hearings
11 examining the Philadelphia criminal justice
12 system for the impact of current policies,
13 and offer recommended strategies for reform
14 that are in the best interest of public
15 safety and the public good.

16 COUNCILMAN JONES: Thank you, Mr. Cohen.
17 Will you please also read the first panel to
18 testify.

19 THE CLERK: Panel 1 is Dr. Sandra L.
20 Bloom and Dr. Kirk Heilbrun.

21 COUNCILMAN JONES: Will you please come
22 to -- are they here? There they are.

23 Can you please come to the Witness
24 Table.

1 THE CLERK: She has a PowerPoint.

2 COUNCILMAN JONES: Would any of the
3 Members like to speak?

4 MR. BETHEL: Just would like to thank
5 Dr. Bloom. She came last minute. She was
6 away, but responded to ur email over the
7 weekend. And is going to be here to testify
8 to really give us a setup of understanding,
9 Councilman, the trauma. And so, what's good
10 about what Dr. Bloom will provide us with is
11 a real understanding of what gets us to this
12 place and the kind of things our young
13 people go through and the development that
14 goes with that.

15 So, I am really delighted that she would
16 take time out of her day and on her trip
17 back to respond and be here. So on behalf
18 of the Committee, I want to thank you.

19 COUNCILMAN JONES: That's one of heck of
20 an introduction and accolade. Why don't you
21 state your name for the record, and bring
22 that mic a little bit closer to you. There
23 we go. And state your name for the
24 stenographer.

1 DR. BLOOM: Sandra Bloom.

2 COUNCILMAN JONES: And begin your
3 testimony and good afternoon.

4 DR. BLOOM: Thank you for having me.
5 It's a real honor to be here. And I'm going
6 to try to give you an idea about the impact
7 of the trauma informed services and why it's
8 so important in the whole Criminal Justice
9 System but also, basically, for our public
10 health, all of our public health. And I
11 have a PowerPoint to show you.

12 (Begins using PowerPoint with testimony)

13 So the big deal about this issue of
14 trauma is that we are now connecting the
15 notion of development and what has happened
16 to the people who end up in Juvenile Justice
17 and in the Criminal Justice System. I am a
18 psychiatrist by training. I'm now in public
19 health. But for 20 years I ran a program
20 that -- treating adults who had been
21 maltreated as children. And that is where I
22 originally came from on this topic.

23 But given what we know now, we really
24 have to look at it as a major public health

1 issue. It's really impossible to understand
2 the adults we become unless we understand
3 the child, the children that we have been.
4 And what is pretty revolutionary which may
5 seem to most of you like common sense, is
6 that we are looking at things differently
7 and defining the problem differently
8 starting with family dysfunction and then
9 what happens to kids, we call adverse
10 childhood experiences, and then the trauma
11 and loss that many young people in
12 Philadelphia experience resulting in
13 emotional regulation/disregulation and all
14 kinds of behavioral problems. And often,
15 the focus of our interventions just focuses
16 on trying to do something about the
17 behavior. But without understanding what's
18 under the surface, it's not going to get us
19 anywhere. We have learned that with all
20 different populations.

21 It begins long before these children
22 enters the justice system. It begins before
23 they're in school. And it's about the
24 serve-and-return relationship that goes on

1 between kids and their caregivers that is
2 absolutely critical for development. And we
3 are learning so much more about how the
4 brain works.

5 So, the brain develops over time. We
6 are not finished getting wired until we're
7 25 to 30 years old. And it starts from the
8 bottom up. In infants, are developing 700
9 new neural connections a second.

10 There is this process that goes on
11 called pruning. So, we come into the world
12 with twice as many neurons as we are
13 ultimately going to have. And the process
14 of eliminating half of our neurons in our
15 brain is called pruning, like you would
16 prune a shrub. This is what -- this is a
17 picture of what it looks like. There on the
18 left you see 36 weeks of gestation. You can
19 see there are some neurons around it. And
20 then they proliferate until you have by two
21 years of age a whole lot that is going on in
22 the brain, and then the pruning starts. And
23 by age six, the brain looks entirely
24 different.

1 It's a matter of the brain becoming more
2 efficient. And that's really why we put
3 kids into school when they are around six
4 because their brain is actually ready to do
5 the work required for school as long as
6 things have gone well. Because what this
7 means is that most of the brain development
8 occurs after we're born. And what that
9 means is that it's determined by what's
10 going on in the child's early childhood
11 environment. Long before they come to the
12 attention of the police or the justice
13 system.

14 And up until quite recently, we have not
15 identified the problem in that way. We've
16 been looking at the surface behavior and not
17 looking at where it's coming from. And we
18 now know a whole lot more about that.

19 The frontal lobes, which people depend
20 on in order to make good judgments, doesn't
21 really finish developing until we are in our
22 mid 20s. And that's what allows us to
23 really have a sense of self and governs
24 moral reasoning and judgment. So teenagers,

1 that is why they are often so problematic.
2 They don't have all of the equipment
3 necessary yet to really exercise good
4 judgment. And anybody that's been a parent
5 of a teenager or been a teenager can attest
6 to that. It's because of attachment, these
7 early caregiver experiences, really
8 determine how we self-regulate. How we
9 regulate our biology, our cognition, our
10 social development and our moral
11 development. It's all really determined
12 before we even get into school. And that
13 then determines how we are as members of a
14 community.

15 Lots of things can go wrong. Stress,
16 adversity and trauma is really the poison in
17 our lives. It's really poisonous to all of
18 us. But the more stress you have, the more
19 poison it is because of what it does to our
20 bodies. It's what it does to our bodies and
21 what it does to our brains. That's what
22 makes stress, adversity and trauma so
23 damaging. That's a picture just
24 illustrating what it's like to have somebody

1 really stressed and experiencing a traumatic
2 event. It affects our whole selves in ways
3 I'm going to try to describe to you briefly.

4 So there is good stress. There is the
5 kind of stress you get when you go to school
6 and it's good for you and it helps you grow
7 and develop. The ones on the right side of
8 the screen are the bad kinds of stress.

9 Relentless stress, also called allostatic
10 load, toxic stress and traumatic stress.

11 And what I am going to tell you about this
12 isn't my opinion. There is now pretty
13 recently really strong science that backs up
14 everything I am going to talk about.

15 Allostatic load means it's the body
16 adapting to challenging conditions all the
17 time. So, what kind of conditions produce
18 what I call relentless stress?

19 Poverty. Poverty is not necessarily in
20 and of itself traumatic, but it's
21 relentless. So, you don't get to take the
22 weekend off. You don't get a mental health
23 day. You don't get vacations if you live in
24 poverty. It's just always there. The

1 stress of not knowing if you are going to be
2 able to pay the bills, if you are going to
3 be able to feed the children, it's
4 constantly stressful.

5 Racism and other forms of
6 discrimination, constantly relentlessly
7 stressful; trying to parent alone because we
8 are not really well designed at all to
9 parent by ourselves; having two generations
10 of care giving that you never get a break.
11 You are always on, always stressed; having
12 multiply challenged children; having any
13 severe injuries or illness in a primary
14 family member. All of these things are
15 often the subtext for people's experience
16 and then something else bad happens.

17 What's it like to live relentlessly
18 stressed? What happens to humans? We get
19 irritable. We get impatient. We often
20 don't make good decisions. It's really
21 difficult to parent well. And it is a setup
22 for violence within a family or within the
23 community. Relentless stress in parents can
24 lead to toxic stress in children.

1 Toxic stress is the word we are using to
2 describe what happens when a child is
3 exposed to overwhelming conditions when
4 their brain is in a critical period of
5 development. And we know now that toxic
6 stress actually affects the brains
7 architecture, the way the brain actually
8 gets put together. What gets wired to what.
9 How -- and it explains a lot given what I am
10 going to show you about what -- why kids are
11 having such difficulty often when and not
12 really well prepared for school.

13 So, I want to tell you about the study.
14 It's called the ACES study, the Adverse
15 Childhood Experiences Study. It's been
16 around a while now. Came out in 1998. But
17 it's just now really getting traction. And
18 the population that was studied was a
19 Caucasian, largely middle class population
20 from San Diego. And the reason it's been so
21 significant is it's the largest study of its
22 kind that was ever done up until that time.
23 And it was the first really important study
24 to look at what happens across the lifespan.

1 So if you're badly hurt as a child, what
2 happens to you as you age? Can we -- is
3 there anything we can determine or predict?
4 So the categories -- sorry, why this isn't
5 happening right.

6 (PowerPoint stalls)

7 The categories of adversity were when
8 you were 18 or younger, were you physically
9 or psychologically abused by your parents?
10 Did you have contact, sexual abuse from
11 anybody? Were you physically or emotionally
12 neglected? Did you live in a household when
13 you were 18 or younger, was there anybody in
14 your household who was mentally ill or
15 substance abuser or was there domestic
16 violence or were your parents separated or
17 divorced, or where there was anybody
18 incarcerated. So, ten categories of
19 adversity were measured. Not numbers of
20 instances now. You could have been sexually
21 abused 300 times, but you'd still only be in
22 one category. And then you developed a ACES
23 score, just a simple addition category, 0 to
24 10 were the options.

1 What they discovered -- I don't know if
2 this is going to work (PowerPoint stalls
3 again) -- is only a third of this white
4 middle class population from San Diego had a
5 0 ACES score. And a substantial minority, 7
6 percent in this population, had an ACES
7 score of 4 or more. And I will tell you in
8 a minute why that's important.

9 What they found when they sent this to
10 the -- the results to the CDC to be analyzed
11 was that the ACES score was the total amount
12 of stress that a person had experienced in
13 childhood. That's what it was used for.
14 And the higher the ACE score, the more
15 likely a person was to be an alcoholic, to
16 be depressed, be suicidal, to be -- IV
17 drugs, to use IV drugs. In fact, one of the
18 coauthors when the study was here a few
19 years ago. And said if I could wave a magic
20 wand and eliminate childhood adversity based
21 on this study, I could instantly eliminate
22 78 percent of future IV drug abuse.

23 So, that was interesting. And kind of
24 intuitively we know that bad things happen

1 with your kids, so you end up depressed or
2 suicidal or drinking or doing drugs. Like
3 that's not exactly news. Except we didn't
4 have the statistics around it before, and we
5 did not know the higher that the ACE score,
6 the more likely a person is to have ischemic
7 heart disease, cancer, stroke, diabetes.
8 Basically, the ten most common causes of
9 death in the United States. We just didn't
10 know that. We didn't have real evidence
11 that supported that until 1998.

12 Now we know it. And it's pretty
13 startling the conclusions that with an ACES
14 score of 4 or more, because 4 or more looks
15 to be a break point, people are twice as
16 likely to smoke, seven times more likely to
17 be alcoholics, six times more likely to have
18 sex before they're 15, twice as likely to
19 have been diagnosed with cancer, twice as
20 likely to have heart disease, four times as
21 likely to suffer from lung disease, twelve
22 times as likely to have attempted suicide,
23 and ten times more likely to have injected
24 street drugs.

1 So, what we're really looking for is
2 looking at is what's underneath the iceberg.
3 What's going on developmentally that so many
4 people. And there's a direct correlation
5 with the rate of incarceration, as well.

6 Well, in Philadelphia we decided -- I am
7 cochair of ACES task force. We decided
8 to -- I will just give up on this. We
9 decided to do a study in Philadelphia. And
10 our demographics are very different than
11 this original ACES study. And what many of
12 our communities experience are other things
13 in addition to, perhaps, the problems that
14 were in the original study. So, this was a
15 work of Roy Wade and other colleagues who is
16 a pediatrician at CHOP. And he put into --
17 we were doing a telephone survey that the
18 Philadelphia Health -- Public Health
19 Management Corporation was doing regularly
20 in Philadelphia. And so, Roy added on some
21 questions. Witnessing violence, living in
22 unsafe neighborhoods, experiencing racism,
23 living in foster care, experiencing
24 bullying.

1 And what we found is that many of the
2 traditional ACES is more prevalent in our
3 setting, including physical abuse and sexual
4 abuse and domestic violence and living with
5 someone as a child -- living with somebody
6 in the household who was incarcerated. The
7 overlap was substantial. So basically, to
8 summarize since I can't get the pictures for
9 it, only a small percentage had no ACES.
10 17 percent had no ACES. 49 percent had at
11 least one conventional ACE and what Roy
12 called one expanded ACE, at least one.

13 So, we know that we are dealing with a
14 great deal of childhood adversity in our
15 population. And when we looked at the
16 overlap of where are the -- where is the
17 highest proportion of people who have
18 experienced 4 or more ACES, North
19 Philadelphia and Southwest. So, we got all
20 these overlapping issues that are happening
21 for families in our City. And I want to
22 tell you what that means as people grow up.

23 Think of it as when life is a war zone.
24 What you all hopefully are doing right now,

1 your brain is integrating your -- what
2 you're hearing from me, your thoughts, your
3 sensations, your conscious awareness and
4 your knowledge and whatever you're feeling
5 right now. It's all being integrated in
6 your brain constantly. It's stream of
7 consciousness. That's what happens.

8 What trauma does is that if we suddenly
9 hear an alarm go off, we are very quickly
10 going to go to fight/flight mode. Our
11 central nervous system is going to shift
12 almost immediately. And things are going to
13 happen to our body and our brain.

14 The brain when faced with a threat --
15 hey, thank you. (IT fixes PowerPoint
16 presentation.) Keep going because I don't
17 know that I can -- okay. Thank you.

18 So, that's you sleeping last night, I
19 hope. That's you being conscious and aware
20 right now. We suddenly hear a noise. Very
21 quickly we are going into fight, flight,
22 freeze. Normal biological responses, part
23 of our mammalian heritage.

24 What's going in the brain at that time,

1 is there is a high road and a low road of
2 information processing. So, the low road is
3 your senses taking information. And if
4 there's something to be afraid of, there's a
5 little red dot in the middle there. And
6 that's called your amygdala. And that is
7 your brain's alarm bell.

8 Your alarm bell rings. And within a
9 very short time sends information down
10 through the rest of your brain into your
11 spinal cord and you do something. You
12 fight, you defend yourself, you run or you
13 freeze, all of which helps you survive. And
14 then it takes twice as much time for
15 information to get out to your frontal lobes
16 to be assessed. This for me is the best
17 argument for gun control. Because we are
18 just -- our brains are not equipped to be
19 able to respond consciously with full
20 awareness in the time it takes us to pull a
21 trigger.

22 So, that's all happening extremely
23 rapidly within 12 milliseconds. And at the
24 same time, your body is being exposed to

1 very powerful chemicals whether you are 2 or
2 you're 12 or you're 22 or you're 42.

3 Epinephrine, also called adrenaline, is
4 the chemical that makes your heart speed up
5 and makes you -- makes your digestive juices
6 stop flowing and all the blood goes into
7 your muscles to prepare you to fight or
8 flee. The problem with that is that as our
9 heart rate goes up because we are aroused
10 and prepared to fight or run, our
11 performance diminishes. And that is related
12 to heart rate.

13 So as our heart rate increases, we
14 become first really disabled in terms of our
15 fine motor coordination and then gross motor
16 coordination and then cognition. And then
17 we become really irrational at heartbeats of
18 175 and higher. And that -- we have no
19 control over that whatsoever. This is all
20 part of the human biological survival
21 response.

22 So when an officer in a juvenile justice
23 facility or somebody in the streets is
24 confronted with someone who has perceived

1 they are in danger, it doesn't have to make
2 sense. It has nothing to do with making
3 sense. It's about their biology. And at
4 that point, they are a dangerous being
5 because that's what we are capable of.

6 There are two other big chemicals that
7 are a big part of this. Cortisol and the
8 endorphins. Cortisol is our naturally
9 occurring antiinflammatory substance. We
10 can't live without it. It's neuro regulator
11 throughout our bodies. It's part of the
12 stress response because it's
13 antiinflammatory.

14 So if in that picture our guy gets
15 wounded by that tiger's tooth, his arm
16 naturally would swell up. But that might
17 mean him losing his spear. So instead,
18 Cortisol zips around through the body really
19 quickly and diminishes the swelling so it
20 doesn't happen.

21 The same -- the endorphins are naturally
22 occurring opiates. It's why we can get
23 addicted to opiates because already have the
24 receptor sites in our brain. Endorphins are

1 part of the stress response because pain can
2 be paralyzing.

3 So all of that, helps us to explain why
4 that would be so toxic for children to be --
5 to have their brains and bodies exposed to
6 those chemicals throughout their developing
7 life, bodies and brains, over and over and
8 over again is bound to do damage. And we're
9 starting to understand what the damage is.

10 So, all of those chemicals banging on the
11 brain over periods of time is going to cause
12 distortions in all kinds of systems that are
13 related to attachment including moral
14 development.

15 Now another big thing that happens is a
16 loss of language. That is the pictures of
17 brain scans. And what it's showing you is
18 that at moments of peak fear, our ability to
19 take in our experience and do what all of
20 you are doing right now, which is listen to
21 me. I'm using words and you are thinking in
22 words. That capacity when we're at peak
23 fear is offline. It's not working. And
24 instead, all the sensory areas in the other

1 side of our brain are very activated.

2 What it means is that when people
3 experience a traumatic event that in the
4 worse aspects of the experience are not
5 encoded in words. And whatever isn't put
6 into words, we can't think about. We can't
7 share with anybody else. We can't talk
8 about. It can't be processed. So, it lives
9 in a separate space and takes on a life of
10 its own in call kinds of ways.

11 So what we know now is that the hallmark
12 of trauma is the loss of integration. And
13 in Spanish, one of the names for the devil
14 is Diabolos. And that -- the origins of
15 that word means the divider or the splitter
16 into fragments. And that is literally what
17 happens in somebody's brain. And that's
18 what interferes with memory. What happens
19 then is that the experiences of the
20 traumatic event is sensory. There is visual
21 images. Strong emotions, smells. Anything
22 that is sensory separated from any kind of
23 meaning or narrative.

24 So, the person that is haunted by these

1 sensory experiences and they're called
2 post-traumatic reminders, and they become
3 then triggers for all kinds of behaviors.
4 So the sensation occurs, person might walk
5 into a room that's painted green and freak
6 out, run away or become belligerent or
7 faint, do all kinds of reactions because
8 their mind has associated to a traumatic
9 event. And they -- it triggers the survival
10 response without any context. Just walk
11 into a room that's painted green. That
12 makes no sense. It makes no sense to the
13 person. They can't explain it, but they
14 will react because their body is on high
15 alert and is ready to defend them -- their
16 lives even though now there is nothing at
17 stake. And that when it happens over and
18 over again is one of the hallmark
19 characteristics of PTSD.

20 It's called chronic hyperarousal. And
21 it is literally a resetting of the central
22 nervous system. So, people are responding
23 to very, very low levels of stimuli as if
24 they were major threats. And you see that

1 all the time in juvenile justice clients.
2 They respond to just a look or a --
3 something somebody says casually as if it
4 were a threat to life. And of course it
5 isn't, but they respond as if it were. And
6 that then you get these escalating problems.
7 No wonder then that some people end up being
8 really paranoid. Some people run away from
9 everything. Some people are fighting all
10 the time. And some people live in la la
11 land. It kind -- we call it dissociation.
12 Which means the loss of integrated function.

13 That thing is frozen again if somebody
14 wants to -- oh, no. Sorry. Apologize.

15 So when life is a war zone, and this is
16 what's going on in many of our neighborhoods
17 where there is a lot of violence that people
18 are exposed to and kids are exposed to, they
19 become chronically hyper-aroused. They are
20 in a state of high alert. Can't think
21 clearly. Can only attend to what's
22 threatening, are driven to take action, have
23 hair trigger tempers. And then, of course,
24 there is more violence and aggression.

1 We do the best we can to cope. And if
2 we are really lucky, we will have support of
3 family and support of resourced community.
4 And we will turn out okay even if bad things
5 have happened. If we are not so lucky, then
6 maybe what we start to do is drink or use
7 drugs. And we end up with an addiction or
8 maybe we are really avoidant and we end up
9 with a panic disorder or an anxiety
10 disorder. Maybe we use pain as a
11 distraction and we are into all kinds of
12 fighting and self-harming behavior. Maybe
13 we avoid grief and we become suicidal or
14 depressed. Maybe we engage in a lot of
15 risky behavior. In fact, we get hooked on
16 risk because we get hooked on the rush that
17 we get from being really afraid and then we
18 just engage in risk all the time. Maybe we
19 get real controlling, and that tends to
20 alienate other people. And maybe we find
21 out that it feels a lot better to hurt other
22 people than to get hurt ourselves. And
23 that's a pathway to antisocial behavior and
24 to more violence.

1 And unfortunately, the brain has adapted
2 to our evolutionary needs that are so
3 complex by ramping down our frontal lobes
4 that consume the most energy. And the way
5 we do that is by forming habits. We form
6 habits really quickly. And the problem with
7 that is that as long as we are doing
8 something that we are just learning, we are
9 thinking about it. We are able to think
10 about it, concentrate on it.

11 But as soon as something becomes a
12 habit, it goes into our brain called the
13 basal ganglia. And we have no control over
14 that at all. And that's why it's so hard to
15 change bad habits. That's why it's really
16 hard to get kids in the justice system to
17 change because they have developed a lot of
18 really problematic habit. And we don't
19 understand where they are coming from, so we
20 don't know how to undo all this. What
21 happens instead is that people tend to
22 reenact traumatic experience. They get
23 trapped in time and haunted by their own
24 past. They can't be fully present in the

1 present and they keep repeating bad things
2 over and over and over again. Sometimes
3 it's through self-harming behaviors,
4 sometimes it's through harming others.

5 So, that is the short version of trauma
6 theory 101. What happens is that folks
7 become completely organized, (hands up some
8 water) thank you, around, excuse me, the
9 past history of trauma. Thanks a lot. And
10 it undermines their ability to adapt in a
11 healthy way.

12 And so, the way we think about it is
13 that they can't keep themselves safe. They
14 can't manage their emotions. They can't
15 think in the presence of emotions. They are
16 emotionally disregulated. They don't
17 communicate well. They have a lot of
18 trouble with authority in external authority
19 relationships and having authority over
20 themselves. They have a really confused
21 sense of what's fair, what's just. And
22 enormous amount of unresolved loss, grief
23 and an inability to imagine anything else.
24 So instead, they just keep repeating the

1 same stuff over and over again. What
2 complicates this even more is that we know
3 now that we live in a inter-connected,
4 adaptive living world that is literally
5 filled with people who have had adverse
6 individual group and intergenerational
7 exposure to all this. So we have to take
8 account of the entire system, not just the
9 people that we target but the people who are
10 working with those people and the people who
11 are running the show. We have all been
12 exposed to all kinds of adversity and
13 trauma. We know that from all the
14 epidemiological work that's been done.

15 We learned that it was really critical
16 to basically change the fundamental
17 question, to define the problem differently
18 and change the question from it's not really
19 what's wrong with you, it's what happened to
20 you. And once you understand what's
21 happened to a person, then their life makes
22 a whole lot more sense. There are many
23 tasks then, if we are thinking about a
24 juvenile justice population and helping

1 these kids to get on it because their brains
2 are not done, they have got years and years
3 before their brains are fully wired. So,
4 there is a great deal that we can do but we
5 have to identify the problems properly and
6 know what to do. We have to help them get
7 biologically regulated to begin with.

8 They have to develop safety skills.

9 They have to develop emotional management
10 skills and learn how to think in a different
11 way. We have to help all that fragmentation
12 that I was describing which may characterize
13 their entire existence. Have to help it
14 become all integrated so that they can
15 actually describe what happened to them,
16 talk about it and appreciate the impact that
17 it's had on them.

18 We have to help them understand the
19 patterns of repetition, that they are
20 trapped in over living the same things over
21 and over again and living those things out
22 in relationship with staff that they
23 encounter. And we have to help them improve
24 their executive function and really think in

1 a very different way. So, there are tasks
2 of recovery that really once you understand
3 the biology, you can really understand what
4 it is we need to be doing for young people
5 who really are very salvageable for the most
6 part. They don't have to end of being
7 chronically recidivistic. But it means we
8 have to define properly what it is that we
9 need to do and figure out some ways to do
10 it.

11 So, that's why we need a trauma informed
12 community. And that's a summary of why, as
13 far as I'm concerned, this is a major public
14 health issue. And it really the pillars
15 there represent all of our systems. We need
16 to get on the same page. People who end up
17 in our hands often end up in many parts of
18 the system simultaneously. We need to have
19 a real clear understanding of what this is
20 all about, and what we can do to address it.

21 So, those are three books that I've
22 written about this. If you want to go
23 deeper, and I would hope that you would, and
24 that's me. And I want to thank you very

1 much for your attention. And I hope this is
2 helpful to your Committee's work.

3 COUNCILMAN JONES: Thank you so you very
4 much. Don't go anywhere. I almost feel
5 like I was in therapy. I feel so much
6 better now that I realize what in the heck
7 is going on. And I think a couple of things
8 that I took from it was War Zone. And there
9 are -- there are some neighborhoods this
10 does not apply for those who might be
11 watching on television. You know, that life
12 is good. Life is normal.

13 But what happens when in a condensed
14 area, in a laboratory, if you would, trauma
15 is every day?

16 DR. BLOOM: Yeah.

17 COUNCILMAN JONES: And you see things
18 bubble up from it. There is one kid who is
19 afraid to look, doesn't want to go out, just
20 clinging to their parents. Another kid
21 walks boldly into that chaos and adapts and
22 finds his level of chaos. And then another
23 kid just goes right through it, winds up
24 becoming Kenyatta Johnson, goes away to

1 Mansfield and does his thing. I mean, so --
2 so you get different reactions --

3 DR. BLOOM: Yeah.

4 COUNCILMAN JONES: -- to that stress and
5 chaos, if you would.

6 So I guess my question is, how do you
7 deal with that mass pressure cooker as a
8 municipality? How do we begin to create
9 pressure valves, outlets, exit strategies
10 from that kind of madness?

11 And it's not everywhere. I don't want
12 to give the impression that every
13 neighborhood is like that. But I travel
14 through some of them, and when you see kids
15 playing around teddy bear memorials jumping
16 rope like it's nothing, you know, where
17 their friends used to play, that gives me
18 pause to try to figure out how do we make
19 them understand that that is not normal?
20 And B, that you can survive this and move
21 beyond this?

22 DR. BLOOM: So it's -- you're totally on
23 target. Because I -- what happens in
24 situations like that is that what is really

1 abnormal becomes normalized. And we change
2 our social norms, so that is what happens.
3 And it's -- I think your question is really
4 how do we reclaim the territory. And I
5 think now as a public health person, so I
6 think at three levels.

7 There is first, there is what everybody
8 needs to know. So like we know smoking is
9 not good for you and everybody should wear
10 seat belts, right? That was not always the
11 case. We didn't always know that. So,
12 that's taken a massive universal public
13 health approach to say it's not just about
14 some people. That's why I try to say, look,
15 this is everybody. It's an everybody
16 problem that we need to have publicly
17 educate everyone about what I've been
18 talking about.

19 And then we need special attention to
20 what we call secondary prevention or
21 secondary intervention. So all the kids or
22 adults and families who are at risk, right,
23 which would be everybody in some of our
24 really high violent neighborhoods, right?

1 And then we have to be able to provide
2 trauma-specific treatment for the people
3 most effected. And they may be effected, as
4 you pointed out, in a variety of different
5 ways because development is so complex and
6 it goes on for such a long time. That when
7 bad things happen, it depends on what those
8 bad things are and when they happen in a
9 person's development to determine what their
10 outcome is. But whoever has trauma symptoms
11 needs adequate treatment.

12 So, we need to be thinking on all of
13 those levels and know that this has been
14 going on. It's been developing for a long
15 time, so it's not -- there is no quick fix.
16 We have to really look at this as a whole
17 City, not just one piece. But this is a
18 public health emergency. And for many young
19 people, it needs -- we need to think of it
20 as really urgent because they're continuing
21 development is continuing to be affected by
22 the violence that they are surrounded by.

23 We've been doing a project for the last
24 year in Strawberry Mansion. And I went to

1 Temple. I've been working in North Philly
2 since I was a kid. I know what's happening
3 to people. And it's -- we have figure out
4 how to stop this. That means mobilizing
5 that. In everyone community, no matter what
6 violence is, there is also a lot of health.
7 There are healthy people there who don't
8 want -- but feel helpless. They don't know
9 what to do. And we need to activate those
10 because the only antidote we really know to
11 violence and to the trauma that occurs as a
12 result of violence is social support.

13 COUNCILMAN JONES: So, I'm going to turn
14 over to my colleagues. But one of the
15 things that I keep hearing over and over
16 again probably my colleague is going to
17 mention, is a sequence of events happens
18 right after a murder. And it's like a slow
19 bullet that fires.

20 DR. BLOOM: Yes.

21 COUNCILMAN JONES: And it's not always
22 the person jumping down screaming on the
23 floor that you got to watch. It's the kid
24 that's way over in the corner processing by

1 himself that leaves. That's the one you
2 better go find out where he's going, what
3 he's doing. Because he's internalizing it.
4 And is -- his outcry might be different.

5 My question becomes, what can we as a
6 municipality do to create rapid response
7 units that go out and keep a bad day maybe
8 from becoming a bad weekend from becoming a
9 bad week?

10 DR. BLOOM: I think for that, which is
11 you really defining basically a whole
12 neighborhood is at risk at that point. So,
13 the emergency preparedness for the City is
14 actually engaged in getting several hundred
15 people in different neighborhoods trained in
16 an intervention for exactly those situations
17 that are much more widespread and that help
18 people manage their physiology more
19 effectively and understand more about what
20 they're seeing and what's happened to them.

21 So, you're absolutely right. That's
22 what we need to do. And we need to get more
23 people engaged in that, so that members of
24 the community just feel a sense of

1 responsibility to go out there and help
2 particularly the kids be able to process
3 that and do more than the memorials which
4 are not enough and often just are traumatic
5 reminders.

6 So we -- I think we are starting to --
7 the City is starting to take that on. It's
8 just beginning. There has only been one
9 training. And I think there's more coming
10 in June. So, I think that's the way we need
11 to be thinking, exactly the way you are.

12 COUNCILMAN JONES: Councilman Johnson.

13 COUNCILMAN JOHNSON: Thank you for your
14 report. And this is just more of a
15 statement and to just follow up on what the
16 Chairman talked about in terms of how we can
17 have more of a greater impact on the City
18 level.

19 I am glad that we're in this particular
20 session focusing on public safety as a
21 public health epidemic primarily because
22 when you talk about victims of the shootings
23 and the crimes as well as the shooters,
24 there is some level of trauma on both ends.

1 And just as recent as a few minutes ago, we
2 had some young people here in City Council
3 today from Powel Elementary School. And
4 they are doing a service learning project
5 focusing on the issue of youth gun violence
6 and public policy. And several different
7 young people had the opportunity to come up
8 and talk about why we should have background
9 checks here in the State of Pennsylvania.
10 They had to also relate a personal
11 experience that they have had with youth gun
12 violence.

13 And I have had four our five young
14 ladies come to the microphone talk about how
15 they have lost a loved one. And, obviously,
16 one young lady was in tears. And it always
17 brings back home that on the victim's side,
18 and these are young people who not only lost
19 family members to gun violence and friends,
20 but these also are young people that have
21 lost family members who were actually the
22 shooters who are away in prison and how do
23 they process that stress that they are
24 actually experiencing as a result of those

1 incidents of gun violence.

2 For me it's more of a common sense
3 approach. And hopefully with this
4 administration as we move forward, we have
5 the MacArthur Grant and we have a new team
6 that's focusing on reentry. And I'm a
7 strong advocate of juvenile justice.

8 But one young lady when we had hearings
9 on youth gun violence and she just said in
10 the schools, how come we don't have grief
11 teams that will come help us process.
12 Because a lot of these shootings and these
13 fights start on social media, then they
14 spill over into the school. And I know as a
15 young man growing up in South Philadelphia,
16 the same things are going on now were going
17 on when I was a young man. And so, I know
18 what took place inside the school. I know
19 how people responded based upon the trauma
20 and the hurt that they felt as a result of
21 not only just a shooting, but every day
22 stressors that are taking place in
23 low-income communities.

24 Hopefully, when we engage in this new

1 concept of community schools, which really
2 isn't a new concept but it's something we
3 would be taking on as a new initiative with
4 this administration. We will begin to look
5 at grief counseling in the schools, crisis
6 intervention teams that are in the schools
7 that can primarily help young people process
8 some of the stressors that they are dealing
9 with, living in neighborhoods of poverty.

10 But you did mention something interest.
11 I just wanted you to briefly elaborate on.
12 You talked about how the brain structure
13 changes as a result of the stressors that
14 are taking place that young people are
15 experiencing living in their environment,
16 rather family environment or community
17 environment.

18 So from a sociology standpoint, at what
19 time can you take that person out of that
20 environment and then that begins to -- and
21 new environment begins to reconstruct the
22 damage done to the brain? Because
23 oftentimes, I have countless examples of
24 young men who grew up in the inner City of

1 Philadelphia, engaged in the life of crime
2 and violence, go away to Glen Mills.
3 Excellent program, at least when I was young
4 growing up, excellent program. And they do
5 a full 360. Several of my friends went
6 away, played college basketball, some went
7 on to get good jobs all based upon them
8 being taken out of Point Breeze, South
9 Philadelphia, put into a whole different
10 environment and changed the whole trajectory
11 of their lives.

12 How does that impact on the brain
13 structure? Because at one point it kind of
14 seemed that once the brain is going in one
15 direction --

16 DR. BLOOM: Yeah.

17 COUNCILMAN JOHNSON: -- it's like a
18 hopeless cause.

19 DR. BLOOM: We don't have good research
20 yet around looking -- actually looking at
21 the brain that is healing, so I will have to
22 be a little subjective about this because I
23 worked with adults, okay? And they were
24 adults who were largely in the mental health

1 system, not the criminal justice system.

2 But boy were they -- they had very
3 complex enormous problems and were often
4 chronically in and out of the system, high
5 utilizers we say now. And I watched brains
6 heal. I watched people totally change their
7 lives and -- exactly what you're describing.
8 And these were even -- these were adults.

9 So certainly, what we know about child
10 development and adolescent development is
11 that the reason why adolescents are so
12 dramatically different from like the twelve
13 year olds they were is because the sex
14 hormones absolutely reorganize the brain.
15 So, we have an enormous opportunity in
16 adolescents to do exactly what you
17 described, but it takes the whole place.

18 What they're really doing, what you were
19 describing happened at Glen Mills is that
20 they were changing the norms that the kid
21 adopted. They had totally different
22 normative experiences that are -- that prior
23 to that, they didn't even imagine were
24 possible. They had to experience it in

1 their body and their minds to know, wow,
2 this is -- it's possible for me to be okay
3 and to fulfil a whole different mandate than
4 just surviving. And that's what's so
5 important about how do we -- how do we take
6 that knowledge that we have about social
7 norms, how do you as leaders change the
8 social norms for the City that instead of
9 just, oh, well? Because there's a bit of an
10 attitude that you get around the City about
11 well, you know, it's just the way it is.
12 Just gets worse and worse and what can you
13 expect. And no. That's not good enough.

14 We can change that. People can decide
15 they don't want it to be this way anymore.
16 And if enough people do it --

17 COUNCILMAN JOHNSON: I agree.

18 DR. BLOOM: -- we have a tipping point.

19 COUNCILMAN JOHNSON: I think the Board
20 agrees. I know he was going to get up on
21 that one.

22 COUNCILMAN JONES: No. I was going to
23 pass the baton to Ms. Grey and then
24 Mr. Shabazz.

1 COUNCILMAN JOHNSON: Thank you very
2 much.

3 DR. BLOOM: Thank you.

4 MS. BRADFORD-GREY: Thank you, Doctor.
5 Can you hear me?

6 My name is Kier Bradford-Grey. And I
7 really enjoyed your presentation. I have
8 heard it several times before because it
9 informs our practice. And I say "our", the
10 Public Defender Office because, of course,
11 I'm representing juveniles.

12 But what I have seen over the years
13 obviously is that the triggers that you
14 described, when we have kids that
15 unfortunately come into our juvenile justice
16 system, there is not a lot of diagnosis of
17 PTSD. Instead, these kids are diagnosed
18 with ADHD. They are diagnosed with
19 everything else that is being funded and
20 treated but not really addressing the root
21 cause of some of the inability to adjust
22 that you described based on constant being
23 exposed to trauma.

24 I have seen also funding resources open

1 up for Vets who they have understood this
2 same thing because they go over to the war
3 of experience, the same thing that you are
4 saying young kids experience.

5 DR. BLOOM: Right.

6 MS. BRADFORD-GREY: How does your work
7 inform opportunities to release funding so
8 that there are treatment resources available
9 to young kids who don't have private
10 insurance or their -- neither do their
11 parents so that we can start to address this
12 in a practical way and utilizing the
13 appropriate funding to do so?

14 And in my second -- it's a two-part
15 question. Secondly, you are familiar that
16 we do have a child welfare system here. And
17 I think to me that is the first glimpse of
18 what we are going to see in a child that has
19 experienced or going to experience some of
20 the detrimental effects of trauma. Because
21 we get kids at a very early age who have
22 been abused physically, sexually, mentally,
23 all of it.

24 Do you work with our child welfare

1 system to understand a model of
2 trauma-informed therapy that can be utilized
3 that is very effective so that we don't see
4 these same kids trickle into our criminal
5 justice system?

6 That's a two-part question. One is the
7 funding. And one is developing models at
8 the preventive area because, for the most
9 part, those are the children that we see in
10 our juvenile and, of course, our adult
11 system.

12 DR. BLOOM: Big, big questions, right?
13 I -- I hope what I have conveyed is that all
14 of this knowledge, it's relatively new and
15 it is a huge shift for the mental health
16 system because the mental health system now
17 has this -- these categories of diagnoses
18 which are not based on the brain. They are
19 not. They are colorful descriptions of
20 people, okay?

21 So, we have a problem with the
22 diagnostic system, period. It's a huge
23 problem. So there -- with the whole mental
24 health system, the big, big not just the

1 City but everywhere is really undergoing a
2 real questioning of what does it really mean
3 to have treatment? What are we treating?

4 And this changes the real definition
5 just as you've pointed out of what it is
6 we're supposed to treat, which we haven't
7 had before. I am a before and after. I was
8 well trained. We treated people. But I now
9 realize we didn't know what in the world we
10 were doing because we didn't understand any
11 of this.

12 Now that we understand it, it means --
13 but those kind of shits take a long time for
14 whole professions to really undergo. So we
15 are still mid process in that. I think, and
16 this is consistent with Dr. Evans actually,
17 our Commissioner. That we really think --
18 need to think differently about what
19 treatment is and not confine it just to on
20 somebody's therapy office. That there
21 should be trauma-specific treatment that is
22 really for the people most severely
23 affected. But we have got thousands and
24 thousands of people who need help, who are

1 not going to come into traditional mental
2 health settings.

3 So, we need to really think differently
4 about how do we get people mobilized to help
5 each other and be therapeutic. And that
6 begins with public edu -- you got to really
7 educate people so we are all on the same
8 page about what these problems are.

9 MS. BRADFORD-GREY: Can I just ask,
10 you're a professional and deal with a lot of
11 mental health experts and professionals. I
12 do see a lot of wasted tax dollars going on
13 treatment for things that are not being --
14 not the root cause of the problem. So, I
15 know we have many kids that those days that
16 you just described are within a
17 psychological report, which is what most
18 kids get when they come into the juvenile
19 justice system.

20 However, the diagnosis is never PTSD.

21 DR. BLOOM: No.

22 MS. BRADFORD-GREY: The diagnosis never
23 recommends some of the things that you say
24 is kind of like a physical therapy for the

1 brain. And until we start to do that or
2 recognize that, we were sending kids away to
3 get treatment which does not help their
4 underlying issue. And then they are
5 recidivising.

6 DR. BLOOM: Exactly.

7 MS. BRADFORD-GREY: And they are coming
8 back.

9 DR. BLOOM: And they become more
10 hopeless.

11 MS. BRADFORD-GREY: Yes.

12 DR. BLOOM: Yep. I agree.

13 MS. BRADFORD-GREY: How do we work at
14 least with the healthcare professionals to
15 change that to allow some funding
16 opportunities for these types of therapeutic
17 programs?

18 DR. BLOOM: Well, I think that -- I
19 don't have a simple answer for that. I
20 think that's why I agreed to do this today.
21 Was that you are all in a leadership
22 position. And when you and the people
23 beyond, you know, the larger justice system
24 say this is mandatory, you know, we have to

1 become trauma informed. We've have to
2 really have trauma specific treatment. We
3 really need to change our policies and
4 practices because we haven't identified the
5 problem correctly. That's how it will
6 happen.

7 It won't -- it's not going to -- it's
8 not going to come from outside. It's going
9 to have to come from within. We have
10 done -- we have done work in New York and in
11 Colorado in the justice system. And it
12 really has to be -- it will not change from
13 below. It has to change from people like
14 all of you going, this is why it needs to
15 change and it needs to change.

16 And that change is -- it is beginning.
17 The justice system is gradually taking on
18 this knowledge about the brain because it
19 makes sense. And it correlates, I think,
20 with a lot of people's experience.

21 Now your comments about the child
22 welfare system. Yeah, I think that's --
23 that's where we see the beginning often of
24 where intervention can occur. But when I

1 did start doing work with the child welfare
2 system, I kind of -- I just -- I had this
3 delusion in mind for no reason that kids
4 automatically got treatment because they
5 were in child welfare. And that's not true
6 at all. So only the squeaky wheels get the
7 grease. And so, we miss a whole lot of, you
8 know, dealing right at the ground with
9 families who are in -- clearly in distress.
10 There is a whole lot more that can be done.
11 But that means reorienting the child welfare
12 system.

13 They're beginning. But it's still --
14 all of this is still very new in any of our
15 systems. So it's -- it's very complex. And
16 how do we get whole systems to change? It's
17 not like moving a sailboat. It's moving
18 these huge cruise liners. It takes a whole
19 lot more and it really takes leadership. It
20 won't happen without leadership.

21 COUNCILMAN JONES: Thank you.

22 Tariq Shabazz.

23 MR. EL-SHABAZZ: Thank you. Good
24 afternoon. I'm Tariq El-Shabazz. If I am

1 to understand your presentation correctly,
2 from a prevention standpoint, you took great
3 pains to explain the development of the
4 brain of the child. And we have been
5 talking about how to rehabilitate people,
6 how to deal with people once they become
7 part of the juvenile system.

8 My question basically deals with early
9 childhood development and education. Based
10 on what you're saying, one of the avenues to
11 attack the trauma that people experience at
12 home is daycare, preK, kindergarten, those
13 things that this Administration talked about
14 putting money into.

15 DR. BLOOM: Yes.

16 MR. EL-SHABAZZ: And developing the
17 professionals that are equipped to recognize
18 a traumatic situation that may exist with
19 the child, to address that at that
20 particular time so that we can somewhat
21 prevent --

22 DR. BLOOM: Yup.

23 MR. EL-SHABAZZ: -- that from occurring.
24 So, would you suggest as one of the many

1 avenues to address this ill, an influx of
2 money even if it's going to be painful to
3 some lobbyists and some people, an influx of
4 money into preK, into kindergarten and, in
5 fact, into nursery school areas to begin to;
6 first of all, identify; secondly, address;
7 and thirdly, follow up so that we don't get
8 the teen with the trauma and the stresses
9 but we begin to identify it?

10 If we identify it early enough, we may
11 be able to assist that family that may have
12 that single parent mother who works three
13 jobs and comes home frustrated because she's
14 trying to make ends meet with three children
15 or, in this day and age, single parent
16 father that is in the same situation. We
17 can identify. We can address it on that
18 level as Ms. Grey has said, address it on
19 that level. But we also can address it
20 through education, public education,
21 something that has been forgotten when
22 people started to, in my own personal
23 opinion, benefit from charter schools. But
24 that's just my own personal opinion. That's

1 not anyone else's. That's mine. For the
2 record, I don't want anybody to get mad at
3 anybody else. That's Tariq El-Shabazz's
4 position.

5 So would you suggest an influx of
6 finances, resources into our early childhood
7 development that's involved, daycares, preK,
8 kindergarten, first, second, third when that
9 brain is actually being developed the way
10 that you described it?

11 DR. BLOOM: Right.

12 MR. EL-SHABAZZ: And whatever we need to
13 do as a municipality --

14 COUNCILMAN JONES: Careful. He sounds
15 like hes' for the soda tax.

16 MR. EL-SHABAZZ: I'm for children in
17 education. And if a soda tax is going to be
18 influx into children in education, I am for
19 that.

20 DR. BLOOM: Me too.

21 MR. EL-SHABAZZ: It's a difference
22 between a grocery tax and a soda tax. But
23 anyway, that's not my platform. I'm sorry.

24 DR. BLOOM: I think it's where you get

1 the biggest bang for our buck. Is that
2 that's where we should be focusing on taking
3 care of people before the problems submerge.
4 And I think with the -- if the justice
5 system is farsighted enough to get that,
6 then that will influence all the other parts
7 of the system. You know, to know that --
8 that we are basically closing the barn door
9 after the horse has already gotten out,
10 right? It's a waste to spend all our money
11 on preventable problems.

12 But we have to -- and we need to realize
13 that that is going to go long -- long after
14 one administration even if there's two
15 terms. This is a long term strategy. So,
16 we can't expect to see, you know, a funding
17 improved on one end and then immediate
18 results. It's going -- it's going to be --
19 this has been generations in the making.
20 It's going to take generations to undo it.
21 But we can at least start making progress.

22 And I think it's entirely possible that
23 if we were focusing on kids and families, we
24 would then have a healthier city a

1 generation from now and a less violent one.

2 MR. ROJAS: Let's say that what you laid
3 out is actually one of the biggest problems
4 that we are confronting. Looking around
5 Philadelphia, in minority communities there
6 is proliferation of mental health clinics
7 that are opening up with federal funding,
8 state funding and city funding.

9 Have those organizations are they -- is
10 there an oversight as to the kind of
11 therapeutic intervention they are providing
12 and the persons that are providing that
13 therapeutic intervention with the child and
14 the families?

15 DR. BLOOM: You know, I'm probably not
16 the best person to ask. It would probably
17 be -- you'd have to ask Dr. Evans about
18 that. I think that the department has been
19 really focused on trauma-informed services
20 for the last few years. And I think they've
21 been doing a lot to try to increase the
22 level of knowledge in all of the City
23 settings around for mental health service
24 delivery.

1 Now whether or not that has yet been
2 effective, I am not in a position to know.
3 But I think they are moving in the right
4 direction. But as I said, it takes -- this
5 is a major reorientation for anybody who is
6 delivering mental health services. They
7 have to think in a really different way
8 about what they have been doing sometimes
9 10, 20, 30 years and what they have to do
10 going forward. And it's a process of change
11 that you kind of have to undergo.

12 And our mental health system is very
13 stressed. And not -- parts of it not well
14 funded. So I don't -- I can't answer any
15 better than that.

16 Very good question.

17 COUNCILMAN JONES: One of the reasons
18 this Committee was formed was to look -- and
19 I hate using the term to look outside of the
20 box, but look inside the box where things
21 are funded and whether we should do things
22 differently. Because the reverse of that
23 question is what happens when we don't
24 intervene? And what does it cost on the

1 other end? And how much does it cost by way
2 of what does trauma cost? And what other
3 health-related symptoms happen or outcomes
4 where people are incarcerated?

5 So, you have to look at where you spend
6 those dollars and how you spend them.

7 DR. BLOOM: See, a big problem in the
8 mental health system is that there has not
9 been historically an emphasis on defining
10 outcomes. So in -- if you were a cardiac
11 surgeon, you operate. And either the person
12 lives or they don't. In mental health, it's
13 been much more of an art than a science.
14 And partly because we haven't had a good
15 explanatory framework for what the problem
16 was. You can't fix a problem if you haven't
17 defined it properly. We haven't up until
18 now defined it properly.

19 So, the outcomes we should be able if
20 somebody gets into treatment, they should
21 get better. Maybe not all the way better,
22 depends on all the other factors that are
23 involved in what's happened to them. But
24 they should be better than when they came

1 into treatment. Something should have
2 changed. But we -- but the mental health
3 system is not accustomed to looking at
4 change. Looking at how much has the person
5 really recovered. What do they say about
6 their level of function? So, that's a huge
7 shift for a system that's not really been
8 held accountable for outcomes before.
9 Because we've been so unclear about what the
10 outcomes are supposed to be.

11 Now it's a lot clearer. And in our
12 program which closed in 2001, that was the
13 main criteria that we used is did the person
14 change when they were us. Was short term.
15 It was a short term program. Only lasted
16 like a week or two weeks. But during that
17 time, did something change? And if it
18 didn't, then what did we not do right?

19 Because people are -- we are possible
20 agents of change for our whole lives. My
21 father is 101 and he's still learning
22 things. So, we can change forever. And if
23 we're not changing, then something is
24 keeping us fixed in place. And so, the

1 system should be ultimately held responsible
2 for that. But we are in a -- in a learning
3 curve. And -- and I think sys -- the mental
4 health system is struggling to figure out
5 what does that look like? How do we measure
6 it? What does it mean? Is it real? Is it
7 scientific?

8 MR. ROJAS: You mentioned something at
9 the very beginning about the role that
10 racism possibly plays in this. Is that
11 institutional racism, or is that individual
12 racism?

13 And how do we address the -- if it's
14 institutional, how do you address the
15 institutional racism of the mental health
16 community as it relates to providing
17 services to a community that's culturally
18 different? Because different people get
19 treated differently.

20 DR. BLOOM: Well, racism is another
21 really broad subject. And it can be
22 individual. And certainly, we know that
23 it's been a part and parcel of our --
24 historically, of our national structure.

1 So -- and we're trying to undo it, get away
2 from it, stop it, prevent it in all kinds of
3 ways. But I don't -- I think that's what's
4 most important probably is in every place,
5 we are able to have conversations about it
6 which don't happen that much. Meaningful
7 conversations about what people experience
8 who are discriminated against often don't
9 happen in workplace settings.

10 People are scared. Scared to have the
11 conversations. Scared of where it might go.
12 Scared of what it means. And I think we
13 have to have those conversations about what
14 it means and how it affects people. And
15 we -- you know, I think that that's --
16 that's such a big -- it's a such a big thing
17 for us in our City because we are so
18 diverse. And there is so much that's built
19 into the structure that people don't intend,
20 but now it's there.

21 And we have to -- we have to do
22 something to level the playing field. And I
23 think the way -- in many ways, the way to do
24 that is by funding the people who are most

1 discriminated against. And those are likely
2 to be people who live in pretty profound
3 poverty and who have been subjected to many
4 generations of racism. And their -- their
5 social norms are what we have been talking
6 about. So, how do we shift that? How do we
7 prioritize the most traumatized
8 neighborhoods, the most traumatized people
9 and get their families they help they need?

10 I think there is a lot we can do to
11 dismantle it.

12 COUNCILMAN JONES: Thank you so much
13 very much.

14 DR. BLOOM: You're welcome.

15 COUNCILMAN JONES: Are there any other
16 questions for this witness?

17 Seeing none, thank you.

18 DR. BLOOM: Thank you.

19 COUNCILMAN JONES: It was so
20 informative. And we may have to reach out
21 and tap your expertise again.

22 DR. BLOOM: You betcha.

23 COUNCILMAN JONES: Thank you.

24 Will the clerk please read the next

1 witness to testify.

2 THE CLERK: The next witness is Kirk
3 Heilbrun.

4 COUNCILMAN JONES: Thank you for your
5 patience. Please approach the Witness
6 Bench. Who else do we have?

7 THE CLERK: Second panel is Ashley
8 Sawyer and Angel Flores.

9 COUNCILMAN JONES: If you'd like, you
10 can come up to behind the bar so that the
11 distance won't be so long for you.

12 Please come in. Have a seat. Bring the
13 mic to you. State your name for the record
14 and begin your testimony.

15 (Witnesses approach Table.)

16 Good afternoon.

17 DR. HEILBRUN: Good afternoon, sir. My
18 name is Kirk Heilbrun. I'm a psychologist
19 and a professor at Drexel University. Very
20 pleased to be here. Thank you for the
21 invitation.

22 COUNCILMAN JONES: Pleased to have you.
23 Please begin.

24 DR. HEILBRUN: All right. Well, I have

1 a brief two-page handout. Don't have any
2 slides for folks. But as I was thinking
3 about what I might say during my testimony
4 this afternoon, and I particularly
5 appreciate my colleague Kevin Bethel who was
6 kind enough to extend the invitation to me,
7 I thought in the beginning that what I might
8 do is talk a little bit about some
9 evaluations that I do as a psychologist for
10 the juvenile courts. But then I decided
11 that that was not going to be quite so
12 interesting. And I thought I might broaden
13 the focus of this little bit.

14 I'm pleased that I did because I had the
15 opportunity to listen to Dr. Bloom's
16 testimony. And I think what I'm going to
17 have to say over the next few minutes is
18 going to be very consistent with the kinds
19 of things that she's talking about, although
20 she talked about one part of what I am going
21 to describe a bit more broadly.

22 So, what I would like to say after
23 thanking the Special Committee on Criminal
24 Justice Reform for the invitation to speak

1 to you this afternoon, is I am going to be
2 talking about ten things that I think
3 policymakers could do to reduce the risk of
4 crime and violence in our adolescents.

5 And so, what I will do is describe this
6 in the context of two important
7 constituencies. One of those are the
8 individual kids and their families.
9 That's -- that's a consideration for me, an
10 important consideration. But the other
11 constituency is our community and sort of
12 the issue of public safety more broadly.
13 And these are two kind of ends of the
14 spectrum. And there is always a balance
15 that needs to be struck.

16 And so, one of the things I am going to
17 try to do in my comments here is strike that
18 balance so that I am talking about what's
19 important to kids and their families, but
20 I'm also talking about what's important to
21 communities and the issue of public safety.
22 So, let me see if I can describe ten things
23 that I would offer to you as suggestions in
24 your role as policymakers.

1 And one of the considerations here is
2 that this -- these are not the first thing
3 ten things that occurred to me off the top
4 of my head. What I have tried to do here is
5 talk about what the behavioral science,
6 which I represent in part in my role here as
7 a psychologist and a researcher and a
8 scholar, what that would offer to
9 individuals. What I am trying to do is give
10 you a list of ten things that would make the
11 most sense. If I were to talk about what
12 the science -- the behavioral science tells
13 us in terms of what we might do, what you
14 all might do as policymakers to reduce the
15 risk of crime and violence. So let me talk
16 about this a bit if I could.

17 Number one is to adopt a public health
18 perspective. Now you heard Dr. Bloom for
19 the last hour or so talking about trauma and
20 various other kinds of things. And what she
21 was really doing in some very important ways
22 is speaking as someone who approached things
23 from a public health perspective. When I
24 say that, even though I'm a psychologist.

1 I'm not a -- I don't have a MPH. There is
2 an important consideration about what you're
3 doing when you adopt a public health
4 perspective. That is, in particular, you
5 look at crime and violence not as something
6 that evil people do or something like that.
7 Instead, though, you look at it -- you look
8 at it as a public safety, a public health
9 problem.

10 And so, one of the things that you can
11 do when you do that is to talk about what we
12 call risk factors and protective factors.
13 And risk factor basically is an influence
14 that occurs as a result of -- or an
15 influence that occurs. And when it is
16 present, it increases the risk that this bad
17 outcome will occur. There are different
18 kinds of outcomes, of course. I mean, you
19 can talk about crime and violence as one.
20 You can talk about heart attacks or cancer
21 or other kinds of public health problems, as
22 well.

23 But -- so one consideration is risk
24 factor. And a protective factor is just the

1 flip side of a risk factor. Something that
2 when it is present reduces the risk that
3 crime and violence will occur. And so, one
4 of the things that we can really talk about
5 doing then is to speak about some risk
6 factors that basically are what we call
7 static. They don't change.

8 If you spoke about -- not necessarily
9 the case, but if you spoke about gender,
10 that does not change as a risk factor. On
11 the other hand, there are some things that
12 do change. What we call them are dynamic
13 risk factors. They are malleable. They are
14 things that can be done differently.

15 And so, what we can do here as
16 policymakers if you make the right kinds of
17 intervention or as intervention agents is
18 that you can reduce the strength of a risk
19 factor. And over the course of a kind of
20 broad period of time, interventions, you can
21 actually reduce the risk of crime and
22 violence.

23 So if you were to think about this from
24 a public health perspective, then one of the

1 things you would be asking is what are the
2 malleable dynamic risk factors associated
3 with adolescent crime and violence. And
4 then secondly, once you have identified
5 those, what could you do to reduce those --
6 the risk of that kind of thing occurring?
7 And you would also from the public health
8 perspective ask the question, what are the
9 protective factors? What can we do to -- to
10 kind of strengthen people's outcomes and
11 approaches and so on? And if you do that,
12 then that also reduces the risk of crime and
13 violence.

14 The other thing that you can do from a
15 public health perspective is you can think
16 about kids who are at different levels of
17 risk. Low risk, somewhere in the middle
18 moderate risk, and then high risk. Now
19 there are different things that go into
20 creating this kind of risk level. And one
21 of the things is the number and strength of
22 risk factors and protective factors that are
23 present. But your interventions can be
24 keyed to an individual's risk level.

1 I heard a question earlier about should
2 we be investing resources in -- in preK and
3 kindergarten and those kinds of
4 interventions. And if we were able to do
5 that, then the question really would become
6 could we take kids who otherwise might
7 become moderate or high risk and keep them
8 at a relatively lower risk level. So that
9 would be number one is think like a public
10 health individual when you are making
11 policy.

12 The second thing has to do with making
13 policies developmentally informed. One of
14 the things that we now know as psychologists
15 and psychiatrists and other people who study
16 developmental scientists study adolescents
17 is that what parents intuitively have known
18 over the years, which is kids are different.
19 They are much -- were much better at
20 identifying how they are different and the
21 extent to which they are different and so
22 on. And there are some particular ways
23 related to crime and violence that
24 adolescents are different. And I have

1 jotted a few of these down here.

2 One is that kids are much more
3 influenced by their peers. And so if you
4 happen to have kids who are spending time
5 with peers who are antisocial and themselves
6 inclined to crime and violence, then you
7 have a kid who is going to be influenced in
8 that direction. Kids are much more
9 impulsive than they will be when they --
10 when they are later in their lives starting
11 in early to mid 20s. They take risks much
12 more than they will later in their life.
13 Even though they don't have a problem
14 recognizing risks in the same way that
15 adults do, they just don't act on that
16 recognition. They weigh risk and rewards
17 differently.

18 And then the other thing about policies
19 that are developmentally informed, the
20 majority of adolescents age out of being at
21 greater risk for crime and violence. And
22 when we say that, what we mean is there is
23 something called the age crime curve.
24 Meaning, basically, that the highest risk

1 for violence and offending are between the
2 ages of 15 and 24. And even for kids who do
3 pretty seriously wrong stuff in terms of
4 offending and being violent around those
5 ages, the majority of them will not continue
6 to do that as adults. So the question is,
7 what could we do as policymakers to speed
8 that distance along.

9 The third thing is that we can as
10 policymakers do things that are important in
11 schools. One of the things that we can do
12 in particular is to address the problem of
13 bullying. We can discourage and reduce the
14 incidence of bullying in our schools. And
15 if we can do that, that's a really important
16 consideration. It's one of the biggest
17 problems in our schools in terms of
18 aggression.

19 We can strengthen the effectiveness in
20 recognizing things like problem behaviors
21 and learning disorders and the kinds of
22 things that Dr. Bloom talked about earlier,
23 which is kids who are at high risk for
24 trauma who have themselves been traumatized

1 and things like that.

2 Another important consideration is how
3 well we can retain kids in our schools.
4 There are policies in some schools knowns as
5 zero tolerance. Which is -- basically means
6 that if you do something no matter how
7 minor, you can get yourself removed from the
8 school by suspension, out-of-school
9 suspension or expulsion. And that is a big
10 problem for our youth. Because once you are
11 out of school, your risk of a variety of bad
12 outcomes, including dropping out of school
13 entirely and some other things, goes up
14 considerably.

15 So if we were to take seriously the idea
16 that we are not going to have zero tolerance
17 policies but instead formal threat
18 assessment policies with graduated outcomes.
19 So depending on the severity of the threat
20 and the genuineness of the threat, we might
21 do something sort of at the last kind of --
22 the sort of thing where we would remove kids
23 only as a last resort. But instead, what we
24 do is we would increase the risk for justice

1 involvement, increase the risk for school
2 drop out if you actually have kids who are
3 leaving schools.

4 And then finally, the more kids who
5 complete high school and possible go on to
6 do job training jobs or college, the better
7 off they are going to do.

8 Number four is families. The better we
9 can do with families, the more you are --
10 you are doing much better with kids in terms
11 of reducing the risk of crime and violence.
12 And I have mentioned some ways on here that
13 you might strengthen families and reduce
14 dysfunction having to do with parental
15 management, abuse and neglect, conflict,
16 more modeling and a parent who is
17 overwhelmed.

18 Families keep coming up over and over
19 and over again in terms of youth who are --
20 have problems with being just as involved,
21 have problems with being violent. The more
22 you can do in terms of doing a
23 community-based family-based intervention,
24 the better it works out typically what the

1 science shows.

2 Substance abuse is something that's
3 number five that comes up again over and
4 over. We, pretty much as a society, known
5 for many, many years that drugs and alcohol
6 are a problem. I'm here to tell you today
7 that the science is very strong on saying it
8 continues to be a huge problem. And the
9 better we can do with keeping it out of
10 kids' hands, the better we will do in terms
11 of reducing the risk of crime and violence.

12 There are under number six some personal
13 characteristics. And unfortunately, the
14 general public tends to think of number six
15 as the main kinds of considerations that
16 reduce crime and violence. They are not the
17 main ones, but they are on the top ten list.
18 So, kids who have personal problems with
19 anger management, with impulsivity, with
20 things like ADHD or criminal thinking, those
21 are some of the things that you can
22 recognize those and see that those are
23 addressed in various ways. And when a kid
24 needs that kind of intervention, that can be

1 very helpful.

2 Number seven you have heard about for
3 the last hour, so I won't belabor it, but it
4 is on the top ten list. It's an important
5 consideration.

6 Number eight, is pro-social activity.
7 And this basically has to do with modeling.
8 The more you can get kids involved not --
9 outside of the classroom. But the more you
10 can get them involved with things like clubs
11 and sports and other sorts of things where
12 there are other pro-social youth around and
13 there are responsible adults there as well,
14 the better you are going to be doing.

15 One of the things that I came to
16 appreciate more about my own high school
17 years when I started seeing kids who are
18 juveniles is to recognize that I had a lot
19 of opportunities to be on sports teams, and
20 clubs and other sorts of things. And most
21 of the kids that I evaluate in the juvenile
22 justice system don't have those kinds of
23 opportunities. So the more they do, the
24 more a kid tells me that he likes to play

1 basketball, that he's on the football team,
2 that he's on this sort of club and so on,
3 the more I check that off as this is really
4 good. Keep it up. Keep it going.

5 Number nine is not going to come as a
6 surprise to anyone. But the more community
7 disorganization there is, the more violence,
8 the more poverty, the more problems we have
9 with kids who just are going to continue to
10 see that as a big problem.

11 And then finally, if you look at the
12 things, particularly number eight, number
13 nine, number seven and so on, if you look at
14 kids having some sort of reason to hope and
15 it's not there, that's a big problem. It
16 doesn't have to be anything in particular.
17 It could be very various kinds of thing.

18 If you are talking about responsible
19 adolescents or, excuse me, responsible
20 adults outside of the family taking an
21 interest in kids whether it's a teacher or
22 coach, big brother, a minister, Rabbi, Imam,
23 those are individuals who can make a big
24 difference in a kids' life. Even public

1 figures who are good models from various
2 kinds of areas, if you ask about those
3 individuals and get a kid to pay attention
4 to someone who is basically doing well and
5 lays it out there and has a foundation and
6 talks about these sorts of things, then
7 these are considerations that are important
8 to kids.

9 But the bottom line is and, number ten
10 and maybe this shouldn't be number ten but
11 it's definitely on the list, is give this
12 kid who is potentially at risk for crime,
13 for violence, give this kid a reason to hope
14 and a reason to think pro socially rather
15 than antisocially.

16 Those are my top ten. I thank you for
17 very much for your attention. And I'd be
18 happy to take any questions you might have.

19 MR. PODJUSKI: I do a lot in the adult
20 world in terms of -- oh, Rich Podjusk.

21 I do a lot in the adult criminal justice
22 world in addressing criminogenic needs and
23 looking at offenders from a risk and a needs
24 perspective. And we do a lot in terms of

1 targeting those -- those interventions, a
2 lot of the things you talked about.
3 Targeting the interventions to the highest
4 risk individuals.

5 DR. HEILBRUN: Yes.

6 MR. PODJUSKI: We use to help us
7 identify, we use actuarials that give us the
8 ability to not only assess risk but to
9 identify need.

10 Do you know of any -- any -- any
11 specific actuarials that we could use on a
12 juvenile population to not only help us
13 identify youthful offenders or youths who
14 are at risk, but to help us identify what
15 interventions that they may -- they may, in
16 fact, need?

17 DR. HEILBRUN: Yes. First of all, in
18 your question you talked about risk and
19 needs. And that's part of a larger theory
20 known as R&R, Risk Need Responsivity.

21 MR. PODJUSKI: Right. R&R.

22 DR. HEILBRUN: And so one of the things
23 that you mentioned is using an actuarial
24 approach to identify risk level. And one of

1 the things that the science tells us
2 particularly over the last 20 or 25 years is
3 that we have done a pretty good job of
4 getting better at identifying kids who are
5 at higher risk. So relative to 20 or 30
6 years ago, we were -- we are really doing
7 much better right now at saying this is a
8 high risk kid. This is a low risk kid.
9 This is somewhere in between.

10 However, I use the word or the term
11 guardedly because when I said pretty well,
12 what I mean is that we have gotten up to a
13 certain point, but I don't think we're going
14 to get much higher in terms of saying this
15 is a -- this is a level of risk where we can
16 be real precise about this. We're pretty
17 good at saying this is a high risk kid, low
18 risk kid. The important thing, though, is
19 not combining that risk level with those
20 needs that you talked about.

21 And you mentioned you did a lot in the
22 adult system in terms of intervening for
23 criminogenic needs. If I can describe a lot
24 of what I talked about here, these basically

1 are criminogenic needs. And so, what I
2 would say is that we don't have to be hugely
3 precise about what exactly the number is and
4 so on. What I did was I did my best to
5 identify the things that are the strongest
6 dynamic risk factors that we can focus on.
7 And I put those on this top ten list. Now,
8 there are some others, as well.

9 But I think if we were able to, say,
10 focus on the strongest dynamic risk factors
11 not only for kids who are already just as
12 involved, but going back earlier into their
13 lives, going back into their communities,
14 going back into their families, going back
15 into their preschool years and things like
16 that, that would be helpful. And if you did
17 that consistently over a period of time,
18 then what you would find in a community, the
19 science tells us is those levels dropping.

20 MS. BRADFORD-GREY: Thank you, Doctor.

21 I think one of the things I really took
22 from your presentation was when you talked
23 about the high risk youth offenders being
24 between the ages of 18 and 24.

1 DR. HEILBRUN: Ah, 15 and 24.

2 MS. BRADFORD-GREY: Very good. Even
3 better. I think that that strikes me.
4 Because obviously in our criminal justice
5 system, what we are talking about we
6 consider an 18 year old an adult.

7 DR. HEILBRUN: Yes.

8 MS. BRADFORD-GREY: And they are
9 treated, generally, like an adult for
10 behaviors that they display and things that
11 they do that they commit. I know across the
12 country there are several states exploring
13 the option of a young adult court, per se,
14 for that age level where their brains still
15 haven't quite developed, but they are at
16 risk of more or they are kind of the ones
17 that are demonstrating the more risky
18 behavior because they have a little more
19 freedom and flexibility. They have the
20 ability to do things like drive a car or do
21 certain things that the younger kids do not.

22 What have you -- have you looked at any
23 of the research around creating courts that
24 have certain rehabilitational aspects to it

1 such like the juvenile system, per se,
2 that -- that deal with kids between the ages
3 of 18 and 24? And what do you suggest, what
4 have you noticed about those courts? Or
5 what have you -- what information have you
6 derived as to whether or not those are good
7 models to use to kind of stop this behavior
8 level so that, you know, as they grow older,
9 their risk factors go down.

10 DR. HEILBRUN: Yes. That's a really
11 good question. One of the things that just
12 appeared in the last month in the New York
13 Times is an article by one of my colleagues
14 from Philadelphia, a gentleman by the name
15 of Larry Steinberg, a developmental
16 psychologist at Temple. I see some heads
17 nodding around the room.

18 And the topic was what do we think about
19 the idea of increasing that age of 18 to
20 have the juvenile system kind of expand to
21 cover more of those 19, 20, 21 year olds, 18
22 year olds and so? Interestingly enough,
23 considering that Dr. Steinberg has been a
24 strong proponent of kids are less culpable.

1 His perspective in that article was do not
2 do this. Do not take the juvenile justice
3 system which is kind of set up as you
4 described for 14, 15, 16, even 17 year olds
5 and drop a number of 18, 19, 20, 21 year
6 olds in it. Instead he said, but recognize
7 that they are still somewhat different than
8 young men and young women up to the age of
9 22, 23, 24.

10 And so, take a part of our -- probably
11 our adult criminal justice system and
12 develop something that has the prospect for
13 working with those individuals, individuals
14 between the ages of 13 and 22. And one of
15 the things that we might do is look at the
16 problem solving court model, which has been
17 really interesting and quite successful in
18 some important ways.

19 So, we have mental health courts. We
20 have drug courts. We have Veterans courts.
21 We even have some juvenile problem solving
22 courts. Now, I think this is generally a
23 good idea. But one of the things about
24 problem solving courts is that they tend not

1 to focus on the highest risk or the most
2 serious offenders. And so, that would be
3 one of the considerations that we would have
4 to be real careful about. If you set
5 something up like that, is that you couldn't
6 take young offenders -- 18, 19, 20 year olds
7 -- who had been charged with armed robbery
8 and carried a weapon and put them in that
9 problem solving court. It would be -- that
10 would be a difficult thing for a community
11 to handle, I think. But there are a number
12 of individuals who are still at that age who
13 might actually be much more appropriate for
14 problem solving court.

15 MS. BRADFORD-GREY: One of the models
16 around the country is not necessarily a
17 problem-solving court, per se, but it is a
18 young adult court that recognizes on the
19 probationary end or whatever disposition
20 that a youth -- and I say youth -- between
21 the ages of 18 and 22 --

22 DR. HEILBRUN: Yes.

23 MS. BRADFORD-GREY: -- could get more
24 services related to rehabilitation, as well.

1 So it wouldn't be that they are going
2 through our traditional types of
3 diversionary programs if they have committed
4 certain offenses. However, we are
5 recognizing that there are some
6 developmental or rehabilitational
7 programming that could be utilized so that
8 this young adult does not end up
9 systemically in the system. And we are not
10 treating them exactly like we are treating
11 adults.

12 Also, the separation of youth that go
13 into adult prisons, they have certain
14 prisons that have certain rehabilitational
15 programming that go on inside that
16 institution for our youth that are charged
17 as adults. And these are kids that are 15,
18 14 and all that. It's more of a model
19 recognizing bringing more rehabilitational
20 programming to that dispositional phase or
21 even in the beginning phase. If we are
22 going to have, like, a problem-solving court
23 for certain offenses or certain youth. But
24 it is an understanding that kids in that age

1 group are not adults. And we should really
2 stop treating them like adults, address the
3 behavior, but also put something in place
4 for the rehabilitational aspect, as well.

5 DR. HEILBRUN: Yes, I agree. That makes
6 a lot of sense. They are not adults. It's
7 true because we -- the science begins to
8 recognize full fledged adults fully
9 developed brains and so on around the age of
10 25, 26, something like that. But they are
11 also not 14, 15, 16 year olds.

12 So, you are right. There is sort of
13 another -- there is another phase in there.
14 There is another level in there that it
15 would make sense to implement some of these
16 things we've talk about that distinguishes
17 those from adults and from younger
18 adolescents.

19 MS. BRADFORD-GREY: Thank you, Doctor.

20 DR. HEILBRUN: Yes. Absolutely.

21 MR. PODJUSKI: I just want to -- I just
22 want to say your observations on a
23 pro-social activity I think is very
24 important. We find that that positive

1 reinforcement at a four-to-one ratio for
2 adult offenders seems to be the -- the right
3 number. But I guess my -- my question, I
4 guess, pertains to number six when you talk
5 about personal characteristics. I am
6 thinking about the youthful offender and
7 specifically some of our findings with
8 technical parole violators and youthful
9 offenders. They seem to exhibit the same
10 sorts of criminal thinking errors and anger
11 management problems and impulsivity. And I
12 probably add to that unrealistic
13 expectations when they're coming out of
14 prison.

15 So, how do you reconcile these sort of,
16 what I would say, you know, opportunities
17 and cognitive restructuring with trauma that
18 they may have experienced as a youth? How
19 do you -- how do you see the two influencing
20 one another?

21 DR. HEILBRUN: Dr. Bloom is a good
22 colleague, and I heard her speak a number of
23 times before. She was pretty clear in her
24 testimony that her background is primarily

1 mental health, and that she comes into this
2 from the standpoint of juvenile justice and
3 criminal justice is somewhat different.

4 And so, one consideration there is that
5 just because somebody is displaying things
6 like anger problems and criminal thinking
7 and ADHD, doesn't mean that they also didn't
8 experience a fair amount of trauma. It's
9 just that people respond differently to
10 traumatic events. And sometimes -- I mean,
11 it's interesting given how often people
12 experience adverse events and trauma and so
13 on that there is not more post traumatic
14 stress disorder. But it's not -- it's by no
15 means a hundred percent of people that
16 experience that.

17 But what can happen sometimes, and you
18 know this very well from the standpoint of
19 working with individuals in the criminal
20 justice system and the juvenile justice
21 system, is that one response to experiencing
22 trauma in someone is not so much that I turn
23 it against myself, is that I turn it against
24 you. And so, it's a difficult thing to do

1 basically. If I'm doing things, I'm robbing
2 and I'm violent and I'm doing other crime
3 and so on, for you to look at me and say,
4 you know what, I'm not entirely going to
5 look at this and say I am going to excuse
6 that behavior. But I can recognize that
7 that behavior and those habits and so on
8 began and were influenced by the background
9 and the models and some of the things that I
10 had growing up.

11 So, it's -- it's a difficult
12 consideration what you're talking about.
13 And one of the reasons that I began with the
14 kind of balance between public safety and
15 our communities and the individuals and
16 their families is if you tip too far in one
17 direction, then it doesn't quite make sense
18 anymore.

19 MR. PODJUSKI: Would you add companions
20 and antisocial behavior.

21 DR. HEILBRUN: I absolutely would add
22 companions, yes. That, of course, would
23 have been on the top ten. I did slide peers
24 in there and peers susceptibility and so on.

1 But yes, companions are in there.

2 MR. PODJUSKI: That's it. Thank you.

3 MR. ROJAS: One question. How do you
4 envision having an interface with school
5 psychologists who deal with children who are
6 at risk and people entering the criminal
7 justice system, if any?

8 DR. HEILBRUN: There is something that's
9 been called the school-to-prison pipeline.
10 And it's possible to get a lot more kids
11 involved in the juvenile justice system and
12 subsequently the criminal justice system if
13 you look at the sorts of things that they do
14 in school and say we are not going to
15 tolerate this. You are out of here, and we
16 are going to let the juvenile justice system
17 handle them.

18 Rather than doing that, if you recognize
19 that we really want for the most part to
20 keep you in school, and it doesn't matter if
21 that means we have to work harder -- and I
22 think Kevin Bethel can tell you some of the
23 things that he and some other folks are
24 doing to work harder to keep kids in school.

1 But the more we can do that, the harder we
2 can work to keep kids in school, the more we
3 reduce that school-to-prison pipeline. And
4 the more we give many kids the advantage of
5 possibly kind of working things out in a way
6 that doesn't put them at a huge
7 disadvantage.

8 So partly the answer to your question is
9 recognizing things that make it harder for
10 kids to learn, undiagnosed attention deficit
11 hyperactivity disorder, for instance,
12 learning problems, making sure that kids
13 have the opportunity to -- to look at these
14 sorts of things. And if they need
15 treatment, if they need an intervention,
16 they need an IEP, they get it. That's one
17 of the things that school psychologists can
18 really -- can really help with.

19 MR. BETHEL: All right, Doctor. I want
20 to thank both you and Dr. Bloom for
21 informing us today. I mean, part of this
22 process for us is -- I know some people may
23 get frustrated. Why you bring a researchers
24 into the room. But if we don't bring

1 research and we don't bring science and we
2 don't bring other ways of understanding what
3 we are doing, I mean, we are sitting here
4 sometimes. And it's like, hey, no kidding
5 moment. But the reality is, is we build
6 this report and we try to inform the folks
7 in the field. I think when we bring that,
8 particularly for the folks who have been
9 coming in like yourself who are on the
10 ground doing work in the field and not just
11 sitting at 50,000 feet and understanding
12 what's going on.

13 So we want -- was there a question? Did
14 I miss your question? I apologize.

15 MS. SCHWARTZMAN: That's okay.

16 MR. BETHEL: No. Go ahead. I
17 apologize. I'm closing out, but I open back
18 up.

19 MS. SCHWARTZMAN: Sorry.

20 MR. BETHEL: That's okay. I didn't see
21 the red light down there.

22 MS. SCHWARTZMAN: I am Ann Schwartzman
23 with the Pennsylvania Prison Society. I was
24 just wondering, you look at modeling as

1 something very important that makes the top
2 ten list?

3 DR. HEILBRUN: Yes.

4 MS. SCHWARTZMAN: Are you considering
5 that as mentoring? Is this something else?
6 A different kind of twist to mentoring that
7 maybe we should be looking at or how are you
8 defining that.

9 DR. HEILBRUN: I'm considering mentoring
10 to be very much a part of modeling. But
11 there are some interactions that aren't so
12 much simply modeling that are mentoring.

13 For instance, comment earlier about
14 working with people in a criminal justice
15 context. And one of the powerful kinds of
16 interventions that you can -- you can use is
17 positive reinforcement. Don't focus on when
18 somebody screws up and does something wrong.
19 When you catch them doing something right,
20 thank you very much. Well done. And that
21 sort of thing.

22 And so yes, I think modeling is one of
23 the most powerful ways of learning to behave
24 that we have. And given that we have one of

1 the most powerful ways of learning to
2 behave, we should use it in this context.

3 MS. SCHWARTZMAN: Thank you.

4 DR. HEILBRUN: Quite welcome.

5 MR. BETHEL: I think I closed it out,
6 but I will say thank you again. Thank you
7 to you both.

8 DR. HEILBRUN: Thank you all very much.
9 I appreciate the opportunity.

10 MR. BETHEL: We will going to our second
11 and final panel.

12 (Panel approaches Table.)

13 THE CLERK: Again, the second panel is
14 Ashley Sawyer, Angel Flores and also Timene
15 Farlow. If all three can come to the
16 Witness Table, please.

17 MS. BRADFORD-GREY: Ready when you are.

18 MR. BETHEL: Ashley, you want to start
19 or whomever.

20 MR. FLORES: Good afternoon. My name is
21 Angel Flores.

22 MR. BETHEL: Pull it a little closer,
23 Angel. A little bit more.

24 MR. FLORES: My name is Angel Flores.

1 I'm the Deputy District attorney for the
2 Juvenile Division here in the Philadelphia
3 District Attorney's Office. And I want to
4 thank you for the invitation to be here and
5 certainly on behalf of the District Attorney
6 Seth Williams. We welcome a chance to talk
7 about the programs that we have created to
8 reduce the number of juveniles coming into
9 the system as well as programs that we have
10 teamed up with others to lessen the impact
11 of the juvenile system on the youth.

12 There is a handout that was prepared.
13 And hopefully, you can follow along with it.
14 But one of the first places that we will
15 have to start in are the schools. The
16 schools is where we have a captive audience
17 with our young people. And that is where we
18 need to bring our prevention programs to. I
19 heard Dr. Heilbrun talk about bullying and
20 the effects of bullying that take place at
21 school and how that leads to further
22 involvement in the system.

23 District Attorney Seth Williams has a
24 bullying program, anti-bullying program that

1 he takes to the elementary and middle
2 schools so that they can discuss these types
3 of behavior openly and they can talk about
4 where that may lead to and how the
5 consequences of that are something that
6 would have to be dealt with if the young
7 people find themselves in the juvenile
8 justice system.

9 One of the other things that we do is
10 have our Assistant DAs go out to the school
11 and talk to the class. Before I was the
12 Deputy of the Juvenile Division, I was the
13 Chief of East Division where I spent an
14 enormous amount of time going to the schools
15 in that division where we have many, many
16 challenging issues there and talk openly
17 with the young people about the issues that
18 they confront and dispel many of the myths
19 that they find within the criminal justice
20 system and the juvenile justice system.

21 I don't have to tell you of the many
22 myths that exist out there. People are
23 misinformed. People are not fully aware of
24 the consequences that take place for their

1 action. Talking to a young person about the
2 crime of conspiracy and how they don't need
3 to touch the drugs in a drug transaction.
4 That all they need to be is a lookout and
5 yell certain words, that they are just as
6 culpable as the person who is actually
7 selling the drugs and educating them. So
8 that when they are perhaps put in that
9 position, that they are able to make an
10 informed decision.

11 We take great pride in going out to the
12 schools and talking to the young people.
13 It's one of the areas where you can have a
14 very open dialogue with the young people and
15 they feel that they are in their own
16 environment, so they are not intimidated by
17 us being there and speaking with them.

18 We also have supported when we talk
19 about the school setting, Kevin Bethel's
20 program for the school Diversion. We have
21 diverted through his program over 1,100
22 cases a year. Think about removing those
23 cases from the justice system and the stigma
24 attached with it. And we have had per the

1 statistics that have been shown, enormous
2 success with those programs. And one of the
3 things that I enjoy greatly about that
4 program is that we are not only dealing with
5 the young person, but we are trying to deal
6 with the environment in which they come
7 from. If there is any lesson to be learned
8 when we talk about youth offenders and
9 programs within the juvenile justice system,
10 we will only be effective if we are able to
11 deal not only with the juvenile but
12 certainly with the environment in which they
13 come from. And we have to get better in
14 that regard.

15 Tomorrow I will also be testifying
16 before a senate panel on youth courts and
17 how they are greatly a credit to our
18 schools. And when they are in our schools,
19 youth courts can be very, very instrumental
20 in avoiding the zero tolerance and removing
21 kids from the school. Because we know as
22 has been mentioned by the other two previous
23 speakers, that keeping kids in school,
24 keeping them involved is critical in keeping

1 them away from the juvenile justice system.

2 We have also partnered with a couple of
3 groups in going out and speaking to young
4 people. The youth and law enforcement
5 training where we had teamed up with the
6 Disproportionate Minority Contacts
7 Committee, going out to groups of young
8 people with law enforcement, police and
9 airing out the concerns that they have. We
10 can't hide behind the fact that there is
11 enormous issues involving young people and
12 law enforcement. And we have to do
13 everything that we can to break down those
14 barriers to deal with them head on and not
15 be afraid to call someone out.

16 One of the interesting things that I saw
17 when I went to view one of these training is
18 the role reversal. Where we have the youth
19 playing the police officer and the police
20 officer playing the youth. And quickly,
21 there was some realization of the other
22 person's position and what they were going
23 through. And I would love to see that being
24 replicated at a grander scale so that people

1 can truly appreciate the roles that they
2 play that they have.

3 We also teamed up with part of our focus
4 deterrents a program called Lace Up Speak
5 Up. And it's through our partnership with
6 the Commission on Human Relations. We take
7 some very high risk people, youth in South
8 Philadelphia, and we bring law enforcement
9 in to create that dialogue, to break down
10 those barriers and obstacles that they may
11 feel exists between them, to air them out.

12 At the end, there is this friendly game
13 of basketball to show and to humanize both
14 sides of this divide. That if there is this
15 dialogue that exists, you may not agree on
16 everything. But the more and more you
17 discuss things, you will have a greater
18 chance of finding commonality and seeing
19 things from a different perspective, as
20 well.

21 When I was asked to speak here, I was
22 excited to talk about our truancy prevention
23 program, our Project Go. I can't tell you
24 the crisis that this truancy problem is for

1 this City. When I took over as Deputy of
2 the Juvenile Division, the first meeting I
3 attended was a truancy meeting where the
4 School District was there, our colleagues at
5 DHS were there, the Courts were there. And
6 I learned that out of 144,000 students in
7 the Philadelphia School District, 40,000 are
8 truant. And when you try to digest that and
9 analyze that, it's a scary proposition.
10 Because ultimately, if our young people
11 aren't graduating, their road to success is
12 going to be very difficult, filled with
13 many, many obstacles.

14 And one of the first signs of a person
15 being delinquent is that they failed to go
16 to school. That they dropped out of school.
17 At last that I had heard, the number of our
18 Latino males that don't graduate is around
19 50 percent. The number of African-American
20 males that don't graduate is around
21 40 percent. And digest that for a moment
22 because these young people are not leaving
23 our City. They are going to remain here and
24 they are going to want exactly the same

1 thing in life that you and I want. But when
2 they lack the skills to do anything that's
3 productive, anything that can allow them to
4 go into the workforce and make meaningful
5 salary, they are going to turn to things
6 that we don't want them to turn to. And
7 that is what brings them into our justice
8 system.

9 We have to be very, very cognisant that
10 this is an enormous crisis that we have to
11 deal with. And our truancy program is
12 headed up by this amazing District Attorney,
13 Assistant District Attorney Ebony Worthem
14 who last year alone dealt with a thousand
15 truant kids with enormous success. But we
16 had a meeting recently with the courts. And
17 out of those thousands kids, we have five
18 kids going into reginal court for truancy.
19 The remaining we have made enormous progress
20 with.

21 It's a lot of hard work. You can only
22 imagine the issues that we have to deal
23 with. And when we talk about truancy, the
24 fallacy is that we are dealing with ninth

1 grader and tenth graders that just don't
2 want to wake up, right? That's what we
3 normally think about. The reality is we
4 have first graders, second graders who are
5 missing 100 days, 110 days and beyond of
6 school because their parent and their
7 guardian are dealing with very challenging
8 issues that they feel overcome -- that they
9 cannot overcome and leads to their child
10 being truant. Ebony spends an enormous
11 amount of time dealing with those families
12 and those parents, working with our
13 colleagues at DHS trying to figure out a
14 solution to deal with those underlying
15 issues.

16 Our other program that we have is the
17 Youth Aid Panel, which is an enormous
18 program that diverts about 600 cases a year.
19 And these are first-time offenders coming
20 into the juvenile justice system where they
21 admit their guilt. And I am a firm believer
22 that an individual who is prepared to admit
23 their guilt, is someone who tells me that
24 they are on the road to success. That they

1 have accepted, that they owned their
2 mistake. And when we have these individuals
3 who admit what they have done, they go
4 before a panel of community members. These
5 community members are your neighbors, are
6 your grandparents, are your students in
7 college who decided to volunteer their time
8 and enter into a contract with the youth
9 where they are able to commit to certain
10 conditions that they will have to meet.

11 Normally, it lasts about three months.
12 And if they complete their terms of their
13 contract, they will get their case
14 dismissed. And more importantly, their
15 arrest and their whole process through the
16 system expunged. You will hear me discuss
17 many of the programs where we are
18 incentivizing youth to engage in the program
19 because it leads to an expungement.

20 Reporting Consent Decrees are another
21 program within the juvenile justice system
22 that is closely akin to the ARD Program on
23 the adult side. There is no admission of
24 guilt. A person goes in there. They are

1 asked to meet certain requirements and
2 certain conditions such as restitution,
3 community service hours, stay away orders
4 from certain places or certain people. And
5 if they complete these conditions, these --
6 their case is also withdrawn, leading to a
7 very early expungement six months after the
8 discharge if they are able to stay arrest
9 free during that time period.

10 One of the other programs that we are
11 very proud of and we have partnered with
12 many great agencies and group is our drug
13 treatment court in the juvenile setting.
14 Unfortunately, as you can imagine, we are
15 seeing more and more young people who, if
16 not addicted to drugs, they are certainly
17 abusing drugs. Initially, we all think
18 about abusing marijuana. And certainly,
19 that's still one of the leading causes that
20 brings a child into our drug treatment
21 court. But we are seeing a greater trend
22 where young people are being -- have started
23 abusing prescription drugs.

24 And again, when I talked about

1 prescription drugs, no one thinks that it's
2 a problem because it's in grandmom's
3 medicine cabinet. We see it there all time.
4 Unfortunately, we are seeing a trend where
5 young people are starting to use it. We all
6 know that once you start using prescription
7 drugs, at some point that's no longer going
8 to be enough to satisfy your craving that
9 you are going to turn to something harder,
10 something much more toxic and dangerous such
11 as heroin.

12 So our drug treatment court partners up
13 with not only the courts and probation and
14 our friends at the Defenders Association,
15 but certainly institutions that deal with
16 drug addiction and -- and help it both
17 through inpatient and outpatient deal with a
18 person's abusing of drugs. Our Crossover
19 Court is something that we were instrumental
20 in developing with the courts, again with
21 the help of DHS providing services. But
22 those are courts where we have a juvenile
23 who has a dependent as well as a delinquent
24 case.

1 But the dependent situation that they
2 are dealing with outweighs the delinquent
3 case. We are comfortable that close
4 monitoring of those individuals in dependent
5 court through the crossover program is where
6 we are going to get the greater chance of
7 success for that individual. And the
8 results currently will bear that out, that
9 we have had enormous success with the
10 Crossover Courts headed up by Judge
11 Olefshevski who takes great pride in
12 ensuring that his youth who appear before
13 him are provided all the services that they
14 need to become successful.

15 And finally, the last program that I
16 wanted to talk about is one that is fairly
17 in its infancy. It's called WRAP Court.
18 Working to Restore Adolescent Power. And
19 it's a pilot program that deals with young
20 individuals who have been identified as
21 victims of commercial sex exploitation or
22 human trafficking.

23 Currently, we had 23 individuals in that
24 program. The more and more we learn about

1 human trafficking and sexual exploitation,
2 there is a sense that there is a greater
3 population than what we see here currently
4 in Philadelphia. And we got to learn how to
5 identify these young people so that we are
6 able to address their needs.

7 So, we are doing all of these things
8 with the hope that we are able to steer
9 people away from the juvenile justice
10 system. And if they are in the justice
11 system, that we don't graduate to the
12 criminal justice system. One of the things
13 that we are very mindful of are the fact
14 that young people will make mistakes. One
15 of the things that I always try to stress to
16 them when I go speak, is that mistake should
17 not be there to define who they are. It's
18 how they work their way out of the mistake.

19 We are a firm proponent of using the
20 expungements. We will try to induce certain
21 cases for an individual to admit and work in
22 an expungement. We believe that ultimately
23 if they have that to work towards, that that
24 would be a greater incentive for them to

1 stay on the straight and narrow and avoid
2 reentering the justice system.

3 So, thank you for giving us this
4 opportunity to speak before you. We welcome
5 partnering with whomever in order to prevent
6 our people from coming into the justice
7 system whenever possible.

8 MR. BETHEL: We will let you all each
9 start testifying. And if there is any
10 questions for anyone in the group, we will
11 do that. Thank you. Thank you, Angel.

12 You deferring to Ashley? She's the
13 young one in the group, so -- she's supposed
14 to go last, but we will let her jump in
15 there. I'm just having fun. Come on,
16 Ashley.

17 MS. SAWYER: Good afternoon. My name is
18 Ashley Sawyer.

19 MR. BETHEL: Pull it up a little bit
20 more, Ashley.

21 MS. SAWYER: My apologies. Is this
22 better? Great.

23 Good afternoon. My name is Ashley
24 Sawyer. And I am a Stoneleigh Emerging

1 Leader Fellow and an attorney at the
2 Education Law Center. Thank you very much
3 for giving me the opportunity to speak to
4 your Committee. And thank you very much,
5 Mr. Bethel, for the opportunity.

6 I just want to give you a little bit of
7 background about my understanding of these
8 issues. For the past 21 months, I have been
9 doing direct representation, policy
10 advocacy, some site visits of juvenile
11 justice facilities and the juvenile justice
12 system as it pertains to youth with special
13 education needs and youth -- the education
14 rates of youth generally.

15 Education Law Center mission is to
16 ensure quality education for all students in
17 Pennsylvania. And that includes the most
18 vulnerable groups of students, particularly
19 students who are in the juvenile justice
20 system, students with disabilities, students
21 exploring homelessness. Many of those
22 students are the ones that end up in the
23 juvenile justice system.

24 So throughout the past year and a half

1 of my fellowship, I met a number of students
2 who were already in the juvenile justice
3 system who are incarcerated or who are
4 recently incarcerated. And there is some
5 pretty consistent trends along the lines of
6 trauma and their needs, mental health needs
7 and special education needs.

8 The national data is pretty telling.
9 About 75 percent of the youth in juvenile
10 justice system have either a special
11 education need or diagnoses. And sometimes
12 same we overlap or conflate mental health
13 needs with special education. But special
14 education services are those entitlements
15 that student have once they have an
16 individualized education plan or an IEP.
17 And many of those needs are coming out as a
18 result of mental health needs that were not
19 met.

20 We also know that a very
21 disproportionate number of the students who
22 end up incarcerated have an emotional or
23 behavioral disorder that was not addressed.
24 And in Philadelphia, the students that I

1 have worked with, I met with one young man
2 who is in his late teens and who does not
3 know how to read. I met him in juvenile
4 court. And it was very clear to me that the
5 acting out and the behaviors that he had
6 that got him suspended and expelled over the
7 years were very much a response to his
8 embarrassment about not being able to read.

9 In addition, I met a student who was
10 incarcerated in one of our state secure
11 facilities from Philadelphia originally.
12 And he was there initially for a very, what
13 I considered to be a smaller or minor
14 offense. But the special master on his case
15 felt that he should stay in placement to get
16 a high school diploma, which goes against
17 the expectations of the Juvenile Act, but it
18 also goes against the clear data which
19 indicates that a longer a student is in
20 placement or in a juvenile justice facility,
21 the more likely they are to reoffend and the
22 more harm it has on them mentally and
23 emotionally.

24 That young man was very much harmed by

1 being away from his mother, his siblings.
2 And we know the data is very clear when you
3 disconnect a person from their community and
4 their families, the trauma is exacerbated,
5 and it also increases their likelihood of
6 reoffending.

7 Overall, the students that I have worked
8 with have been failed by their schools at
9 every turn. There is really no nicer way --
10 there is not a very nice way to put that.
11 And the challenges that these students face,
12 excuse me, are often a byproduct of
13 inadequate funding and resources for the
14 schools that they attended prior to system
15 involvement. I don't think that's a
16 surprise.

17 And I think that we need -- as we are
18 working on interventions around the criminal
19 justice and the juvenile justice system,
20 cannot ignore the ways that the
21 school-to-prison pipeline continues the
22 involvement of our students. So, I also
23 want to sort of highlight a couple of really
24 important policy issues that are influencing

1 the recidivism that are related to the
2 trauma that we spoke about earlier today,
3 and that are about affecting the outcomes of
4 our very vulnerable groups of students.

5 First, we should be mindful of the very,
6 very low graduation rates for the youth who
7 are in the juvenile justice system. The
8 juvenile justice system, particularly
9 incarceration placement, is not improving
10 their education outcomes contrary to what
11 some might think. It is not making them
12 better or less likely to reoffend. It's
13 actually putting them in a position where
14 they are more likely to never graduate and
15 to end up in the criminal justice system.

16 Second, I think it's important for us to
17 think about the ways that incarceration
18 specifically deprives students of quality
19 education and increases their chances of
20 reoffending. So currently, juvenile
21 probation lets me know that there are about
22 800 young people who are incarcerated from
23 Philadelphia. So throughout the state,
24 obviously, there are more. But from

1 Philadelphia County, there are about 800
2 young people which is a great improvement
3 from years past, but it's still very
4 startling particularly given what we know.

5 According to the Federal Government,
6 only about 27 percent of the youth in our
7 juvenile justice system get a high school
8 diploma. So that's less -- that's almost a
9 quarter of them get a high school diploma.
10 And the rest do not. A recent study by
11 Brown University and MIT found that
12 nationally only about -- students who go
13 into placement are 39 percentage points less
14 likely to graduate once they go to a
15 facility.

16 So understanding that even if a student
17 has been adjudicated delinquent, that does
18 not necessarily mean we have to incarcerate
19 them. There are other ways that we can try
20 to meet their needs. But we find that when
21 we do make the decision to send them to
22 placement, and I use the term incarceration
23 to describe placement as well. When we do
24 that, we often are doing more harm for their

1 education outcomes. And I imagine the
2 myriad of other outcomes. But I will speak
3 specifically about education.

4 We look locally. CHOP Policy Lab did
5 their Project U-Turn Research. Students
6 across the City have improved their
7 graduation rate. Two groups of students
8 have not. Youth in the juvenile justice
9 system and pregnant and parenting students.
10 We are seeing that youth in the juvenile
11 justice system are particularly vulnerable
12 and they are being left behind. So, we need
13 to do a better job of keeping them out of
14 the system, otherwise they will be filling
15 our adult jails.

16 I just want to really emphasize that
17 these are our most educationally vulnerable
18 youth. And many of them have experienced
19 trauma. So while they have committed what
20 we consider to be a delinquent act, over the
21 course of their lives they have witnessed
22 and been victims of trauma on numerous
23 occasions. And the way that they respond to
24 trauma may not be the way that we would like

1 or expect. But yet, they are still very
2 vulnerable groups of children.

3 In 2014, the US Department of Education
4 and Department of Justice released federal
5 guidance specifically around the education
6 needs and rights of youth in the juvenile
7 justice system. Many of those
8 recommendations are very applicable in
9 Pennsylvania. That guidance package in
10 incredibly detailed. One of the first
11 things that we need to be thinking about are
12 memorandums of understanding between our
13 state juvenile justice agencies and our
14 education agencies so that we are not
15 working in silos.

16 What I have come across is that the
17 Pennsylvania Department of Education doesn't
18 focus particularly on youth in the juvenile
19 justice system. And our JCJC, Bureau of
20 Juvenile Justice Services or juvenile
21 justice agencies are focusing on the
22 criminogenic needs of our youth almost to
23 the exclusion of education. So, there is no
24 understanding about how we are going to

1 ensure that these incredibly vulnerable
2 groups of students are getting everything
3 that they need. And we also need to make
4 sure we are having adequate monitoring.

5 Just a couple things to be mindful of.
6 The students who are incarcerated in
7 Pennsylvania generally very behind, several
8 grade levels behind when they get there.
9 The facilities that I have seen and that I
10 have read about and that I have visited and
11 met with other students to talk about as
12 well as reviewed many of assessments are
13 available, they perform very poorly. Very
14 few certified teachers.

15 I recently visited a facility with --
16 and I won't give too many details. Let's
17 just say they did not have -- they only had
18 one certified teacher and they had several
19 hundred students there. So, it's something
20 that we should be mindful of.

21 The class time in those facilities is
22 shortened. It's not a full amount of time
23 that a student would receive if they were in
24 a traditional public school. Several

1 facilities that I visited only do
2 software-based learning or worksheets. So
3 if a student has a special education need
4 and they are entitled to differentiated
5 learning, I can't really see how that would
6 be happening if everyone is doing a packet
7 and working on the same thing.

8 Credits are not transferring in a timely
9 fashion. I met a young man here in
10 Philadelphia, came back from placement
11 confident that he was ready for a high
12 school diploma only to find out that he had
13 never taken Biology and he could not get
14 that high school diploma. So, you can
15 imagine how defeated he might have felt as a
16 result of the systems not coordinating well
17 enough to make sure he got things he needed.

18 We spent close to \$265 a day per kid
19 with a special education need when we send
20 them to a juvenile justice facility. And we
21 don't have a lot in place to make sure that
22 we -- those facilities are doing what they
23 are supposed to. I'm really excited to be
24 working with Ms. Timene Farlow to implement

1 an education assessment tool whereby DHS can
2 begin to look at what facilities are
3 providing with regard to education and think
4 long term about who we will contract and who
5 we will work with to ensure that we are only
6 working with providers who really are
7 providing quality education for our
8 students.

9 But the most important things, as I will
10 wrap up, we want to keep our kids out of
11 those facilities. So while it's important
12 to be assessing the quality of education if
13 a student is in one of those facilities and
14 making sure that we are providing
15 accountability for those providers, it is
16 way more effective to educate them in their
17 community then it is to try to educate them
18 when they are in some remote part of the
19 state, western part of the state in a
20 facility separated from their community and
21 their family. The State of New York has
22 moved towards keeping kids closer to home
23 because it's more effective. We also know
24 that the Federal Bureau of Prisons keeps in

1 mind that when people are able to make
2 contact with their family, the people who
3 love them, they are less likely to reoffend.
4 They are more likely to be successful, so we
5 should be doing the same thing for our
6 children in Philadelphia. And we
7 shouldn't -- we should not be overlooking
8 them.

9 We spent -- the School District of
10 Philadelphia spent \$64 million in their most
11 recent audit on outside institutions.
12 That's not just juvenile justice. That's
13 dependent providers as well as special
14 education providers. But that's a huge
15 chunk of that was also juvenile justice. We
16 are spending a great deal of money to
17 educate our kids outside, but not
18 necessarily looking at ways to keep them in
19 the community and provide the best quality
20 education for them here or looking to make
21 sure that the places that are providing
22 education are doing the best that they can.

23 So again, I want to emphasize as people
24 have said before, closing or dismantling

1 that school-to-prison pipeline, reducing
2 suspensions, expulsions, transfers to
3 alternative education for disruptive youth,
4 those suspensions and expulsions have a
5 direct correlation with the likelihood that
6 the student will end up in the juvenile
7 justice system. So to the extent that we
8 can eliminate those, we have an opportunity
9 to prevent losing our kids.

10 We need to utilize antiracist,
11 culturally competent, restorative justice
12 practices so that a little bit of extra work
13 keeping that student in school and
14 responding to trauma, giving them support
15 services and giving them whatever tutoring
16 they need will be much more effective and a
17 much more productive use of our time as well
18 as more helpful for our students than
19 incarcerating them or kicking them out of
20 school.

21 And if we do find that we have to
22 adjudicate a child delinquent, using
23 placement as the last and only last resort
24 is the better way to go because the students

1 who are being sent away are not coming out
2 better particularly around education. They
3 are actually more harmed. The education is
4 more harmed by being sent away. We have to
5 invest seriously in community-based
6 placements just at the first glance at the
7 outcomes of PYAP, or the Philadelphia Youth
8 Advocate Program, those outcomes are a lot
9 better than the outcomes we are seeing in
10 our long term juvenile delinquency
11 placement.

12 So, we should be utilizing the programs
13 that we know work effectively keeping kids
14 in the community, and at no greater risk to
15 the community I might add. And taking time
16 to think critically about how we can utilize
17 our community-based placement so that
18 students can continue to be educated here in
19 the School District of Philadelphia.

20 So, thank you very much for giving me
21 the opportunity to present. And once my
22 time has come, I will be happy to answer
23 questions.

24 MR. BETHEL: I want you all to write

1 down Ashley Sawyer's name because she is
2 going to be a power. And I see the
3 acknowledgement of your mentor over there to
4 your right sitting there with much pride in
5 her face when you are talking. So, I will
6 transition over to you, Timene, but I know
7 how you feel about Ms. Young Ashley and the
8 work she's doing.

9 MS. FARLOW: Absolutely. I am delighted
10 always refreshed and encouraged whenever I
11 hear Ashley speak.

12 Good afternoon, Councilman Jones and
13 Members of the Special Committee on the
14 Criminal Justice Reform. My name is Timene
15 Farlow. And I'm the Deputy Commissioner for
16 the Department of Human Services, Juvenile
17 Justice Services Division. I'm here today
18 to testify as to the strategies employed by
19 our agency and its contracted providers to
20 explore and respond to the trauma with which
21 so many of our young people in our
22 Philadelphia juvenile justice system
23 present.

24 We recognize that responding to this

1 trauma is in culturally competent,
2 professional and supportive ways is an
3 essential first step to bringing these young
4 people closer to the state of healing and
5 wholeness they'll need in order to become
6 the most stable and productive citizens they
7 can be. Left unaddressed, we know that
8 children exposed to violence in their homes,
9 schools and communities can come to have
10 mental health and substance abuse disorders,
11 school failure, increased risk taking and
12 participation in the juvenile justice
13 system. These are outcomes that none of us
14 wants for our City's most vulnerable
15 citizens.

16 Given that young people touch the
17 juvenile justice system in multiple points,
18 we have tried to be thoughtful about
19 ensuring that there are no missed
20 opportunities for exploring and responding
21 to trauma that might otherwise have gone
22 unrecognized or un-responded to. I will
23 begin by talking about the strategies used
24 within our secured juvenile detention

1 facility, the Philadelphia Juvenile Justice
2 Services Center.

3 Our entire complement of line staff are
4 trained in "Think Trauma." A full day
5 training which examines the impact of
6 psychological trauma on the lives of young
7 people involved in juvenile justice system.
8 Designed by the National Child Traumatic
9 Stress Network, this training provides
10 tangible skills for supporting adolescents
11 who have been exposed to traumatic life
12 events. We are also trained in Youth Mental
13 Health First Aid which teaches the skills
14 needed to identify, understand and respond
15 to young people experiencing behavioral
16 health challenges or crises.

17 Given the unique vulnerability of LGBTQ
18 youth in the juvenile justice system and
19 especially in secure detention, all JJSC
20 staff receive LGBTQ sensitivity training
21 during their orientation and as part of
22 their continuing education requirements.
23 These trainings are taught by qualified
24 trainers with expertise in working with

1 LGBTQ youth and cover best practices with
2 how to better serve this population. Given
3 that LGBTQ youth are at high risk for
4 significant distress and self-destructive
5 behaviors due to high rates of depression,
6 anxiety, substance abuse and suicidal
7 behavior, training for our staff includes
8 information about suicide prevention.

9 Screening for mental health issues is
10 critically important to our ability to
11 ensure the safety and emotional well being
12 of the youth in our custody. And to
13 accomplish this, we administer the
14 Massachusetts Youth Screening Instrument or
15 the MAYSI within 24 to 48 hours of each
16 youth's admission to our detention center.
17 The MAYSI-2 is a standard and reliable
18 self-report inventory designed to identify
19 potential mental health problems that may
20 require prompt attention. The screen is not
21 intended to make psychiatric diagnoses,
22 decisions about long term placements or
23 rehabilitative decisions. But it can give
24 us some insights as to whether a youth has

1 experienced traumatic events that warrant
2 further exploration and detention.

3 If so, we have on-site behavioral health
4 services provided through Pennsylvania
5 Hospital's Hall Mercer Community Mental
6 Health Center to which youth may be
7 referred. Staffing consists of two
8 part-time child and adolescent psychiatrist,
9 one of whom is Dr. Steven Berkowitz,
10 Director of the Penn Center for youth and
11 family trauma.

12 In addition, we have one full-time
13 therapist and three part-time therapists who
14 provide an array of behavior health
15 interventions to the youth in our custody,
16 all of which are trauma focused. Through
17 our strong partnership with the Department
18 of Behavioral Health and Intellectual
19 Disabilities, the youth detained at the
20 center also benefit from monthly wellness
21 sessions provided by EMOC. That stands for
22 Engaging Males Of Color, a newly established
23 targeted initiative under the direction of
24 Dr. Arthur Evans, Commissioner for that

1 department.

2 The goal of the program is to improve
3 the health status of males of color by
4 increasing behavioral health literacy and
5 access to resources and services while
6 reducing stigma and known disparities while
7 building system capacity in order to sustain
8 wellness. Many of the adjudicated youth in
9 Philadelphia's juvenile justice system will
10 be court ordered to participate in programs
11 or to receive services that address the
12 underlying trauma and other behavioral
13 health issues which are believed to have
14 contributed to their offending behaviors.

15 To this end, DHS contracts with an array
16 of service providers both residential and
17 community based to deliver such programs and
18 services for both pre and post adjudicated
19 youth. Behavioral health evaluations, which
20 document the trauma histories of youth in
21 the system, serve to inform efforts to
22 properly match youth with programs best
23 suited to meet their individual needs.

24 Youth with the most significant trauma

1 histories, for example, are often served in
2 residential treatment facilities which are
3 both funded and overseen by Community
4 Behavioral Health, the nonprofit
5 organization contracted by the City of
6 Philadelphia to provide mental health and
7 substance abuse service for Philadelphia
8 County Medicaid recipients.

9 Each provider in the CBH network
10 provides a comprehensive treatment and
11 education program in a safe, nurturing and
12 trauma-informed environment to assist
13 children and adolescents experiencing
14 serious emotional and behavioral issues.
15 Many of the non-RTF providers with which DHS
16 contracts also provide programming which
17 addresses trauma. Some are certified as
18 sanctuary models, blueprints for clinical
19 and organizational change which promote
20 safety and recovery from adversity through
21 the active creation of a trauma-informed
22 community. Others offer evidence-based
23 interventions like cognitive-behavioral
24 therapy proven to be the most effective type

1 of counseling for post traumatic stress
2 disorder.

3 Community-based programs like our
4 evening reporting centers, in-home detention
5 program and intensive supervision programs
6 all available exclusively to youth by way of
7 court orders each effect linkages to
8 trauma-based services on behalf of youth and
9 families on their case loads. So, too, do
10 our six community-based intensive prevention
11 services providers.

12 Finally, preventing youth from having a
13 traumatic experience of being arrested,
14 formally processed or admitted into a secure
15 detention facility is the primary goal of
16 two major programs of which we are involved,
17 the Police School Diversion Program and the
18 Juvenile Detention Alternatives Initiative.
19 During the school arrests, students are
20 handcuffed, removed from school, transported
21 to the police station, fingerprinted,
22 photographed and held for processing for up
23 to six hours. The trauma of the arrest
24 process can be devastating to a young

1 person. The School Police Diversion Program
2 provides a unique diversion strategy
3 allowing for avoidance not only of the
4 traumatic arrest and processing experience
5 for these youth, but also avoidance of
6 formal penetration of the juvenile justice
7 system.

8 JDAI, on the other hand, addresses the
9 matter of youth that have already
10 experienced the initial trauma of having
11 been arrested and formally processed but who
12 could nevertheless avoid the additional
13 trauma of being held in a secure detention
14 facility. Launched by the Annie E. Casey
15 Foundation in 1992 and now in place in over
16 150 jurisdictions across the country, JDAI
17 efforts aim to support jurisdictions with
18 reducing unnecessary reliance on the use of
19 secure detention, recognizing that in
20 contrast with common perceptions, the
21 majority of youth in facilities nationwide
22 are not guilty of serious violent offenses.

23 Finding alternatives to secure detention
24 prevents the exacerbation of trauma that

1 inevitably occurs when youth are placed in
2 such environments. Not only does this serve
3 to save considerable taxpayer dollars, it
4 also addresses the important matter of
5 disproportionate minority confinement. DHS
6 takes seriously the matter of how
7 Philadelphia can best explore and respond to
8 the trauma needs of its youth. We are
9 committed to continuing strong partnerships
10 with our behavioral health provider
11 community and the many stakeholders who have
12 an interest in emotional health and well
13 being of children and can be relied upon to
14 join with others in addressing this
15 important issue.

16 Thank you for this opportunity to have
17 presented to you today. And I'm prepared to
18 respond to any questions you may have.

19 MR. BETHEL: Before we start the
20 question, I just want to -- they brushed
21 across an area that you know is dear to me
22 as I left my job in the Police Department
23 and now a Stoneleigh fellow at Drexel
24 University around the school diversion

1 program. I just wanted to highlight, you
2 know, obviously this is a collaboration with
3 the District Attorney's Office, Angel
4 Flores, Deputy Commissioner Timene Farlow.
5 I see David Bruce back there, his supervisor
6 Mr. Walker who runs it, the JJC and others
7 are not in the room, David Trem.

8 But today we reached our thousand youth
9 mark. We had a little exchange amongst
10 ourselves that we diverted over a thousand
11 kids from being formally entered into the
12 system. Diverted them on a trauma form
13 approach, asking the questions why.

14 I have to give acknowledgement. DHS is
15 going to the houses of these young people,
16 engaging in the information to find out
17 what's going on at home. Really routed in
18 the trauma approach, then moving those kids
19 into programs, staying with those kids in
20 programs up to 90 days and sometimes beyond
21 that. So for anyone who is listening,
22 because it's not many people in the room,
23 but the listening audience, oftentimes DHS
24 is not given the credit that they rightfully

1 deserve. But the work that they are doing
2 to help young people and using this
3 trauma-informed approach is something that
4 endeared me to leave the department and work
5 on it full time. But more importantly,
6 Commissioner Farlow as you know, I want to
7 publicly again, as I always do, acknowledge
8 you and your team for your continued work in
9 this area to really, really change the
10 projection and trajectory we talked about
11 for young people in the City. So, thank you
12 and your team.

13 MS. FARLOW: Thank you, sir. It's been
14 a great partnership.

15 MS. BRADFORD-GREY: Thank you for all of
16 your information. I really did find it
17 informative. Ashley, you know, I love your
18 work. Was by -- the Defender's Association
19 works really well with some of your
20 information and trying to push better
21 policies.

22 Some of the things that I want to ask is
23 that, Angel, I love the perspective you
24 bring to the juvenile justice system. I

1 think that you have a very good mind, very
2 well intended for what to do with these
3 kids. Even as well intended as you and I
4 may be, I think some things become normal to
5 us. And what has been normalized over the
6 years is how many youth come into our
7 juvenile justice system which was a lot
8 different than, I would say, when you and I
9 may have been growing up.

10 Now I'm seeing youth come in for
11 behaviors that I have myself have displayed.
12 And I am wondering when are we kind of going
13 to shift the thought towards when do we not
14 need to use the juvenile justice system for
15 these youth? I like the fact that we have a
16 program that diverts youth from school. But
17 it begs me to understand, what kind of
18 offenses are those youth displaying?

19 And why are we calling them offenses,
20 number one, because they are things that,
21 you know, youth do?

22 And two, why do we not equip the schools
23 to make the referrals to DHS to do the
24 holistic understanding of what's going on?

1 Why do we use -- not to discredit the
2 program because I think it is very helpful
3 for those whose behavior is causing a risk
4 to safety. But I think a lot of things get
5 tangled into this process. Where we are now
6 taking what we may call kind of normal youth
7 behavior and labeling it as an offense
8 versus, you know, behavioral pattern that we
9 should deal with in the therapeutic school
10 setting, using the right personnel, using
11 the right professionals to deal with that.

12 Has there been any kind of visionary
13 look at how are we going to deal with youth
14 behavior as a non-criminal justice issue at
15 all? I mean, not even as a diversionary
16 issues using school resources officers, but
17 really using certain behaviors as a non
18 criminal justice related issue and saving
19 the criminal justice system for those who
20 pose real, real threats, real dangers that
21 we really need more therapeutic support such
22 that the juvenile justice system is designed
23 for?

24 MS. SAWYER: Well, my initial response

1 is to agree with you. Certainly, Education
2 Law Center is working around issues of the
3 school-to-prison pipeline where zero
4 tolerance, this attitude of zero tolerance
5 has a tendency to take a behavior that many
6 people grew up understanding is just
7 childlike behavior and making it into a
8 violation.

9 What we see outside of Philadelphia or
10 across the country are model of restorative
11 practices where it stays in the school and
12 doesn't involve contacting law enforcement,
13 doesn't involve sending a student to the
14 District Attorney's office but thinking
15 about how school, staff and community
16 members even this other student if there was
17 an -- even the student who might be the
18 victim can all be involved in a conversation
19 about how we improve the behavior.

20 Oakland, California has a pretty good
21 model. There are other studies who are
22 really employing restorative practices.
23 They need to be done with fidelity. They
24 need to be done in a way that is culturally

1 competent. We still see a lot of
2 dis-proportionality in our suspensions and
3 expulsions as well as juvenile justice
4 involvement. So we can't just say the
5 students that I like, when they get in
6 trouble, they can do restorative program.
7 And the students that I don't particularly
8 care for, they don't do the restorative
9 program. Thinking about how we can also use
10 school-based mental health services.

11 But all of the things I just described
12 require additional resources. We can't --
13 we can't expect teachers and staff to do
14 restorative practices unless they get the
15 training and support and the resources that
16 it will require to implement those programs.
17 But I would be happy to provide this
18 Committee with a list or some additional
19 information about the restorative practices
20 that are happening all over the country.

21 MS. BRADFORD-GREY: Couldn't we shift
22 some of the resources that we currently use
23 for justice system and look at some of the
24 profile of the kids that we kind of shuffled

1 through our system? Even with giving them
2 opportunities for consent decrees,
3 opportunities for diversion. There are some
4 in that group that are real good kids. And
5 they have done something that caused the
6 attention of a school resource officer or
7 someone else. I look at some of these kids
8 through direct services and they are doing
9 things -- I think I did worse than they did
10 as a kid. But they are being tagged and
11 labeled as system involved youth. And I
12 think that's detrimental.

13 If we can just be bold enough to shift
14 some of these resources and put them into
15 the school, I think we have a better process
16 to deal with child behavior.

17 MR. FLORES: The one thing that I wanted
18 to correct on this, Ms. Grey, is in fact we
19 are at the lowest level ever in the juvenile
20 justice system with offenders coming in. As
21 comparison in 2003, we hit around 10,000
22 petitions being filed. Last year we were
23 less than 2,500. So we have made enormous
24 inroads in that regard.

1 With the -- with the diversion program
2 started up by Kevin Bethel, we have seen
3 schools' offenses dramatically decrease. As
4 you can imagine, there is a disparity based
5 on what school you go to where you may see
6 things. And that's where I think we need to
7 work on. So that, a kid in West
8 Philadelphia is being treated the same as
9 someone in Northeast Philadelphia. And
10 that's, I think, where we need to get better
11 at.

12 But one of the things that I don't want
13 to lose here is that once we have an
14 individual who comes into the justice
15 system, that we utilize the resources to not
16 only deal with the youth but with the family
17 at that time to deal with some of the issues
18 that they may have. It's an unfortunate
19 situation that may find themselves in the
20 justice system.

21 But while we are there, we have to
22 address some of the issues that they
23 confront whether it's through a diversion
24 program or whether it's through court

1 intervention ideally it's with an
2 expungement built in.

3 MS. BRADFORD-GREY: And I get that. I
4 think we've become too reliant on juvenile
5 justice system for these types of services.
6 And maybe, just maybe just like we all have,
7 we all had bad days in school. We all have
8 things that made it difficult in school
9 settings. But maybe if we utilize those
10 same approaches that you use in diversion to
11 address the family from a school setting
12 perspective, couldn't we accomplish similar
13 things for certain kids? I'm not talking
14 about everyone.

15 I think that we have been so ordained --
16 it's become so normal to use the juvenile
17 justice system for kids. I think that we as
18 a juvenile justice system overburden our
19 resources. And we start to kind of, you
20 know, utilize them in a way that maybe some
21 kids don't need to.

22 But also, Angel, to your credit, I get
23 it. We were part of it, too. The number of
24 petitions have decreased. However, the

1 number of minority petitions have stayed the
2 same. So if there are only 2,000, our
3 statistics are -- I mean, our in terms in
4 Defenders Association representation,
5 revealed that 79 percent are minority youth.
6 So even though there is 8,000 less
7 petitions, the minority youth -- percentage
8 of minority youth petitions are still very
9 high. And I don't know if we can do
10 something to look at that while it may not
11 be an intention, it is a factor.

12 MS. FARLOW: I was just going to
13 comment. I really appreciated your point.
14 And I think you made some really powerful
15 ones. When we think about normalcy and we
16 think about what happens in terms of young
17 people making their way through and into the
18 juvenile justice system for what is normal
19 adolescent behavior. And today's
20 presentation by Dr. Bloom and others that
21 talked about the fact that there are
22 behaviors that are not unique to
23 adolescents. In fact, many adolescents do
24 those same things. Everything we know about

1 adolescent brain science tells us that kids
2 are going to make mistakes. But I think
3 it's how we respond to that. Do we need to
4 criminalize behavior that is certainly
5 viewed as perfectly normal in other
6 communities?

7 To your point, kids don't necessarily
8 have to be diverted from penetrating the
9 juvenile justice system. They're never even
10 considered for penetration to begin with.
11 And so, but that is a huge cultural shift
12 paradigm that needs to happen all across the
13 city.

14 For those young people who did make
15 their way into the juvenile justice system,
16 I think we need to think earnestly about how
17 we plan to respond to them. Because there
18 are some kids who aren't going to get that
19 opportunity to have been diverted. They are
20 already in. How do we respond to them?

21 I think about young people who are in
22 some of our residential facilities and how
23 provider agencies respond to behavior that
24 is really normal adolescent behavior. How

1 do you respond? Do you call in law
2 enforcement when that happens or do you deal
3 with it in a way that allows that young
4 person to continue on a more positive
5 trajectory, or do you sort of take him or
6 her off track by having him or her
7 rearrested and sometimes occurring new
8 charges even while they're in a treatment
9 program.

10 MS. BRADFORD-GREY: Thank you.

11 MR. PODJUSKI: Just a quick question for
12 Mr. Flores. I'm really excited about the
13 Project Go and the truancy initiative. We
14 have one at the state currently up in Erie.
15 Senator Wiley and one of our board members,
16 Board Member Potter is spearheading the
17 effort.

18 But I guess my question is, do you --
19 would you characterize Project Go as
20 enforcement or preventive in nature?

21 MR. FLORES: It's strictly preventative.
22 I know it comes under the auspices of the
23 District Attorney's Office. And there has
24 been some individuals who would state that

1 we are criminalizing truant behavior. I am
2 here to tell you that not one person in the
3 existence of Project Go has ever been
4 prosecuted for their child not attending
5 school. It is not the manner in which we
6 wish to utilize it.

7 Clearly, we have found, and I think it's
8 been borne out by others that when you just
9 use the name the District Attorney's Office,
10 that people will fall in line a lot quicker
11 and be more accepting of services and deal
12 with the issues. But I am here to tell you
13 in no uncertain terms that it is a
14 preventive program. Not one person has ever
15 been prosecuted for their child not
16 attending school.

17 MR. PODJUSKI: That's good to hear.

18 Thank you.

19 MR. ROJAS: Yeah. Wilfredo Rojas, how
20 are you?

21 MR. FLORES: I'm doing well.

22 MR. ROJAS: First of all, I wanted to
23 offer my belated congratulation on your
24 appointment.

1 MR. FLORES: Thank you.

2 MR. ROJAS: One of the questions I have,
3 and I guess it's more picking your brain
4 than it is venting. We are -- I was able to
5 take a regional approach to some of our
6 regional problems in the area or a regional
7 approach to other problems that our City
8 confronts.

9 When we shift these kids out to
10 facilities that are far removed from
11 Philadelphia, we are trying to get rid of
12 the problem now. Doctor this morning, this
13 afternoon spoke about poverty. And if we
14 look at the problems associated with youth
15 incarceration to the prison of poverty, we
16 see that a lot of these kids don't know
17 anything but poverty. A lot of these kids
18 don't ever get an opportunity to leave their
19 one mile radius and their community.

20 So I guess my question is, how can we
21 take a regional approach to have some type
22 of interlink with suburban communities that
23 are also in the State of Pennsylvania and
24 can actually -- our kids can be exposed to

1 how the other America lives. To realize
2 that the America that we know in the inner
3 cities is not the only America, so it
4 doesn't just become a problem setting on
5 incorrigible kids out to suburban facility,
6 but actually have them go out and experience
7 how the suburban communities live so they
8 can get a sense that there is something more
9 than just the inner city three-block radius
10 where they live.

11 MR. FLORES: That's always been the
12 challenge where it's a matter of lack of
13 exposure for young people to experience
14 something beyond their four-block radius
15 from their home, their comfort level. And
16 that's a challenge to all of us to ensure
17 that they are exposed to other things
18 whether through recreational activities or
19 some other form.

20 But in terms of juvenile justice, there
21 is a greater push to do more community-based
22 services whether it is through inpatient or
23 outpatient. And I think that the
24 conversation has already started in terms of

1 developing more community based to keep them
2 within their community to treat them for
3 some of their deficiencies and some of their
4 issues within the community. At the same
5 time, dealing with their environment that
6 they were in before they got put into an
7 inpatient facility.

8 MR. ROJAS: Have you ever thought of
9 doing a cross analysis of how much money we
10 would save if you began to partner with
11 other communities that have more funds than
12 we do?

13 MR. FLORES: You know, I can't tell you
14 that I have. I can tell you this, the
15 challenge is always for us is to convince
16 the suburbanites to accept the Philadelphian
17 problem. You can imagine the amount of
18 protest we would be hearing at that point,
19 as I see some heads shaking.

20 So while it's a great thought that that
21 would be able to exist, I think there will
22 be some enormous obstacles that we would
23 have to overcome.

24 MR. BETHEL: Just a quick question. Can

1 you -- when I -- first, let me though
2 something out there. I work with the School
3 District, so I have to -- I know they get a
4 lot of push back, as well. I also have to
5 give them compliments for the work they are
6 doing. They are doing, as you know, Ashley,
7 some restorative justice practice. I know
8 Rachel and Jody Greenblack are very much
9 involved. They changed the code of conduct.

10 As you indicated, the incidents have
11 come down in that regard. And many of the
12 cases that they would normally call us for,
13 they stop calling for it, disorderly conduct
14 and some of the offenses. The reductions we
15 have seen, they played a critical role in
16 those reductions because they are not
17 calling for offenses that they used to.

18 Speak to the question of -- one of my
19 frustrations moving into this world was the
20 inability of sharing information. You know,
21 these silos. When I go to the School
22 District, it's FERPA. When I go here, it's
23 something else.

24 How do you create a template -- I know

1 you have this Crossover Program which is
2 pretty much I guess silo somewhere. How can
3 we build a system of care for young people
4 if many of the things we can't talk? You
5 know, I can't walk into DHS and get
6 information. You can't walk over.

7 How do we build something that can be
8 sustainable and really work to change that
9 child's trajectory if we can't even really
10 bring that conversation and all that
11 information to the table to dissect it?

12 I know you may not have an answer, but
13 is there an idea? Is that something that we
14 need to look as a Committee to really start
15 to push in creating that ability that when
16 Kevin Bethel is at the table, can everybody
17 talk about Kevin Bethel or does everybody
18 have to sit and whisper? I can talk to you
19 as a cop, but I can't talk to you -- it just
20 seems sometimes very confusing to me.

21 MR. FLORES: Well, I think you've -- you
22 have touched on a point that's of
23 frustration to us, as well. I know in our
24 dealings with the School District, we have

1 had to deal with the FERPA law where their
2 translation of it is a little bit different
3 than what our translation is of the FERPA
4 law. We have dealt with that issue in terms
5 of truancy with them.

6 I think it's going to require greater
7 dialogue. And require greater dialogue at a
8 different level. And any assistance we can
9 get from this committee, we will greatly
10 appreciate it.

11 MR. BETHEL: Ms. Farlow, what's your
12 thoughts?

13 MS. FARLOW: I agree that our problem of
14 inability to share data has probably
15 prevented us from saving many lives. And
16 sadly, the only -- I was thinking of which
17 forums I'm a part of where information is
18 freely shared. And the one meeting that I
19 think of is the medical examiner's office
20 when we talk about deceased children.
21 Somehow it doesn't seem to matter. And even
22 then it's ex post facto. The child is
23 already deceased. And then we learn that
24 you knew him. I knew him. There were red

1 flags when he was in third grade. All of
2 these things were amiss, but none of us had
3 the ability to do anything because we don't
4 share data.

5 I don't know what the fix is for that.
6 I know that it needs to be fixed, obviously.
7 And maybe it does need to come from someone
8 higher than the folks who have raised those
9 conversations in the past.

10 MR. BETHEL: It's amazing you say that.
11 When you talk about where you can share the
12 information because the kid is deceased. I
13 think that's, again, something we really
14 need to talk about as a Committee. I used
15 to laugh. Say, where is the FERPA police?
16 If I violate, are they going to come get me.
17 I keep waiting for him or her. I want to do
18 good for a child, and you are going to come
19 lock me up for that.

20 I keep waiting for HIPPA/FERPA police to
21 come grab me, but they haven't gotten me
22 yet. This is something we need to -- law
23 enforcement. I think we really need to
24 bring that to bear if we're going to go down

1 this path of trauma reform and going to go
2 down this path of really understanding the
3 development approach. It will require us to
4 really be able to share realtime data to be
5 able to address the needs of that child at
6 the moment.

7 It's unfortunate teachers are sitting in
8 rooms and they don't even know they have a
9 child who's been traumatized or you're
10 sitting there with a kid and you can't get
11 information, Angel, because you know that's
12 ready and available to you. That's not
13 going to change the system. It's going to
14 be about collaborating and sharing that
15 information. That's my soapbox.

16 I think that's it. Without seeing any
17 other questions, we are going to have to --
18 we are going to excuse the panel. We want
19 to thank you all very, very much for your
20 testimony. And keep up the great work you
21 are doing.

22 MS. BRADFORD-GREY: Does that conclude
23 our questions? All right.

24 I know that we have all have a report,

1 an interim report that was generated. And
2 so, I am going to kind of close out the
3 session today. And I know that we have a
4 quorum at this time. And we will now go
5 into our public meeting to consider the
6 actions to be taken on the interim report
7 under consideration by the Special
8 Committee.

9 - - -

10 (Public Hearing adjourns and the Public
11 Meeting commences.)

12 - - -

13 MS. BRADFORD-GREY: The Chair recognizes
14 Kevin Bethel for a motion of interim report
15 on the Special Committee on Criminal Justice
16 Reform as it was considered by this
17 Committee at the public hearing on May 13,
18 2016 and May 23, 2016.

19 MR. BETHEL: Thank you, Madam
20 Chairman -- co-chairperson.

21 I move that the interim report of the
22 Special Committee entitled Summer of 2016
23 Youth Action Plan as it was considered by
24 this Committee on May 13, 2016 and May 23,

1 2016 be issued by this Committee to the
2 council.

3 MS. BRADFORD-GREY: Anyone second the
4 motion?

5 (Duly seconded.)

6 MS. BRADFORD-GREY: It's been moved and
7 properly seconded that the interim report of
8 the Special Committee Entitle Summer of 2016
9 Youth Action Plan as it was considered by
10 this Committee on May 13, 2016 and May 23,
11 2016 be issued by this Committee to the
12 Council.

13 All those in favor of the motion will
14 signify by saying aye.

15 - - -

16 (Chorus of Ayes)

17 - - -

18 MS. BRADFORD-GREY: Those opposed?

19 The ayes have it and the motion carries.
20 The report will be issued to the Council at
21 the next session of Council.

22 MR. BETHEL: Without any final
23 questions.

24 MS. WERTHEIMER: We are putting on the

1 record Julie Wertheimer is abstaining.

2 MR. MCSORLEY: And putting on the Rich
3 McSorley from the First Judicial District is
4 abstaining.

5 MR. BETHEL: All right. We recess to
6 the call of the Chair. Thank you everyone.

7 (Special Committee Public Meeting
8 adjourned at 4:01 p.m.)

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C E R T I F I C A T I O N

I, hereby certify that the proceedings and evidence noted are contained fully and accurately in the stenographic notes taken by me in the foregoing matter, and that this is a correct transcript of the same.

ANGELA M. KING, RPR
Court Reporter - Notary Public

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