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Transition Planning and Recidivism Among Mentally Ill Juvenile Offenders

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Abstract

This retrospective study described the pre- and post- release planning and service contacts for mentally ill juvenile offenders. The study examined the effectiveness of transition planning in reducing recidivism among mentally ill juvenile offenders. Participants were mentally ill adolescent offenders incarcerated for six months or more in one of three Washington State Juvenile Rehabilitation Administration (JRA) institutions. Retrospective chart and database reviews were conducted on the 44 participants in the final sample. Legal and medical file data were examined to determine the extent to which each youth received documented discharge planning and community services. Computerized criminal records of all study participants were examined for the year following community release to document new adjudicated offenses. Youth with more identified mental health and substance abuse needs received more services and received a greater number of post-release discharge planning contacts. Pre-release contacts occurred at a low frequency (mean of 1.86 contacts per youth). Youth who reoffended received less extensive post-discharge planning than non-reoffenders, but there were no significant differences in pre-discharge planning. Adolescents who reoffended were less likely to receive mental health treatment or financial assistance during the three months following discharge. Results indicate that even a low frequency of post discharge transition planning and service provision appears to have a positive impact on subsequent criminal behavior. These findings are instructive to juvenile justice administrators who are responsible for utilizing diminishing resources in effective ways.

Introduction

Although the rate of youth incarceration has stabilized from the steep increases of the 1980's and early 1990's, the incarceration rate for minority youth and youth with co-occurring mental health and substance use disorders is continuing to increase at an alarming rate (Cocozza & Skowrya, 2000). The juvenile justice system, like the foster care system, has become responsible for many of the same multiple-problem youth served by the mental health and substance abuse systems, but without an analogous mission or resources (Trupin, Tarico, Low, Jemelka, & McClellan, 1993).

The high rate of co-occurrence of delinquency, mental disorder, and substance abuse has been well documented in this population (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002; Elliot, Huizinga, & Menard, 1989; Farrell, Danish, & Howard, 1992; U.S. Department of Health and Human Services, 1995). The prevalence of Axis I mental disorders other than conduct disorder in juvenile offenders ranges from 9 – 22% for affective disorders, such as major depression, bipolar disorder and dysthymia (Teplin et al., 2002; Wasserman et al., 2002; McManus, Alessi, Grapentine, & Brickman, 1984; Weirson, Forehand, & Frame, 1992; Edens & Otto, 1997), 38% for attention deficit hyperactivity disorder, and 8-9% for psychotic disorders (Alessi, McManus, Grapentine, & Brickman, 1984; Davis, Bean, Schumacher, & Stringer, 1991; Davoli & Stock, 1982; Cocozza, 1992). Anxiety disorders and post-traumatic stress disorder have also been found to be prevalent in juvenile justice populations (Wierson, Forehand, & Frame, 1992; Edens & Otto, 1997). The special population of juvenile offenders who have evidenced both mental illness and substance abuse represent youth at the extreme end of the continuum of risk for adverse adult outcomes (Cocozza, 1992).

This high incidence of mental health disorders among juvenile offenders has led to the development of effective interventions to prevent incarceration and criminal recidivism, most notably, Multisystemic Therapy and Functional Family Therapy (Henggeler, Clingempeel, Brondino, & Pickrel, 2002; Sexton & Alexander, 2000). Similarly there has been increasing recognition of the role of the juvenile justice system in providing effective treatment to

incarcerated youth (Terry, VanderWaal, McBride, & Van Buren, 2000; Trupin & Boesky, 1999; Trupin, Stewart, Beach, & Boesky, 2002). The risk of incarceration among youth in the mental health system has also been widely acknowledged (Evens & Vander Stoep, 1997). Consequently, growing evidence that many detained youth experience co-occurring disorders has led the Office of Juvenile Justice and Delinquency Prevention to initiate a major effort to improve knowledge of prevalence rates and specify best practices (U.S. Department of Justice, 2001).

To date, many programs have been developed to identify and treat mental disorders through diversionary programs and community based interventions (Aos, 1998). Yet, limited attention has been focused on developing strategies for youth with co-occurring disorders to coordinate follow-up care, and to successfully transition from secure facilities to their own communities. The provision of post release mental health services has been shown to be an important means of reducing recidivism and impairment in incarcerated adults (Trupin, Wood, & Harris, 1999), suggesting such strategies might be of benefit to juvenile offenders as well. Studies of incarcerated adolescents have demonstrated that many aspects of community functioning, including family functioning, academic achievement and substance use are amenable to intervention (Weirson & Forehand, 1995; Dembo, Cervenka, Hunter, & Wang, 1999).

From a public policy perspective, state governments, often driven by negative media attention (Butterfield, 1998) and litigation (United States v. Louisiana, 121 F.Supp.2d 943 (M.D. La. 2000); Christina A. v. Bloomberg, 167 F.Supp. 2d 1094 (D.S.D. 2001); United States v. Georgia, No. 98-CV-836 (N.D. Ga.) (Memorandum of Agreement signed March 18, 1998), have begun to recognize the need for juvenile justice facilities to not only provide treatment to mentally ill juvenile offenders, but also to facilitate a transition to continued mental health and substance abuse care in the community (Terry et al., 2000). A notable example of these initiatives is the collaboration between the State of Washington, Juvenile Rehabilitation Administration (JRA) and the University of Washington (Terry et al., 2000). In 1997 the UW developed a screening questionnaire (Stewart & Trupin, in press) and decision matrix utilizing the Massachusetts Adolescent Youth Inventory (Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001) in order to identify and prioritize all incarcerated youth in need of treatment. At discharge, transition planning was shared both by staff at the secure facilities and by community-based parole officers. The overall intention of the program was to engage youth and

families systematically in structured, community-based treatment designed to maintain behavioral gains made by youth during their stays in secure correctional settings. However, the process of assisting community reintegration was not driven by a universally-adopted protocol, and juvenile justice staff were not trained to adhere to specific transition planning guidelines.

The following retrospective study was conducted to examine the effectiveness of transition planning in reducing recidivism for one year post release. Adolescents who received more discharge planning (documented contact with community treatment providers) and more community services (mental health treatment, substance abuse treatment, financial assistance, and school placement assistance) were expected to have lower rates of reoffending in the year following release from incarceration. Adolescents with higher levels of psychiatric functional impairment were expected to receive more follow-up services.

This research was reviewed and approved by the Washington State Institutional Review Board on December 7, 2001.

Methods

Participants

Participants were mentally ill adolescent offenders incarcerated for six months or more in one of three Washington State Juvenile Rehabilitation Administration (JRA) institutions (Maple Lane School, Echo Glen Children's Center, and Green Hill School). Participants were identified by JRA staff as high utilizers of mental health services, having received at least one documented DSM-IV diagnosis in addition to Conduct Disorder from a staff psychologist or psychiatrist, and having received documented mental health treatment while incarcerated. To allow for a follow-up period of one year after discharge, only adolescent offenders who were released into the community between 1/1/96 and 6/30/97 were considered eligible for the study. A total of 44 youth met all selection criteria and were included in the final sample. Participants' mean age at release was 16.9 years (range = 14-20). Thirty-five (79%) were male and nine (21%) were female. Twenty-three participants were Caucasian (52%), twelve were African American (27%), four were Hispanic (9%), three were Native American (7%) and two had no identified ethnicity (5%). Participants averaged 5.1 (range = 0-16) criminal adjudications prior to the offense that led to their incarceration. Age, gender, ethnicity and number of prior offenses in the mentally ill

offender sample were highly similar to the general population of adolescents incarcerated throughout the three juvenile rehabilitation institutions (Wood, Trupin, & Turner, 1999).

Procedure

Retrospective chart and database reviews were conducted on the 44 participants included in the final sample. Legal and medical file data were examined to determine the extent to which each mentally ill adolescent offender received documented discharge planning and community services intended to facilitate transition following incarceration and to reduce reoffending.

Discharge Planning

Documented evidence of discharge planning in the form of pre-release and post-release contacts between JRA staff, community treatment providers and parents was collected from a review of medical and legal files. Pre-release contacts were examined for the period of time six months prior to release, and post-release contacts were examined for the first three months following release. Discharge planning contacts between Juvenile Rehabilitation Administration staff and community providers were tracked in each of the following categories: mental health services, substance abuse services, financial assistance (e.g. Medicaid), school, prospective employment, housing, medical services, children and family services, and parents. An aggregate variable reflecting the total number of different kinds of planning contacts was computed for each participant (range 0-9).

Community Services

Documented evidence of community treatment during parole period was also collected from a review of medical and legal files. Receipt of mental health services, substance abuse services, and school placements was monitored for the first three months following release. An electronic database file supplied by Medical Assistance Administration was also reviewed to identify which participants received financial assistance during the same three-month period. Variables reflecting the receipt of each service (yes or no) were recorded for each participant.

Mental Health

The functional mental health status of all study participants was assessed using the Child and Adolescent Functional Assessment Scale (CAFAS). The CAFAS provides a standardized assessment of mental health by evaluating the degree of psychiatric impairment in eight areas of life functioning: role performance at school and work, role performance at home, role performance in the community, behavior towards others, moods and emotions, self-harm, substance use, and thinking (Hodges & Wong, 1996). For the purposes of the present study, the three role-performance subscales were omitted. Subscale scores were acquired by chart review and determined by the fourth author. Documented mental health difficulties were compared to a symptom reference list to obtain a score between 0 and 30 reflecting increasing levels of impairment. Total scores were obtained by averaging the five subscale scores. Psychiatric diagnoses were obtained for each study participant by chart review.

Reoffenses

Computerized criminal records of all study participants were examined for the year following community release to document new adjudicated offenses. Participants were coded as “reoffenders” if they were adjudicated for a new criminal offense during the follow-up period.

Results

Mental Health Characteristics

Primary psychiatric diagnoses, functional impairment, and reoffense rates were examined for the study sample. A total of 9 adolescents (21%) received a primary diagnosis of attention deficit hyperactivity disorder and 8 adolescents (18%) received a diagnosis of major depression. Six adolescents (14%) had a diagnosis of dysthymia. Other diagnoses included bipolar disorder for 4 adolescents (9%), post-traumatic stress disorder for 3 adolescents (7%), borderline personality disorder for 1 adolescent (2%), fetal alcohol syndrome for 1 adolescent (2%), identity disorder NOS for 1 adolescent (2%), and psychosis NOS for 2 adolescents (5%), and conduct disorder for 5 adolescents. For the remaining 4 adolescents, no diagnosis was clearly identified as primary, but all had documented histories of major depressive episode, conduct disorder, and substance abuse or dependence. Thirty-seven participants (84%) were assigned to specialized

mental health cottages during their incarceration. Thirty-four (77%) were identified as needing current treatment for substance use. All but one adolescent (98%) had been placed in special confinement for behavioral disruption (temporary assignment to an intensive management unit) during the course of incarceration. Adolescents received an average total functional mental health (CAFAS) score of 17.68 (SD = 5.62), with an average behavior towards others score of 27.72 (SD = 4.23), an average moods and emotions score of 18.18 (SD = 8.96), an average self-harm score of 12.95 (SD = 12.12), an average substance use score of 23.18 (SD = 10.29) and an average thinking score of 6.36 (SD = 8.38).

Reoffense Characteristics

During the one-year follow-up period, 21 (47.7%) of adolescents committed a new criminal offense. Functional mental health was not related to reoffending behavior. Adolescents who were adjudicated for a new criminal offense did not receive CAFAS scores indicating significantly lower functional mental health..

Discharge Planning and Community Services

Community transition assistance in the form of discharge planning was assessed by tallying the number of different community treatment providers (ranging from 0 to 9) contacted by Juvenile Rehabilitation staff. During the six months prior to release, an average of 1.86 (SD = 1.68) different contacts were recorded for each incarcerated adolescent. An average of 2.34 contacts (SD = 1.71) were recorded during the three months following release (see Table 1). The receipt of specific community services was also monitored for a three-month period following release. Only nine mentally ill offenders (20.5%) received documented mental health services, 17 (38.6%) received substance abuse services, 13 (29.5%) received financial assistance, and 15 (34.1%) received school placement (see Table 1).

Mental Health and Discharge Planning/Community Services

The relationship between the standardized measure of functional mental health status (CAFAS total score) and the receipt of discharge planning and community services was examined for the study sample. Adolescents who received mental health treatment in the first three months prior to discharge had significantly higher CAFAS scores ($F = 12.08$, $df = 1, 39$,

$p < .001$). Adolescents who received substance abuse treatment within three months of discharge also had significantly higher CAFAS scores ($F = 4.69$, $df = 1,39$, $p < .05$). Psychiatric functional impairment was not related to the receipt of financial services or school placement (see Table 2). Community transition assistance in the form of post-release discharge planning was related to total functional impairment. Adolescents with higher CAFAS scores received a greater number of post-release discharge planning contacts ($r = .44$, $p < .003$). Pre-release discharge planning was not related to CAFAS scores (see Table 2).

Discharge Planning/ Community Services and Reoffense

New criminal offenses during the year following discharge were examined to determine if reoffending was related to the receipt of community transition assistance or community services. Adolescents who reoffended received less extensive post-discharge planning (fewer contacts with community treatment providers) than non-reoffenders ($F = 5.03$, $df = 1,42$, $p < .05$), but there were no significant differences in pre-discharge planning (see Table 3). Reoffending was also related to the availability of community services. Adolescents who reoffended were less likely to receive mental health treatment ($\chi^2 = 6.55$, $df = 1$, $p < .05$) or financial assistance ($\chi^2 = 4.50$, $df = 1$, $p < .05$) during the three months following discharge. Reoffending was not related to the receipt of substance abuse services or school placement (see Table 3).

Table 1

Discharge planning and community services received by adolescent offenders within first three months of release

| Elements of Community Transition | # Youth who received assistance (n=44) | Number of contacts |
|----------------------------------|--|------------------------------|
| Pre-release Discharge Contacts | 35 (79.5%) | M = 1.86 ± 1.68 ¹ |
| Post-release Discharge Contacts | 39 (88.6%) | M = 2.34 ± 1.71 ¹ |
| Mental Health Services | 9 (20.5%) | |
| Substance Abuse Services | 17 (38.6%) | |
| Financial Assistance | 13 (29.5%) | |
| School Placement | 15 (34.1%) | |

¹ Standard Deviation

Table 2

Functional impairment of adolescent offenders and the receipt of discharge planning and community services

| Elements of Community Transition | CAFAS Total Score | | Statistical Test Value | df ¹ | p |
|----------------------------------|---------------------------|---------------------------|------------------------|-----------------|-----------|
| | Received Service | | | | |
| | No | Yes | | | |
| Mental Health Services | 16.00 ± 4.73 ² | 22.67 ± 6.25 ² | F = 12.08 | 1,40 | <.001 |
| Substance Abuse Services | 15.83 ± 5.03 ² | 19.53 ± 5.85 ² | F = 4.69 | 1,40 | .05 |
| Financial Assistance | 17.29 ± 4.91 ² | 18.62 ± 7.18 ² | F = 0.50 | 1,42 | <i>ns</i> |
| School Placement | 16.64 ± 5.35 ² | 19.20 ± 6.22 ² | F = 1.90 | 1,39 | <i>ns</i> |
| Pre-release Discharge Planning | Number of Contacts | | r = .18 | | <i>ns</i> |
| Post-release Discharge Planning | Number of Contacts | | r = .44 | | .01 |

¹The numbers of cases analyzed for different variables are not identical due to missing data.

² Standard deviation

Table 3

Receipt of discharge planning/community services and reoffenses

| Elements of Community Transition | <u>Number Reoffended</u> | | Statistical Test | | |
|--|--------------------------|------------------------|------------------|------|-----------|
| | Yes | No | Value | df | p |
| Received Mental Health Services | | | $\chi^2 = 6.55$ | 1 | .05 |
| Yes | 1 | 8 | | | |
| No | 19 | 13 | | | |
| Received Substance Abuse Services | | | $\chi^2 = 0.34$ | 1 | <i>ns</i> |
| Yes | 9 | 8 | | | |
| No | 12 | 12 | | | |
| Received Financial Assistance | | | $\chi^2 = 4.50$ | 1 | .05 |
| Yes | 3 | 10 | | | |
| No | 18 | 13 | | | |
| School Placement | | | $\chi^2 = 1.50$ | 1 | <i>ns</i> |
| Yes | 6 | 9 | | | |
| No | 15 | 10 | | | |
| Pre-release Discharge Planning Contacts (M±SD) | 1.52±1.08 ¹ | 2.17±2.06 ¹ | F = 1.67 | 1,42 | <i>ns</i> |
| Post-release Discharge Planning Contacts (M±SD) | 1.76±1.41 ¹ | 2.87±1.81 ¹ | F = 5.03 | 1,42 | .05 |

¹ Standard Deviation

Discussion and Conclusions

The primary purpose of this study was to examine the effect of transition planning on subsequent recidivism with a group of juvenile offenders with psychiatric disorders, many of whom also had co-occurring substance abuse disorders.

Diagnostic and treatment histories (individual, group and or psychopharmacologic) were well documented in their medical and legal files. As expected, study youth with more identified mental health and substance abuse needs received more services, both pre- and post-discharge, and received a greater number of post-release discharge planning contacts. These results provide some validation of the process by which youth in JRA with mental health and substance abuse problems are identified and served.

Despite these findings, staff contacts with parents and community providers for these youth as a group occurred at a frequency which was measured at less than 2 contacts in the 3 months prior to a youth returning to his or her community. Rarely were services accessed or sustained when youth returned home. It should come as no surprise that the primary focus of institutional juvenile justice staff is managing the behavior of youth while they are within that setting. Limited communication, contact and planning with other “systems” are certainly not unique to juvenile justice. Within non juvenile justice community treatment settings, be they mental health or those designed to treat chemical dependency, priority is placed on individual treatment rather than treatment that engages parents and incorporates all aspects of a youth’s environment (family, school, community, parole, etc.) (Weisz & Jensen, 2001). It has also been documented that the active involvement of the “systems of care” (Friedman, Katz-Leavy, & Manderscheid, 1996; Bickman, 1996) that impact a youth are a necessary but not sufficient component of empirically supported community based treatments for delinquent adolescents with either internalizing or externalizing disorders (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001).

Results from this study also indicate that even a low frequency of post discharge transition planning and service provision appears to have a positive impact on subsequent criminal behavior. These findings are instructive to juvenile justice administrators who are responsible for utilizing diminishing resources in effective ways and having to struggle with an

ever-increasing population of youth with co-occurring disorders. Given the benefits of even limited transition services as demonstrated in this small study, we are encouraged by the potential improved outcomes when transition services are provided to youth in their community post-release. This study did not examine whether mentally ill youth who did get treatment in the community received a “best practices” intervention. However, based on our knowledge of community providers, it is highly unlikely that evidenced based treatments were available in the settings where these youth received services. The provision of evidenced based interventions (Multisystemic Therapy, Functional Family Therapy, Multicomponent Therapy) could potentially increase the positive outcomes for these juvenile offenders and improve community safety.

This study is subject to some limitations which must be considered. The selection criteria resulted in a small sample size, which may limit external validity. Since the study participants were identified by institutional staff, there exists the potential for a sampling bias. Additionally, this study utilized data collected from review of legal and medical files. Information in these files is often subjective, is recorded by multiple individuals, and lacks validity checks. Despite these caveats, the results of this study support our hypotheses that youth who have greater identified mental health needs and functional impairment are likely to receive more pre- and post- discharge planning and services, and that youth who receive these services are less likely to reoffend.

A report (Wood et al., 1999) of the findings presented in this study was provided to the Human Services and Corrections Committee of the Washington State Senate. This report contributed to the passing of legislation and a budget allocation (Washington State Substitute Senate Bill 6853) to establish a transition intervention program utilizing “scientifically based practices” for youth with co-occurring disorders. Washington State had already initiated legislation through the 1998 Community Justice Accountability Act (CJAA) to divert “low risk offenders” from County Detention settings into either a course of Aggression Replacement Training (Reddy & Goldstein, 2001; Henggeler et al., 2002) or Multisystemic Therapy (Henggeler, Borduin, & Schoenwald, 1998). Senate Bill 6853 further resulted in the development of the Family Integrated Treatment (FIT) Project. FIT draws on the principles and procedures of Multisystemic Therapy (Linehan, 1993), Dialectical Behavior Therapy

Linehan, 1993; Trupin & Boesky, 1999) and Motivational Enhancement Therapy (Miller & Rollnick, 1991). The CJAA program was an outcome of the meta-analysis conducted by the Washington Institute of Public Policy (Aos, 1998) of recidivism, cost outcomes and effect size of interventions with delinquent youth. Legislators were eager to support a similar approach with “deep end offenders” with co-occurring disorders even prior to receiving the findings from the CJAA project. On-going evaluations are being conducted to examine the effectiveness of various intervention programs, including the Family Integrated Treatment Project, on recidivism.

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