

**Aftercare for Youth with Mental Health Disorders in
The Juvenile Justice System: An Assessment of the Aftercare Program of
Williamson County Juvenile Services**

Submitted by:
Candace Moreno Ferguson

An Applied Research Project (Political Science 5397) Submitted to:
The Department of Political Science
Texas State University-San Marcos
In Partial Fulfillment
For the Requirements for the Degree of

Master of Public Administration

(Summer 2005)

Faculty Approval:

Dr. Patricia M. Shields

ABSTRACT

Purpose: The purpose of this study is first to describe the ideal characteristics of an effective mental health aftercare program based on a review of the literature. The second purpose is to conduct a case study and assess the aftercare program in Williamson County, Texas using the ideal characteristics. Finally, recommendations that should assist all juvenile probation departments in Texas more effectively to supervise youth with mental health needs are developed. *Methodology:* The methodologies used in this case study of Williamson County Juvenile Services include structured interviews, document analysis and archival data analysis. Document analysis was conducted using the County's policy and procedure manual and archival data such as case plans and chronological notes were used as a supplemental data collection method as well. A systematic sample of archival data was conducted of 21 youth randomly selected from a total of 103 youth sent to or released from post-adjudication facilities in Williamson County, during 2004 – 2005. *Results:* Overall, the Aftercare Program in Williamson County adheres to the practical ideal type model developed through the literature, but could improve services by: providing set guidelines in Policy and Procedure, providing specialized training for Aftercare Officers, developing a specialized Aftercare Team, and providing staff development through ongoing training and evaluation.

TABLE OF CONTENTS

CHAPTER 1. INTRODUCTION	7
Research Purpose	8
Chapter Summaries	9
CHAPTER 2. OVERVIEW OF THE JUVENILE JUSTICE SYSTEM.....	11
Purpose	11
Juvenile Court Inception	11
Juvenile Court Terms & Processing	13
Statistics	14
Mental Health in the Juvenile Justice System.....	16
Residential Programs	26
CHAPTER 3. MODEL AFTERCARE PROGRAM.....	48
Purpose	48
Conceptual Framework	53
Summary of Conceptual Framework Linked to Literature	55
Community Supervision	55
Mental Health Aftercare	59
School Involvement	65
Family Involvement	77
Conclusion	80
CHAPTER 4. RESEARCH SETTING	83
Purpose	83
Williamson County Juvenile Services.....	83

Profile of Residential Programs	84
CHAPTER 5. RESEARCH METHODOLOGY	87
Purpose	87
Case Study Research	87
Structured Interviews	88
Document Analysis	89
Archival Data	89
Population	91
Operationalization Table.....	94
CHAPTER 6. RESULTS	96
Purpose	96
Community Supervision Results	96
Mental Health Aftercare Results	103
School Involvement Results	107
Family Involvement Results	109
CHAPTER 7. CONCLUSIONS & RECOMMEDATIONS.....	112
Purpose	112
Recommendations Summary Table	113
Community Supervision Recommendations.....	114
Mental Health Aftercare Recommendations	116
School Involvement Recommendations	117
Family Involvement Recommendations	118
Conclusion	119

BIBLIOGRAPHY.....120

APPENDICES

Appendix A- Juvenile Board Approval Prospectus

Appendix B- Interview Questions

Appendix C- Placement Aftercare Supervision Policy & Procedure

Appendix D- Juvenile Exit Interview/ Transition Plan

Appendix E- Case Planning & Management- Residential Placement Policy &
Procedure

Appendix F- Field Supervision Case Plan

Appendix G- Child/ Family Case Plan- Residential Placement

Appendix H – Residential Placement Child/ Family Case Plan Review

Appendix I- Contracted Services for Juveniles Policy & Procedure

List of Tables

Table 2.1: Axis I Disorders	23
Table 3.1: Summary of Conceptual Framework Linked to the Literature	55
Table 5.1: Operationalizing the Conceptual Framework	94
Table 6.1: Transition Planning Archival Results.....	94
Table 6.2: Intensive Supervision & Treatment Archival Results	100
Table 6.3: Interagency Collaboration Archival Results	102
Table 6.4: Community Supervision- Overall Results	102
Table 6.5: Assessment & Screening Archival Results	105
Table 6.6: Mental Health- Overall Results	107
Table 6.7: School Involvement Archival Results	109
Table 6.8: School Involvement- Overall Results	109
Table 6.9: Family Involvement- Overall Results	110
Table 7.1: Williamson County Aftercare Program Recommendations Summary	113

CHAPTER 1

INTRODUCTION

According to Foster et al. (2004), youth with mental health involvement are also more likely be involved with the juvenile justice system, and the “obverse is also true that youths in the juvenile justice system suffer from mental health problems” (859). The overall consensus among researchers is that juvenile crime is rising, among all youth, particularly youth with mental health needs (Rawal et al. 2004, 242). About 80% of youth involved in the juvenile justice system have a mental health diagnosis and one out of five has a serious emotional disturbance (SED), which is described as interfering with daily functioning (Kamradt 2002, 1).

Juvenile justice systems have typically relied on restrictive out-of-home placements as a punishment for delinquency but this reliance has had major consequences (Gies 2003, 2). Furthermore, research has shown that institutionalization does not necessarily correct bad behavior. And, “because youth are often released to disorganized communities, where it is easy to slip back into the habits that resulted in arrest in the first place, any gains made by juvenile offenders in correctional facilities may quickly evaporate following their release” (Gies 2003, 2).

A youth’s ability to change once released to the community depends on how much care is available in the community (Byrnes et al. 2002, 12). According to Gies (2003), there is an estimated 50 percent recidivism rate for serious juvenile offenders returning to a community without aftercare.

Research estimates that at any given time, 9-13 percent of youth in the general population have a diagnosable mental health disorder. The numbers are increasingly

higher for the 1.8 million juveniles entering the system each year, however there is not much research on the needs of these offenders (Ashcroft et al. 2003, 28). According to Ashcroft et al. (2003) the fact that there are very few mental health services and a “lack of aftercare or reentry programming for these incarcerated juveniles is also of particular concern” (28).

According to Armstrong (1991), research recommends using specific criteria to categorize offenders with certain needs so that supervision and rehabilitation can be catered to the specific needs of the population. “Growing concerns about institutional crowding, high rates of recidivism, and escalating costs of confinement have fueled interest in developing innovative ideas and programs for juvenile offenders, including juvenile aftercare/ parole philosophy and practice” (Josi & Sechrest 1999, 52).

Therefore, the importance of implementing transitional services and aftercare is to reduce high recidivism rates, which would also reduce overcrowding and high costs of out-of-home placement expenses (Gies 2003, 2).

RESEARCH PURPOSE

The purpose of this research is threefold. First, the purpose is to describe the ideal characteristics of an effective mental health aftercare program based on a review of the literature. The second purpose is to conduct a case study and assess the aftercare program in Williamson County, Texas using the ideal characteristics. The final purpose is to make recommendations to assist all juvenile probation departments in Texas to supervise youth with mental health needs in a more effective manner.

The first portion of this paper reviews the literature in order to develop the characteristics of an ideal aftercare program. These components establish the ideal aftercare model for youth with mental health needs. The four components are as follows:

1. Community supervision
2. Mental health aftercare
3. School involvement
4. Family involvement

The second portion of this paper assesses the aftercare program in Williamson County, Texas by gauging how closely the aftercare program compares to the practical ideal type identified and developed through the literature. In order to establish if Williamson County's aftercare program is in accordance with the practical ideal type, structured interviews, document analysis, and archival data analysis are used. After compiling the data obtained from these methodologies, recommendations are made for improving the aftercare program in Williamson County, Texas.

CHAPTER SUMMARIES

Chapter 2 provides an overview of the juvenile justice system and begins with a history of probation services for juveniles in the United States. Next, the chapter describes the characteristics of youth diagnosed with mental health disorders involved in the juvenile justice system and evaluates the aftercare services in place for them.

Chapter 3 continues reviewing the literature in order to develop the ideal components for a model aftercare program for youth with mental health disorders while also developing the conceptual framework.

Chapter 4 describes Williamson County Juvenile Services, the research setting for the project. Next, Chapter 5 discusses the methodology used to complete the study and provides the operationalization of the components within the practical ideal type.

Chapter 6 describes and summarizes the results obtained from the various data collection methodologies in this study. Finally, Chapter 7 assesses whether or not the aftercare program in Williamson County meets the ideal characteristics developed throughout this course of study. In this final chapter, recommendations for the improvement of aftercare programs not only for Williamson County, but also for all juvenile probation departments in Texas are made in order to better serve the juvenile population with mental health needs and those who work with them.

CHAPTER TWO
AN OVERVIEW OF AFTER CARE FOR YOUTH
WITH MENTAL HEALTH DISORDERS IN
THE JUVENILE JUSTICE SYSTEM

PURPOSE

The purpose of this chapter is to review the current literature on aftercare services for youth with mental health needs released from residential placements. After reviewing the literature, the goal is to develop ideal components for a model aftercare program for youth with mental health needs. A case study is used to assess the components of the Aftercare Program at Williamson County Juvenile Services against the model developed from this literature review. Yet, the ultimate goal is for the model to serve as a guide to all agencies working with juvenile delinquents with mental health needs.

This chapter begins with a history of probation services for juveniles in the United States. Next, it describes the characteristics of youth diagnosed with mental health disorders involved in the juvenile justice system and evaluates the aftercare services in place for them. The components of a model aftercare program are introduced in Chapter 3.

JUVENILE COURT INCEPTION

The Illinois Juvenile Court Act of 1899 established the first juvenile court in the United States (Abadinsky 2003, 102). By 1925, most of the States had their own juvenile courts and offered probation services. Still, the focus was on rehabilitating delinquent youths by treating them and turning them into “productive citizens” (Bilchik 1999, 2).¹

¹ During the 20th century, these juvenile courts were established to deal with juvenile offenders and were more informal than adult courts.

The primary goal of the juvenile court was to provide treatment and supervision for troubled youth (Boesky 2002, 10). In fact, since the inception of the first juvenile court, the approach has always leaned toward the rehabilitation of delinquent youth (Rawal, Romanowsky, Jenuwine, & Lyons 2004, 242).

Shift in Focus

During the 1960's, the effectiveness of the rehabilitative efforts of the juvenile courts came into question. This was also a time when offenders were given legal rights and the courts became more formal (Boesky 2002, 11).

The 1980's saw an increase in juvenile crime as well as public perception that the juvenile justice system was too lenient, causing significant policy changes (Boesky 2002, 11). In fact, "...the pendulum began to swing toward law and order...and many States responded by passing more punitive laws" (Bilchik 1999, 4).

During the 1990's, juvenile laws became tougher and youth were held more accountable for their actions, many even bypassed the juvenile system and went straight to the adult criminal justice system (Boesky 2002, 11). Changes in the juvenile justice system were partly due to the "get tough" policies of the 1990's that shifted the focus from rehabilitation to punishment (Cocozza & Skowyra 2000, 5). Sadly, the "nothing works" philosophy has plagued criminal justice for more than twenty years. While certain studies have shown that correctional programs can be effective, the overall consensus is that some programs work at reducing recidivism, while some do not (Armstrong 1991, 396).

In the last 25 years, the implications of get-tough policies have caused changes in the juvenile justice system in addition to the public calling for more severe sanctions such

as longer juvenile confinement periods (Josi & Sechrest 1999, 53). Proponents of the “get tough” laws that spark political debate do not favor ideas such as delinquency prevention, diversion or aftercare (Josi & Sechrest 1999, 52).

Over one hundred years ago, the focus of the juvenile court was on the juvenile offender instead of the offense. For the most part, that is still the case today. According to Shay Bilchik (1999, 1), juvenile courts must balance rehabilitative efforts and treatment along with more severe sanctions such as incarceration.

Presently, the focus of the juvenile justice system is geared toward holding juveniles accountable for their actions, protecting the community, and ensuring that the punishment fit the crime. While deterring future behavior and rehabilitation are still important, they do not take precedence (Boesky 2002, 11).

JUVENILE COURT TERMS & PROCESSING

The nonpunitive terminology in juvenile courts differs from that of adult courts (Abadinsky 2003, 103).² In order to determine whether a juvenile has engaged in delinquent conduct, the juvenile must go through an adjudication hearing (Stephens & Arnette 2000, 3). Whereas in the adult system, an adult would face a trial or prosecution, a juvenile is adjudicated of a delinquent act not found guilty (Puzzanchera, Stahl, Finnegan, Tierney & Snyder 2003, 32- 36).

If a juvenile is found to have engaged in delinquent conduct, they go through a punishment or disposition hearing (Stephens & Arnette 2000, 3). Traditionally, disposition hearings determined what services or needs the juvenile court would provide (Abadinsky 2003, 115, 127).

² Puzzanchera et al (2003, 5) defines delinquent acts as acts committed by juveniles that, if committed by adults would result in criminal proceedings.

Numerous options exist at the disposition hearing (Stephens & Arnette 2000, 3) including probation, placement in a residential treatment facility or placement in a secure facility (Abadinsky 2003, 141). Dispositions such as probation or residential placements depend on the severity of the charge. Probation is the sanction that is favored by juvenile courts (two-thirds of the juveniles adjudicated in 1999, 62 percent resulted in probation). Yet, of all the delinquency cases in 1999, 24 percent of adjudicated youth were sent to out of home placements (Puzzanchera et al. 2003, 32- 36).

STATISTICS OF YOUTH IN THE JUVENILE SYSTEM

According to Purva Rawal et al. (2004, 250), one of the first contacts many youth have with any type of state system is the juvenile justice system. Over the past 15 years, the juvenile crime rate has significantly increased at almost 22 percent (Rawal et al. 2004, 242). Juvenile courts handled approximately 1.7 million delinquency cases in 1999 and this number increased 27 percent since 1990 (Puzzanchera et al. 2003, 6).

In 2002, Michael Bullis, Paul Yovanoff, Gina Mueller, and Emily Havel and again in 2004, Bullis, Yovanoff and Havel reported that over 100,000 incarcerated youth are in the United States. According to Rawal et al. (2004, 243), most were boys, most were minorities; and between 12 and 70 percent had special education disabilities. Research suggests that these youth, labeled with academic deficits were more likely to return to the juvenile system. In fact, studies show that about half of these youth will return to a correctional setting after release (Bullis et al. 2002, 8).

Youth from minority groups are more prone to disruptive behavior than white youth (Rawal et al. 2004, 250). In fact, Rawal et al. (2004, 243) found in a U.S. Department of Justice report released in 2000, “well over 20% of the overall juvenile

justice system” were minorities and this percentage is projected to grow because the African American population is slated to increase 19 percent whereas the White population is only projected to increase 3 percent between 1995 and 2015.³

The significance of this finding is that many times criminal behavior as a youth will follow into adulthood and cause problems at work and with family (Bullis et al. 2004, 80). Rawal et al. (2004, 242) reported during the past 15 years that juvenile crime has increased among all youth, particularly girls and youth with mental health needs. Lisa M. Boesky, Ph.D. (2002, 38) concludes there are many far-reaching fiscal consequences to antisocial behavior as each year, over one billion dollars is spent on the juvenile justice system.

As previously stated, probation is the sanction favored by juvenile courts (Puzzanchera et al. 2003, 21-36). But, in 2003, Steve V. Gies (2) reported that the number of adjudicated cases resulting in out-of-home placements rose 51 percent nationally from 1987- 1996. In a report by the Office of Juvenile Justice and Delinquency Prevention, Attorney General John Ashcroft, Assistant Attorney General Deborah J. Daniels, and Administrator J. Robert Flores (2003, 12) found that in 1997, upwards of 125,800 youth nationwide were placed in residential facilities.

Some studies show about half of the juvenile population released from incarceration will return to juvenile facilities (Bullis et al. 2004, 80). “...Recidivism is defined as a return to criminal activity after previous criminal involvement” (O’Brien, Newton, Zinnecker, & Parr 2005, 7). The Texas Youth Commission defines recidivism as “subsequent incarceration in the juvenile justice or adult criminal justice systems” (O’Brien, et al. 2005, 7). According to John O’Brien et al. (2005) between 1996- 2000,

³ Information about the growth of the Hispanic population was not reported.

the recidivism rate has been about 50 percent. Furthermore, research shows that if someone is likely to reoffend it will be within three years (O'Brien et al. 2005, ii).⁴

MENTAL HEALTH IN THE JUVENILE JUSTICE SYSTEM

According to Boesky (2002, 34), approximately 20 percent of the adolescent population suffers from a true mental health “*disorder.*” However, the growing number of youth involved in the juvenile justice system with mental health needs is cause for concern although overall, juvenile incarceration rates have stabilized. The rates for minorities and youth with other disorders such as substance abuse problems or mental health disorders classified as “co-occurring” needs, has drastically increased. While the exact number is unknown, “it is clear that the rate of mental health disorders is higher among youth involved with juvenile justice versus their peers in the general population” (Boesky 2002, 3).⁵

The general consensus among researchers seems to be about 80 percent of youth involved in the juvenile justice system have a mental health diagnosis and one out of five has a serious emotional disturbance (SED), which is described as interfering with daily functioning (Kamradt 2002, 1). Several recent research studies have shown a “high rate and wide range of diagnosable mental illness within the juvenile justice system...” (Rawal et al. 2004, 243). In fact, according to several estimates, over half of incarcerated youth have more than one mental illness diagnosis demonstrating a considerable overlap between the juvenile justice and mental health systems (Rawal et al. 2004, 243).

⁴ Recidivism can be calculated by following a group of individuals who had received treatment or punishment over a certain amount of time. “The number that ‘fail’ within that specified time period, divided by the total number in the group, is used to determine the recidivism rate”(O'Brien et al. 2005, ii).

⁵ Co-occurrence is a recognized problem among this population (Trupin, Turner, Stewart, & Wood 2004).

“Across the nation, the question of how to effectively address the mental health needs of youths entering the juvenile justice system is being asked and people are struggling to find a responsible way to answer it” (Spriggs 2003, 64).

Many of these mentally ill youth do not function well in placement facilities because of their inability to concentrate, their mood disorders, and their low intellectual functioning (Boesky 2002, 3). According to Troy L. Armstrong (1991, 270), subpopulations of offenders require specialized treatment and attention and “policies must be implemented so that appropriate programs are delivered to the appropriate group of offenders.”

Of the 20 percent of youth in the general population diagnosed with mental health disorders only about one in five will receive treatment from a mental health agency (Boesky 2002, 271). While many challenges to mental health treatment exist for juvenile justice agencies, “juvenile offenders with mental health disorders need mental health treatment” (Boesky 2002, 250).

According to Joseph J. Coccozza and Kathleen Skowrya (2000, 4), coordination of care and information sharing between mental health and juvenile justice systems is insufficient. The change in the level of concern has only recently come about because of the increasing number of youth involved in the juvenile justice system with unmet mental health needs and the increasing reliance on the juvenile justice system to provide care for these juveniles (Coccozza & Skowrya 2000, 4).

The juvenile justice system has failed many youth by being unable to identify their mental health needs or provide proper treatment (Ruffolo, Sarri, & Goodkind 2004, 243). In order to develop effective mental health services to this population, Sara Ruffolo

et al. (2004) found it essential to understand the risk factors youth face. Denise C. Herz (2001, 172) argues for more than a decade that this “benign neglect” has garnered attention because more juvenile offenders have mental health problems and juvenile justice systems are ill equipped to handle them (172).

Presently, there is only limited research on mental health disorders and juvenile crime, but the studies are growing (Boesky 2002, 3). The lack of research on the subject makes it difficult to develop effective intervention plans (Boesky 2002, 3). Therefore, Armstrong (1991, 270) maintains it is imperative for juvenile probation departments that work with offenders with mental health needs to have policies and procedures written specifically for this population.

Evolution and History of Needs

Antisocial behavior and delinquency among juveniles can be linked to certain mental health disorders (Rosenblatt, J., Rosenblatt, A. & Biggs 2000, 227-228). During the 20th century, mental health experts attempted to diagnose and treat problem behaviors, which linked juvenile justice and individual treatment. Expectations however, fell short and psychiatric admissions did not rise until the 1960’s and 70’s (Herz 2001, 173).

Rawal et al. (2004, 243) defined mental health needs “as a general need for mental health intervention to address problematic symptoms and/ or behaviors...” Around 1998, mental health needs of juveniles involved in the justice system received more attention than in the past ten years. At the Federal level, the Civil Rights Division of the U.S. Department of Justice reviewed documents revealing the inadequacy of services and care for juveniles with mental health needs in correctional institutions across

the nation. Additionally, Congress considered bills and amendments calling for mental health screening and treatment for these youth (Cocozza & Skowrya 2000, 3).⁶

According to Ruffolo et al. (2004, 238), the mental health services available for youth involved in the juvenile justice system are insufficient, which is problematic because these youth become enmeshed in the system at an earlier age. Several factors may contribute to the rise in juvenile justice involved youth with mental health disorders (Boesky 2002, 6). “For example, recent changes in the mental health system have had considerable effects on juvenile justice” (Boesky 2002, 6). It is more difficult for juveniles to access quality mental health services, especially for those youth with a criminal record (Boesky 2002, 6).

Unfortunately, “limits have been placed on the types of mental health evaluations and interventions youth are eligible to receive” (Boesky 2002, 6). According to Boesky (2002, 6), many youth who are eligible to receive mental health services must often endure long waits before receiving only a few visits.

“Youths’ problems tend to come bundled together, often stacked on one another over time” (Howell, Kelly, Parmer, & Mangum 2004, 145). According to Boesky (2002, 6), “when mentally ill youth are not appropriately evaluated and provided effective treatment services, their mental health is likely to deteriorate- resulting in worsening of emotional and behavioral problems.”

Boesky (2002) contends that mental illness alone cannot be blamed for criminal behavior, and all youth should be held accountable for their actions regardless. But,

⁶ The mental health needs of juveniles also garnered recognition at the State level. For example, the Secretary of the Florida State Department of Juvenile Justice stated, “providing specialized services such as mental health... within the juvenile correctional continuum” is the most demanding issue facing juvenile corrections (Cocozza & Skowrya 2000, 4).

juvenile offenders with mental disorders should also receive the proper mental health treatment (Boesky 2002, 11). A major priority for the rehabilitation of delinquent youth, also categorized as “high-risk” is to identify their mental health needs and address them properly (Rawal et al. 2004, 243). James C. Howell, et al. (2004, 145) agrees that an integrated response is necessary because often youth are carelessly sent through the system.

Characteristics of Youth with Mental Health Needs

Juvenile offenders seldom fit into the distinct categories of psychiatric disorders, as do youth outside of the juvenile justice system (Boesky 2002, 27). However, “double jeopardy” youth suffer from delinquency and mild-to-moderate mental health problems (Boesky 2002, 12). The manners in which they present themselves in a clinical setting are often complex; they are sometimes observable and subtle (Boesky 2002, 27).

In order for a youth to be diagnosed with a mental health disorder, they must meet certain criteria in the *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, DSM- IV*. Some of the disorders are psychotic, learning and conduct disorders. For instance, Coccozza and Skowyra (2000, 6) report Conduct Disorders are prevalent among 80 percent of the juvenile population. Typically, youth in the juvenile justice system suffer from ADHD, Learning Disabilities and Major Depression among other disorders (Boesky 2002, 12).

The youths classified with “serious mental health disorder” or “SED” usually have more severe conditions that hinder their ability to function. SED’s include schizophrenia, major depression, and bipolar disorder (Coccozza & Skowyra 2000, 5-6). While it is estimated that one in five youth in the juvenile justice system has a serious mental health disorder that could benefit from some type of services, “there is a sizable

group of youth who critically need access to mental health services because they are experiencing serious problems that interfere with their functioning” (Cocozza & Skowrya 2000, 6).

In the past ten years, the number of girls coming into contact with the juvenile justice system has significantly increased; many requiring services for mental health needs (Ruffolo et al. 2004, 237). Girls in the juvenile justice system are at greater risk of experiencing mental health problems because many suffer from higher levels of depression due to their environment, both family and community (Ruffolo et al. 2004, 243). In fact, white females are eight times more likely to be placed in mental health facilities than any other racial group (Rawal et al. 2004, 243).

Rawal et al. (2004, 244) conducted a study seeking to find out if there were noticeable differences in the mental health needs among minority youth in the juvenile justice system and to what extent their mental health service utilization differed. What they found was that white youth had the highest use of mental health services (Rawal et al. 2004, 250). Compared to white and Hispanic youth, African American youth had greater mental health needs however they are grossly underserved. The key conclusion that Rawal et al. (2004, 251) found was that, “... all youth, regardless of race, probably have underserved mental health needs.”

According to Boesky (2002, 271), juvenile offenders with mental health disorders face barriers from their family, the juvenile or mental health system and even from their own beliefs about mental health treatment. Juvenile’s families may hinder their treatment due to lack of motivation to help them, other stressors in the family, their own mental illness, frustrations from dealing with the behavior over a long period of time, or for fear

of being blamed by others (Boesky 2002, 271). Significant evidence exists suggesting that mental illness carries more of a stigma among minorities and therefore these youth are less inclined to seek treatment (Rawal et al. 2004, 251).

According to Rawal et al. (2004, 251), while “poverty and low income...have been linked to an increased likelihood of having a diagnosable childhood or adolescent mental illness,” minorities often lack adequate resources including health insurance. Additionally, many families are unable to afford the cost of treatment (Boesky 2002, 271).

As previously stated by Ruffolo et al. (2004, 237), the number of youth involved in the juvenile justice system with mental health disorders is higher than that of the general population. Coccozza and Skowrya (2000, 8-9) advocate that “whenever possible, youth with serious mental health disorders should be diverted from the juvenile justice system.” Placing these youth in correctional institutions could have detrimental effects and increase the amount of youth with mental health needs, which would be counterproductive. While impossible to divert all youth from the system because of the nature of certain offenses, it could reduce the number substantially (Coccozza & Skowrya 2000, 8-9).

Types of Disorders

Boesky (2002, 19) defines a mental health disorder as “a clinically significant psychological or behavioral syndrome or pattern that occurs in an individual and is associated with suffering and disability.”⁷

⁷ The DSM- IV “serves as the main resource tool for mental health professionals when providing mental health diagnoses” (Boesky 2002, 21). The DSM-IV allows professionals to be on the same page about diagnosing and treating those with mental health disorders (Boesky 2002, 21).

Many of these youth do not just suffer from one form of mental illness at the same time, but several, which is known as co-morbidity. Co-morbidity makes it difficult to assess and treat these youth as well (Boesky 2002, 4).⁸

Often, there is confusion and misconceptions among juvenile justice professionals about the process of diagnosing mental illness. Many believe that certain disorders such as ADHD and Bipolar and Conduct Disorder are over applied among juvenile offenders and have somehow lost their appeal (Boesky 2002, 18). “In addition, a number of juvenile justice personnel believe that mental health professionals assign psychiatric diagnoses to youth in a fairly arbitrary manner- rendering the information conveyed by a diagnosis meaningless” (Boesky 2002, 18).

According to Eric W. Trupin, Ph.D. et al. (2004), the percentage of youth diagnosed with Axis I disorders also known as affective disorders, are broken down in table 2.1.

Table 2.1 Axis I Disorders

Axis I Disorders	Percentage
Attention Deficit Hyperactivity Disorder	38%
Bipolar Disorder, Conduct Disorder, Major Depression	9-22%
Psychotic Disorders	8-9%

Trupin et al., 2004

Michele Byrnes, Daniel Maccallair and Andrea D. Shorter (2002) and Boesky (2002) agree that the most common diagnoses among the juvenile justice population is Conduct Disorder. In the general population, approximately 3-9 percent of youth are diagnosed with Conduct Disorder compared to 80-90 percent of the juvenile justice involved population (Boesky 2002, 39). Byrnes et al. (2002, 27) asserts that Oppositional Defiant Disorder is just as prevalent among this population. Regarding the link between

⁸ The Great Smoky Mountain study, noted as “a landmark study in psychiatric epidemiology,” found that one in three children had experienced at least one type of psychiatric disorder by their sixteenth birthday (Kaplan 2004, 6).

early aggression and childhood mental disorders, it was found that Oppositional Defiant Disorder (ODD) contributes to Conduct Disorder (CD), which can be one predictor of violent and antisocial behavior (Kaplan 2004, 4).

Youths who suffer from Conduct Disorder or Oppositional Defiant Disorder, which are also known as “disruptive disorders” usually engage in behaviors that are dangerous to themselves and others (Boesky 2002, 36). ODD causes youths to be defiant, annoying, and disrespectful of rules and authority. While these behaviors might be typical of many adolescents, a youth diagnosed with ODD engages in this type of behavior so much “that it interferes with their ability to function adequately at home, school or work” (Boesky 2002, 37).

Many youths with ODD can also develop Conduct Disorder, which consists of a youth violating rules or laws, and is considered the more severe behavior disorder (Boesky 2002, 37-38). To meet the criteria for a Conduct Disorder diagnosis, a youth must steadily engage in antisocial behaviors (Boesky 2002, 39).

Conduct Disorder is most commonly assigned to juvenile offenders especially those who fight, skip school, steal, or run away from home, but often these behaviors can be indicative of yet another disorder, which should not be overlooked (Boesky 2002, 31). Youth diagnosed with Conduct Disorder have a tendency to have problems in school, with personal relationships and abuse drugs or alcohol, and often engage in other “antisocial acts” against people or property (Boesky 2002, 37-38).

Many youths with Conduct Disorder act impulsively and are susceptible to learning disorders and require special education classes (Boesky 2002, 40). The risk factors associated with Conduct Disorder affect several areas of a youth’s life, including

family relationships, school settings and relationships with peers. Therefore, Boesky (2002, 46) insists it is crucial that members in each of these systems work together to intervene and provide viable services for these youth.⁹

Conduct Disorder cannot be fixed in a short time because the disorder is complicated and offers numerous challenges. According to Boesky (2002), interventions must be long-term, involve all areas of a youth's life, and plans for treatment must focus on the youth and their family as well. In order to meet each of these areas, the multiple systems that a youth is involved with including the juvenile justice, mental health and education systems, should work together to coordinate services (Boesky 2002, 46).

Between 32-88 percent of incarcerated youth are estimated to have mood disorders such as Bipolar Disorder and Major Depression. Many adolescents are not properly diagnosed or it is presumed that they will grow out of their mood swings, which has harmful, long-lasting effects. For example, if a mood disorder is improperly treated it could lead to more serious psychiatric problems for that youth (Boesky 2002, 62).

A youth suffering from Bipolar Disorder usually displays symptoms of major depression along with symptoms of mania that can include restlessness, incoherent conversations or impulsive behavior (Boesky 2002, 83). Youth diagnosed with Major Depression are usually more irritable, which could lead to aggressive behavior, such as fighting. Mental disorders, however, typically do not make someone break the law. "Having a mental disorder is not an excuse to avoid taking responsibility for engaging in delinquent acts" (Boesky 2002, 13).

⁹ Incidentally, youth diagnosed with Conduct Disorder often receive more special services among different social service agencies including the juvenile justice system, mental health agencies, and special education (Boesky 2002, 38).

According to Boesky (2002), many juveniles are over diagnosed with Bipolar Disorder, which can often be confused for the normal emotional instabilities that adolescents go through. The distinction between Bipolar Disorder and normal adolescent mood swings occurs when a youth is too impaired to function properly (Boesky 2002, 86). Conduct Disorder and Bipolar Disorder share like symptoms such as irritability and defiance, however CD youth do not exhibit the uncontrollable mood swings (Boesky 2002, 87).

In the juvenile justice system, it is common to find a youth diagnosed with several psychiatric disorders, but the most frequent are Conduct Disorder and Attention-Deficit/Hyperactivity Disorder (ADHD). In fact, these two diagnoses create even more problems for youth in school, at home and in social settings (Boesky 2002, 43-44). Boesky (2002, 92) reports that in the last ten years, ADHD has been the diagnosis for a large amount of youth. While percentages of the disorder vary among the general population and juvenile justice population, it is unmistakable that juvenile justice system-involved youth suffer from higher rates of ADHD (Boesky 2002, 92). ADHD youth continually display impulsive and hyperactive behaviors. They are more impetuous and unconcerned with consequences of negative behavior (Boesky 2002, 92).

RESIDENTIAL PROGRAMS

According to E. Michael Foster, Amir Qaseem and Tim Connor (2004, 859), youth with mental health involvement are more likely to be involved with the juvenile justice system, and the “obverse is also true that youths in the juvenile justice system suffer from mental health problems.” “As a result of system integration, youths with emotional and behavioral problems who break the law or engage in other offenses may

have their problems identified more quickly and may be diverted into the mental health system” and routed out of the juvenile justice system (Foster et al. 2004, 859). This identification is crucial since being incarcerated in juvenile residential facilities can perpetuate the mental health disorder through additional traumatizing experiences (Foster et al. 2004, 859).

Juvenile justice systems have typically relied on restrictive out-of-home placements as a punishment for delinquency but this reliance has had major consequences (Gies 2003, 2). Out-of-home placements are very expensive and overpopulate already crowded institutions. Furthermore, research has shown that institutionalization seldom corrects bad behavior. And, “because youth are often released to disorganized communities, where it is easy to slip back into the habits that resulted in arrest in the first place, any gains made by juvenile offenders in correctional facilities may quickly evaporate following their release” (Gies 2003, 2).

The recidivism rate for serious juvenile offenders returning to the community without aftercare is estimated at 50 percent. Transitional services and aftercare services are important because they reduce high recidivism rates, which reduces overcrowding and high costs of out-of-home placement expenses (Gies 2003, 2).

The decision to place juveniles is seldom a one-time event. Certain juvenile offenders “will be subject to repeated placement decisions within the juvenile justice system” when it comes to post-adjudication placements such as probation or incarceration and even post-incarceration placements such as parole (Armstrong 1991, 275). The choice to place a youth outside their home should be made only after using consistent, methodical, and accurate criteria. In order to properly assess the needs of a

juvenile offender, Armstrong (1991, 272) recommends that a risk assessment be done to determine the “threat of future criminal activity posed by a youth and, therefore, the appropriate level of supervision necessary to protect the community.”

Researchers propose using specific criteria such as assessment tools to categorize offenders with mental health needs so that supervision and rehabilitation can be tailored to the specific needs of the population. Armstrong (1999) believes it is crucial for assessment tools that diagnose these needs to be valid so treatment efforts are worthwhile. Furthermore, Armstrong (1991, 270) expects assessment tools to accurately reflect reality, especially when the assessment leads to removing a juvenile from their home to a much stricter environment.

There are many goals of residential placement including the safety and security of the community as well as the youth. According to Ashcroft et al. (2003, 13), residential placements should provide youth with educational and vocational opportunities, “address underlying behavioral problems, and prepare [them] for responsible lives in the community.” Furthermore, staff of residential placement facilities should seek to “identify and effectively respond to the youth’s physical and mental health problems and to related behavioral problems throughout the course of confinement by using professionally appropriate diagnostic, treatment, and prevention protocols” (Ashcroft et al. 2003, 13).

Because the juvenile justice system cannot pick and choose whom they deal with, they have “become the default placement for many youth with mental health disorders who are not receiving appropriate psychological and psychiatric treatment in the community” (Boesky 2002, 7). The current facilities in the juvenile justice and mental

health systems are too overworked. Treatment programs particularly in residential facilities are ineffective and failure rates are often higher for these youth. Critics such as Howell et al. (2004, 145) note among other problems they face, these systems “are too crisis-oriented, too rigid in their classification of problems, too specialized, too isolated from other services, too inflexible to craft comprehensive solutions, too insufficiently funded, and they are mismanaged.”

According to Boesky (2002, 7), if juvenile justice facilities were properly equipped to handle youth with mental health needs and their policy shifted from punishment to treatment, things might improve. Whereas some juvenile justice facilities offer effective mental health programs including behavior management skills or psychotropic medication, to be effective, all staff must be trained appropriately and there must be firm policies and procedures in place (Boesky 2002, 251). Furthermore, Boesky (2002, 251) adds, “developing and implementing protocols for providing mental health services while youth are incarcerated, as well as when under community supervision (probation, parole), is critical and essential.”

Intake Process

Accuracy during the information gathering, or intake process is crucial to the success of youths both in residential placements and released from placements. Many youth with mental health diagnoses, especially those requiring medication are placed in more restrictive facilities; even those classified as low- risk because more resources are available in these facilities (Boesky 2002, 29). Boesky (2002) asserts that proper screening and assessments at intake can help with placement decisions, prevent a crisis, compile important mental health data and assist in the transition process. According to

Boesky (2002, 227), “obtaining information about youths’ mental health status, suicidal behavior, previous mental health treatment, current and previous psychotropic medications, and the like, is crucial to providing appropriate aftercare services.”

Armstrong (1991, 272) defines needs indicators as instruments that provide information about a youth’s needs that are relevant to placement decisions because they “provide a guide to the types of therapy, education or other services from which a youth will benefit...” and are very important when developing case plans. Furthermore, Armstrong (1991, 273) adds, “needs assessments in juvenile corrections should be an integral part of a classification system. By including needs assessments in the classification system, an agency not only addresses custody requirements and community protection issues, but also the rehabilitative needs of juveniles.” Armstrong (1991, 274) maintains it is crucial that instruments used to make placement decisions address the correct problem because juvenile offenders must be categorized based on their individual needs.

A major problem of treating mentally ill juveniles is the lack of consistent screening and assessment among agencies. Cocozza and Skowrya (2000, 9) insist it is imperative that all juveniles receive proper screening and mental health assessment as early as possible when entering the system.

There are many challenges to conducting thorough mental health evaluations on juvenile offenders. Training and time, both in short supply, are necessary components for mental health professionals to conduct accurate evaluations. Additionally, many mental

health professionals working in residential facilities have high caseloads, which further limit their time (Boesky 2002, 28).¹⁰

According to Boesky (2002, 44), “too often, medical, mental health, and juvenile court, and juvenile justice facility personnel narrowly focus on youths’ aggressive and delinquent behavior. This focus typically results in continuous referrals made to the juvenile justice system and these youth not receiving appropriate-and much needed-mental health assessment and treatment services.” Additionally, mentally ill youth sentenced for an indeterminate amount of time, which means they are only eligible for release once they complete a program successfully, “can remain under juvenile justice supervision longer than nonmentally ill peers who have similar or less serious committing offenses” (Boesky 2002, 10). Boesky (2002, 10) believes their extended stay is not because these youth choose to disobey the rules of confinement, but because they cannot meet the requirements of the program designed for youth without a mental impairment.

According to Howard Abadinsky (2003, 295), “the assessment involves gathering information from documents and through interviews with persons familiar with the offender and the client him- or herself.” Screening juvenile offenders often takes thirty minutes to complete and is used to detect the possibility of a mental health disorder, not diagnose one. Boesky (2002, 226) advises that if screening reveals the possibility of a disorder, an assessment or more comprehensive evaluation should be conducted and a plan for treatment should be put in place.

Additionally, Coccozza and Skowrya (2000, 10) advises that staff be properly trained to administer assessments in order to effectively put a treatment plan into place.

¹⁰ Other factors contributing to the problems associated with diagnosing mental health disorders exist including lack of adequate training, under-reporting of symptoms and the use of drugs or alcohol. All can seriously impair accurate mental health assessments (Boesky 2002, 225-226).

Staff training and mental health screening tools have made the process of identifying youth with mental health needs more simplistic (Boesky 2002, 5). Collaborative efforts should include cross training of staff and teamwork among assessment teams and case managers (Cocozza & Skowrya 2000, 8).¹¹

Delinquent youth with mental health disorders require additional modifications to a typical program, such as intervention services and possibly psychotropic medication. Addressing both issues simultaneously could provide positive outcomes not only for juvenile offenders but also for the entire juvenile justice system (Boesky 2002, 13). “Without proper training in how to identify juveniles with mental health disorders, staff’s ability to appropriately refer youth for proper assessment is severely compromised” (Boesky 2002, 9). According to Boesky (2002, 225), a set of rules must be in place for specific screening and assessment of mentally ill juvenile offenders if treatment is to be successful.

Furthermore, Boesky (2002) maintains treatment of juvenile offenders with mental health needs should combine various strategies that focus on all aspects of a juvenile’s life including psychological, family, school, social, and vocational to be effective. Treatment should also aim to change their criminal thinking as well as their behavior (Boesky 2002, 254).¹²

However, Behavior Management Programs focus on reinforcing positive behaviors and penalizing negative behavior and can be used effectively during

¹¹ Unfortunately, the interventions that have worked in the past such as medication and behavioral management no longer have the same effect (Boesky 2002, 6), but “when youth are evaluated appropriately and accurately, mental health diagnoses can provide a wealth of information about youths’ challenges, and possible directions for effective treatment” (Boesky 2002, 19).

¹² In juvenile justice facilities, there is limited access to therapeutic counseling by trained professionals and often times the treatment that is provided occurs in a group setting (Boesky 2002, 8).

incarceration and upon release to the community. Residential programs can offer the stability and structure, which many juveniles in placement are not used to (Boesky 2002, 254-255).

One of the highlights of Behavior Management Programs is that they offer juvenile offenders constant behavioral feedback. Boesky (2002, 255) affirms these programs should be utilized to teach youth pro-social skills, self-control and most importantly how to maintain those skills over time. Starting Behavior Management Programs in residential institutions can have long lasting effects, especially upon release to the community. These programs teach youthful offenders consistency, which they can take with them anywhere. Treatment is likely to be ineffective if services are not continual (Boesky 2002, 269). Moreover, supervision officers, parents, and others involved in the youth's aftercare should closely emulate the expectations, rewards, and consequences of placement (Boesky 2002, 256). In order for treatment to be effective, those individuals involved in aftercare must focus on long-term improvement in all aspects of a youth's life (Boesky 2002, 268).

Other programs that have proven successful in residential programs are cognitive based. Teaching youth to change the way they think as well as their behavior is a goal of cognitive skills programs. Youth must engage themselves in these programs; simply attending without active participation is insufficient (Boesky 2002, 257). Just as with any other program or initiative, staff must receive adequate training in techniques such as these (Boesky 2002, 256).

Boesky (2002, 51) maintains that "medication can help youth with a coexisting mental health disorder, making it more likely they will be able to participate and benefit

from the intervention strategies specifically designed to address conduct problems.”

Additionally, managing youth with mood disorders requires mental health referrals and treatment. Psychotropic medication, coping skills, and behavior management techniques are crucial (Boesky 2002, 88-89).¹³

“Although psychotropic medication is often prescribed to youth in juvenile justice facilities, far fewer medical professionals are usually available to monitor the side effects of these medications” and often times it is correctional staff who administer medication (Boesky 2002, 8). Unfortunately, many juvenile justice professionals do not receive training to deal with youth with mental illnesses, especially youth who need psychotropic medications. It is often the juvenile correctional staff that first notices behaviors that indicate negative side effects of medication (Boesky 2002, 9).

“Psychotropic medication is only one possible component of an effective treatment plan for juvenile offenders with mental health disorders and should never be used in isolation” (Boesky 2002, 261). According to Boesky (2002, 261), a juvenile should be educated on the type of medication prescribed, show a willingness to take the medication upon return to the community as well as the need and the resources to continue use.

Release

Reintegration is one community-based strategy that focuses on returning the juvenile offender to the community (Josi & Sechrest 1999, 54). The move from an

¹³ “During the past decade, there has been a significant increase in the use of psychotropic medication with juvenile offenders who have mental health disorders” (Boesky 2002, 260). Few studies have been done on the effects of psychotropic medications on adolescents, however psychotropic medication is prescribed at younger ages and it is not uncommon for youth to have prescriptions for several different medications at the same time (Boesky 2002, 260- 261).

institution to the community can cause feelings of “disorientation, estrangement, and alienation” among youth and the fact that they do not have much support and very little opportunity to adjust creates bigger problems (Josi & Sechrest 1999, 56). Furthermore, what a youth learns while incapacitated may be different outside the institution (Josi & Sechrest 1999, 58). And, Byrnes et al. (2002) asserts that for a youth to succeed upon release from incarceration, they must have community support and positive role models. Often, these youth return to the same poverty stricken neighborhoods and the same dysfunctional families. A youth’s ability to change once released to the community depends on how much care they will have by the community (Byrnes et al. 2002, 12).

The first few months after release is very important because this is when many youth fail (Josi & Sechrest 1999, 58). Many youth receive treatment while they are incarcerated but the majority should also receive services upon their release back into the community (Boesky 2002, 250). Aftercare is truly important and it lends support to the deficiencies in the current system of punishment and incapacitation. Mental health aftercare services should lessen the symptoms of a disorder and can help eliminate participation in criminal activity (Boesky 2002, 250).

Transition Planning

The juvenile justice system has had to increase the role they play in providing treatment to youth with mental health disorders. For this reason “... many programs have been developed to identify and treat mental health disorders through diversionary programs and community based interventions... 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”

(Trupin et al. 2004, 600). Trupin et al. (2004, 600) found that mental health services provided upon release from secure institutions play a major role in decreasing recidivism.

Bullis et al. (2004, 80) found many studies about transition planning for students with disabilities in the community setting, however there is not much to go on for the transition of incarcerated youth back to their community. Bullis et al. (2004, 91) suggested “getting started right” regarding transition back to the community, especially for youth with disabilities.

In their research, Bullis et al. (2004) found some encouraging results. For example, the youth who received services from mental health or other social service agencies were more likely to be engaged in positive activities such as work and school within six months of release, which contributed to the same type of behavior at twelve months. On the other hand, Bullis et al. (2004) noted their disapproval that few youth actually received services in the community. Sadly, the participants in their study did not qualify to receive mental health services even after many of them had been diagnosed with substance abuse issues, mental health disorders and special education disabilities (Bullis et al. 2004).

Bullis, et al. (2004, 91) reiterates “the importance of developing a support system of multiple community-based agencies to help these youths return to the community.” Bullis, et al. (2002, 20) asserts, “transition programs for this population do cost money to develop, operate, and maintain; but there also should be benefits realized both in terms of the individual’s success and in terms of costs to the social service system.”

Bullis et al. (2004) created a conceptual model, a Prefacility Phase, Facility Phase, and Facility-to-Community Transition Phase, in order to track the move from a

correctional setting into the community. The Prefacility Phase refers to the juvenile's experiences before they entered a correctional facility. The Facility Phase includes the interventions the youth received while institutionalized. And, the Facility-Community Transition Phase examines the behaviors of the youth at school or work, and social and criminal behaviors, upon reentering the community as well as any follow up services they received from community agencies (Bullis et al. 2002, 11).

“Community transition plans typically outline what services need to be provided once juveniles are released from a residential setting, and a strategy for implementing these services” (Boesky 2002, 282). According to Boesky (2002, 282), transition plans ideally should start upon a youth's entrance into a residential facility and they should involve parents, caseworkers, probation or parole officers, providers in the community, and most importantly, the youth. A detailed transition plan will include: parole or probation requirements, housing, educational goals, mental health treatment, incentives, consequences, and most importantly who is responsible for what (Boesky 2002, 283).

Boesky (2002) contends that during the transition process, information sharing between residential placements and community providers is imperative. It is important that placements and community providers share information about treatment plans, previous juvenile and mental health history and assessments, and length of supervision (Boesky 2002, 279).

Such efforts will require extensive coordination and collaboration prior to and during release from all agencies that will provide aftercare to the youth and their families (Stephens & Arnette 2000, 5). Boesky (2002, 281) found that “when they are not adequately prepared for this transition, many juvenile offenders with mental health

disorders are overwhelmed upon their return to the community.” Furthermore, the longer a youth has been in placement, the more services they will need (Boesky 2002, 281). These strategies can help a youth transition to the community and can impact youths’ future behavior and self-perception (Boesky 2002, 47).

The educational services that offenders receive in confinement should also be similar to mainstream educational services to make the transition smoother (Stephens & Arnette 2000, 4). Coordination of services between correctional institutions and schools is very important for enrollment purposes as youth need accurate information handy in order to avoid delays or lengthy waiting periods to register for school (Stephens & Arnette 2000, 5).

Strategies include communication with school officials to arrange tutoring, special education services, vocational training and additionally to communicate behavior progress or problems (Boesky 2002, 49-50). Delays hinder educational development, which is already difficult during the transition process (Stephens & Arnette 2000, 5).

Providing educational transition services for these youth can have positive results such as increased enrollment, graduation, and job placement. June L. Arnette and Ronald D. Stephens (2000, 18-19) found the youth in their study who worked or went to school after six months were more likely to do so after twelve months and more likely to stay out of trouble, even youth with special education disabilities. But they concluded that these youth should receive more specialized services in the community. Without services, many youth risk undoing any progress they made while incarcerated (Stephens & Arnette 2000, 5).

A California Youth Authority (CYA) study submitted to a State Senate Committee found that practices departed significantly from those suggested (Byrnes et al., 2002). For example, throughout institutionalization and parole, supervision and enforcement were emphasized instead of treatment and intervention. Transition planning did not start until a month or two prior to a youth's release to parole and furthermore, there was variable interaction or coordination of services between agencies providing services (Byrnes et al., 2002). Staff dealing with these youth and particularly youth with specialized needs received little or no training (Byrnes et al. 2002, 14). The California Youth Authority also lacked sufficient staff to deal with the mental health problems of the youth. Furthermore, training and resources were usually reserved elsewhere (Byrnes et al. 2002, 17).

As a result of some of these problems, "criminal justice experts have identified a continuum of care service model provided in a community-based setting as the most effective way to ensure a smooth transition into the community" (Byrnes et al. 2002, 21). "Wraparound is...a comprehensive intervention strategy" that is defined as a "planning process that results in a unique set of natural supports and community services that are designed to achieve a positive set of outcomes" (Byrnes et al. 2002, 21). Wraparound intervention strategies focus on youth and their families and the continuum of services that can be provided from multiple agencies including "mental health, juvenile justice, child welfare, and educational systems" (Byrnes et al. 2002, 21).

According to Trupin et al. (2004, 603), the most common time for recidivism is the first three months post-release and therefore it is crucial to coordinate effective

transition services in the following areas: mental health, substance abuse and school services.

Washington State, the University of Washington and the Juvenile Rehabilitation Administration (JRA) collaborated to develop a screening questionnaire along with the Massachusetts Adolescent Youth Inventory (MAYSI) “in order to identify and prioritize all incarcerated youth in need of treatment” (Trupin et al. 2004, 601).¹⁴ Prior to discharge, both placement staff and community parole officers were responsible for planning the transition services back to the community (Trupin et al. 2004, 601).¹⁵ The goal was not only to involve incarcerated youth, but their parents, as well as community based programs to build upon skills and attitudes the youth learned in placement (Trupin et al. 2004, 601).

The results of the study showed that even the smallest amount of discharge planning and transition services could deter continued criminal behavior. “Adolescents who received more extensive post-discharge planning (greater number of JRA contacts with different community treatment providers) were less likely to reoffend...” (Trupin et al. 2004, 606). Hence, Trupin et al. (2004, 607) implores juvenile justice administrators to take these findings into account when allocating resources to this growing population.

Aftercare

Aftercare has several definitions. Gies (2003, 1) defines aftercare as “reintegrative services that prepare out-of-home placed juveniles for reentry into the community by establishing the necessary collaborative arrangements with the community

¹⁴ Youth with co-occurring needs, such as substance abuse and mental health; received more services both before and after release as well as more community referrals upon discharge (Trupin et al. 2004, 607).

¹⁵This study was used by the Human Services and Corrections Committee of the Washington State Senate and helped pass legislation to increase funding (SB 6853) for transition intervention programs for the youth with co-occurring disorders (Trupin et al. 2004, 607).

to ensure the delivery of prescribed services and supervision.” Abadinsky (2003, 165) defines aftercare as “the planned release of a juvenile from a residential placement...to supportive services in the community.” And, Boesky (2002, 281) asserts that “aftercare” or “continuing care,” services are important for juvenile offenders released back into the community from residential placement and they should help the youth adjust back to life in the community.

Abadinsky (2003, 173) affirms that “the juvenile offender, ‘when he is released back into the community in his twenties- undereducated, unsocialized, unemployable, and at the peak of his physical power- he will be the very model of the very person we wished most to avoid.’” The fact that very few mental health services exist and a “lack of aftercare or reentry programming for these incarcerated juveniles is also of particular concern” (Ashcroft et al. 2003, 28).

At any given time, 9-13 percent of youth in the general population have a diagnosable mental health disorder. The numbers are higher for the 1.8 million juveniles entering the system each year, unfortunately, the needs of this group are poorly understood because rigorous research studies are limited (Ashcroft et al. 2003, 28).

The U.S. Office of Juvenile Justice and Delinquency Prevention recognizes the need for the creation of a model to meet the needs of juveniles with mental health disorders in all facets of the juvenile justice system in order to close the gaps that exist in the continuum of services (Ashcroft et al. 2003, 28).

“Growing concerns about institutional crowding, high rates of recidivism, and escalating costs of confinement have fueled interest in developing innovative ideas and programs for juvenile offenders, including juvenile aftercare/ parole philosophy and

practice” (Josi & Sechrest 1999, 52). In fact, aftercare is important for many reasons and the fact that correctional settings have a poor record in reducing recidivism rates of juvenile offenders only lends support to the concept of aftercare (Josi & Sechrest 1999, 52). For example, Don A. Josi and Dale K. Sechrest (1999, 52) reported over half of the juvenile offenders released from the California Youth Authority failed to meet the terms of their parole requirements and 34 percent failed in the first twelve months.

While aftercare is a somewhat new concept it also offers a new way to deal with offender reintegration. Aftercare, however calls for a change in the way the juvenile justice system currently works. “The current juvenile justice system compartmentalizes the steps in the juvenile justice process and creates competing agendas that overlook what should be a shared goal--- the prevention of juvenile reoffending” (Gies 2002, 5).

Correctional settings can help prepare a youth for transition to the community but they can only control what goes on inside the institution; often times they are not too concerned with what goes on outside the institution. In contrast, parole agencies deal with services and supervision in the community and do not have input as to what goes on in the correctional institution. According to Gies (2003, 5), for aftercare to be effective, all components of the juvenile justice system including the courts, correctional institutions, parole agencies, educational providers, social services and even law enforcement agencies must collaborate to break down any barriers that exist.

“Having a supportive family, positive peer relationships, rational coping methods, and strong interpersonal competences are known as protective factors...” (Ruffolo et al. 2004, 244). When a youth returns to the same family, the same school and the same community, the same negative influences that contributed to their placement may still be

there. These “risk factors...include delinquent peer groups, poor academic performance, high-crime neighborhoods, weak family attachments...and lack of consistent discipline” just to name a few (Stephens & Arnette 2000, 2). The consensus among the literature is that the aftercare process should begin immediately after a youth is placed in a correctional setting, throughout the incarceration, and upon release back into the community, in order to be effective (Gies 2003, 1).

To reduce antisocial behavior, aftercare requires a continuum of services in the community (Gies 2003, 1). There are two key components to aftercare that separate it from the typical model of juvenile justice. First, as opposed to the traditional practice of receiving some kind of supervision and maybe some services, with aftercare a youth must receive both supervision and services. Second, a youth must receive intensive intervention during and after incarceration (Gies 2003, 1).

The components of a comprehensive aftercare model calls for both intervention and community restraint research. “Intervention strategies focus on changing individual behavior to prevent delinquency. Community restraining strategies prevent criminal activities by reducing an offender’s capacity and opportunity to commit crimes” (Gies 2003, 2-3).

Research shows that youth with mental health needs such as emotional and behavioral disorders often commit crimes. Children who are served in the mental health system are three times as likely to be served in the juvenile justice system as well. Youth involved in criminal behavior who also have such mental health disorders demonstrate problems in many areas including school, home, and in the community. One agency

alone cannot deal with the multi-faceted problems these youth face (Rosenblatt, J.A. et al. 2000. 228).

Boesky (2002, 89) emphasizes that referrals to mental health aftercare services are first and foremost for youth released back into the community from incarceration. Ruffolo et al. (2004) adds that intense mental health programs should encompass preventative efforts in schools, community and family. They should not target “their depressive symptoms on an individual level or with medication” as that “will not eliminate the environmental factors related to their depression” (Ruffolo et al. 2004, 244). Masking the problem or simply trying to put a band-aid (medication) over them ignores the underlying issues.

The foundation of establishing an efficient approach to treatment begins with “open lines of communication among all organizations involved with juvenile offenders...” (Stephens & Arnette 2000, 3). Foster et al. (2004, 859) suggests “integration and coordination between the mental health and juvenile justice systems” through a “system of care” with collaboration between both agencies. No one agency is responsible for mental health care; rather the responsibility falls back to the entire community (Foster et al. 2004, 859).

Sharing information and communication can help the negative stereotypes that youth encounter, replication of services, or failure to refer youth to necessary services (Stephens & Arnette 2000, 3). Interagency collaboration is equally important in developing an aftercare model. “Interagency collaboration is a key strategy because it reconnects fragmented human services organizations to create an efficient system that addresses the multiple needs of incarcerated youth” (Gies 2003, 5). According to Gies

(2003), the support system offered in the community should replicate services received while in residential placement to prepare youth for a successful release.

Aftercare has several goals, one of which is to reduce recidivism rates of juvenile offenders (Abadinsky 2003, 169-170). An example is The Regional Youth Educational Facility (RYEF), which is a six-month residential program in California that offers four to six months of aftercare (Armstrong 1991, 395).¹⁶ According to Armstrong (1991, 396), the RYEF “represents an attempt at juvenile rehabilitation or resocialization through a program composed of education, treatment, training and work experience components.”

The RYEF program provided counseling, education services, including remedial and GED preparation, physical education, victim awareness, career education, vocational training and work experience, and aftercare. Aftercare preparation began as soon as a youth arrived and planning services with the assigned aftercare parole or probation officer were ongoing throughout their stay. Aftercare preparation was an important step because it allowed the supervising officer and the youth to develop a relationship prior to their exit (Armstrong 1991, 401-406).

Officers in the RYEF aftercare program had about 15 youth on their caseload, which was in stark contrast to a regular officer’s 65 to 110-caseload size. The reduced caseload allowed the officer to have more frequent and personal contacts with the youth in the community. Armstrong (1991, 407) affirms that “the purpose of intensive aftercare is to encourage...educational, employment and personal objectives”... that were “agreed on prior to release.” In this particular aftercare program, after four to six months, a youth

¹⁶ While RYEF excluded youth with emotional disorders, the aftercare element can serve as a model for youth with mental health disorders.

could be assigned to regular probation depending on their needs (Armstrong 1991, 407). Overall, the RYEF program was a success. The recidivism rates for the experimental group who received aftercare services was 16 percent, the comparison group rate was 45 percent (Armstrong 1991, 413).

According to Gies (2003, 5), in order for any aftercare model to work, there must be support from leadership first who then promote aftercare to staff. While rehabilitative efforts have shown limited success with juveniles, aftercare is simply a necessity because the emotional and social problems that occur in confinement do not just go away upon release (Josi & Sechrest 1999, 53). Aftercare is important because “many chronic juvenile offenders released from secure facilities exhibit additional problems requiring specialized treatment... because of the...emotional and cognitive problems that hinder normal postadolescent development” (Josi & Sechrest 1999, 55).

But, according to Abadinsky (2003, 169), “juvenile aftercare has typically been underfunded, despite its obvious importance.” Many aftercare projects fail not because of the concept itself, but because of a bad program design and inadequate implementation (Gies 2003, 6).

Nevertheless, Gies (2003, 6) maintains there have been successful aftercare programs as well. The Lifeskills '95 Paradigm is an “intensive aftercare treatment program designed to assist chronic, high-risk juvenile offenders, when released from secure confinement...” (Josi & Sechrest 1999, 58). The program was “designed to treat the improperly socialized offender by using a series of lifestyle and life skill treatment modalities in a well-integrated educational approach to healthy decision making” (Josi & Sechrest 1999, 59).

The goal of this program was to “combine innovative strategies to facilitate juvenile offenders’ transition back into the community” and help to reduce the recidivism rate of juvenile offenders (Josi & Sechrest 1999, 58). Josi and Sechrest (1999, 58) believes negative peers, family socialization, or lack thereof, and poor school performance hinders an individual’s ability to adapt to societal norms, which can become a lifelong problem.

Several factors contributed to the programs successful results such as the creation of a positive atmosphere, specialized treatment, and counseling on reintegration.¹⁷ As for actual results, the program helped lower short-term recidivism rates, as the participants enrolled in the program were three times more likely to be successful (Josi & Sechrest 1999, 75).

The next chapter further reviews the literature in order to develop a model aftercare program for youth with mental health needs.

¹⁷ It should also be noted that the program showed success rates for those juveniles displaced from the “negative influences of a dysfunctional family,” negative peers, and impoverished neighborhoods, which they had grown accustomed to (Josi & Sechrest 1999, 75). These results were promising and necessary for those youth who really needed to make a change in their lives (Josi & Sechrest 1999, 75).

CHAPTER THREE

MODEL AFTERCARE PROGRAM

PURPOSE

The purpose of this chapter is to develop the ideal components for a model aftercare program for youth with mental health disorders through a review of the literature. This model aftercare program subsequently served as a guide to assess the Aftercare Program in a case study of Williamson County Juvenile Services. The overall goal is to assist juvenile probation departments in Texas provide better aftercare services for the growing number of youth released from residential facilities with mental health disorders.

COMPONENTS OF AN IDEAL AFTERCARE PROGRAM

The Intensive Aftercare Program Model (IAP) developed by Altschuler and Armstrong, referenced by Steve V. Gies (2003) and Jeremy Travis (1998), is the model used to develop the categories and subcategories for an ideal aftercare program. While all elements are not used in the ideal model, this IAP was chosen because it contains many important components that the researcher considered essential.¹⁸

According to Travis (1998, 1-2), the goal of Altschuler and Armstrong was to create a model for agencies dealing with incarcerated youth to implement services during incarceration and after. The Intensive Aftercare Program Model was developed to lower recidivism rates by “providing carefully targeted services and counseling to youthful offenders throughout correctional supervision, prerelease, community reentry, and

¹⁸ Travis (1998, 1-2) highlighted the research project conducted by David M. Altschuler regarding intensive aftercare for juvenile offenders because of the increasingly crowded juvenile correctional facilities, high recidivism rates, and the costs of incarceration. The problem was increasing nationwide and called for the assistance of the Office of Juvenile Justice and Delinquency Prevention to intervene and provide funding for research (Travis 1998, 1-2).

community supervision. The IAP model stresses the importance of collaboration among juvenile justice agencies, probation and parole departments, and providers in the community (Travis 1998, 1-2).

The IAP consists of three overlapping segments inherent for a continuum of care: pre-release planning, transitional services from participating staff in the institution and in the community, and a long-term, reintegrative approach to ensure proper service delivery for social control (Gies 2003, 7).

Michael Bullis, Paul Yovanoff, and Emily Havel (2004) elaborates on the three-phase conceptual model regarding the facility-to-community transfer as follows: 1) the Pre-Facility Phase, which looks at all the characteristics and experiences of a youth prior to incarceration; 2) the Facility Phase, which includes the educational and social experiences in the correctional setting and; 3) the Facility-to-Community Transition Phase, which looks at “the work, school, independent living, social, and criminal behaviors exhibited by participants upon re-entering the community setting, and the services they received in the community from education and social service agencies” (Bullis et al. 2004, 83).

According to Gies (2003, 7) the main feature of the IAP is the “overarching case management system.” There are five elements to this system that guide a successful transition and aftercare. The first element is risk assessment and classification, which calls for a jurisdiction to use a risk-screening instrument valid at predicting high-risk youth (Gies 2003, 7).

The second element is individualizing a youth’s case plan by using family and community insight. This includes addressing any problems the youth had in school, in

the home, or with peers and incorporating that into their plan not only while in the institution, but during the transition back into the community as well (Gies 2003, 7).

The third element of the IAP model deals with supervision and services. The IAP calls for close supervision of high-risk offenders along with intensive services. This element also calls for qualified staff, small caseloads, and funds to provide services (Gies 2003, 7).¹⁹ The final element of an IAP model calls for an alliance among many agencies and social networks including family, schools, and peer groups and all workers in these agencies must work together to implement change (Gies 2003, 8).²⁰

Several successful IAP models have been implemented by different states including Colorado, Nevada, and Virginia all however, exclude youth with severe mental health problems (Gies 2003, 7). Due to the rise in the number of youth in the juvenile justice system with mental health disorders, perhaps it is time for an IAP model to be replicated for such youth.

The Colorado Intensive Aftercare Program's key component was continuity of service delivery during the institutional phase. During this time, community-based providers offered weekly services that continued during aftercare. The Colorado IAP offered vocational training, individual and family counseling, and upon release weekly contact, and curfews (Gies 2003, 9-10).

The Nevada IAP also offered curfews and intensive supervision to include house arrest, and electronic monitoring. The Virginia IAP did the same and added monthly court reviews. Additionally, Virginia's IAP offered services in the community including

¹⁹ A very interesting element of the IAP model calls for a balance between incentives and consequences. Unacceptable behavior must be punished by standard sanctions that fit the seriousness of the violation, however positive behavior should be rewarded in order to encourage compliance (Gies 2003, 7).

²⁰ Another important objective of the IAP is to continue any type of specialized treatment the youth received in the correctional setting in the community (Travis 1998, 1-2).

mental health, family preservation and alternative education and vocational programs (Gies 2003, 10-11).

An evaluation of Intensive Aftercare Programs in Colorado, Nevada, and Virginia reveals several accomplishments. First of all, these models have demonstrated a difference in the supervision and service delivery than traditional efforts. According to Gies (2003), the team effort and small caseload sizes also show promise. “By focusing on transition-related activities, these programs have dramatically improved the level of coordination and communication between institutional and aftercare staff” (Gies 2003, 11).

After a review of the literature, as well as the following strategies implemented by the Bethesda Day Treatment Center in West Milton, Pennsylvania the components and subcomponents for a model aftercare program have been developed (Gies 2003, 15).

The first category involves **Supervision**. Community supervision includes several components of counseling, including individual counseling to discuss progress, problems, goals and other needs and psychological counseling in order to meet psychological needs. A second component of community supervision requires intensive supervision to hold youth accountable and to ensure they are following treatment plans (Gies 2003, 15). Combining intensive supervision with treatment is a “hallmark” of the system. Interventions are designed to reduce risk while addressing individual needs. Furthermore, the use of rewards and sanctions are necessary in order to punish unacceptable behavior and reward positive behavior (Gies 2003, 24-25). Additionally, school and/ or job visits are important to monitor compliance and improve performance (Gies 2003, 15).

A third component of community supervision by E. Michael Foster, Amir Qaseem and Tim Connor (2004, 859) makes another useful suggestion regarding the implementation of the level of service delivery model, which calls for staff training in areas and issues related to mental health.

The final component for the community supervision category calls for training and support for interagency collaboration, which is highly important to the success of any program seeking to implement consistent services in order to overcome the cynicism that exists (Eber, Sugai, Smith & Scott 2002, 172).

The second category involves **Aftercare**. Aftercare Programs serve as a means to facilitate transition from a correctional institution to the community. Crucial aftercare components include: community links to treatment service providers, assessment and classification instruments in order to refer youths to the proper programs based on their needs and individualized case planning to gauge proper treatment options (Gies 2003, 24-25).

“The wraparound process has emerged from the concept known as *system of care*, which is a community-based approach to providing comprehensive, integrated services through multiple professionals and agencies and in collaboration with families” (Eber et al. 2002, 172). According to Travis (1998), an important goal of the IAP Model is to identify risk factors such as family issues, negative peers, and school involvement, and resources should target deficiencies in these areas throughout the transition process. Everyone, from staff in the correctional facilities, parole officers and other aftercare providers should be involved in the transition process (Travis 1998, 1-2).

The third category centers on **School Involvement**. According to the research conducted by David M. Altschuler, follow up services for school participation are important as many youth could not return to regular school upon release from a correctional setting and therefore alternative schooling options are necessary (Travis 1998, 1-2).

The fourth category is **Family Involvement**. Gies (2003) incorporated several components to family involvement such as home visits, family and parental counseling and family interventions. According to Gies (2003), home visits allow supervising officers to see the youth in their environment, which can provide more detail about the youth and their family. Family counseling opens the lines of communication among family members and parental counseling focuses on the needs of parents and offers support and encouragement to deal with their children. Finally, family intervention and training increases stability, which can help families function on their own (Gies 2003, 15).

The similarities found between these Intensive Aftercare Programs offers a blueprint for other agencies to implement aftercare programs designed to help in the transition from a correctional setting back into the community (Gies 2003, 25) and have provided the basis for the ideal aftercare model to assess Williamson County.

CONCEPTUAL FRAMEWORK

The purpose of this research is gauging and the conceptual framework that will be used is a practical ideal type. Conceptual frameworks are “tools” that can be used “to help connect the problem to observed data” (Shields 1998, 210). Gauging allows a researcher to measure a problem or policy against a standard (Shields 2003, 8).

According to Shields (1998, 215), “practical ideal types can be used as standards or points of reference.”

A review of the literature and an examination of the components of a model aftercare program have established the characteristics for a practical ideal type aftercare model, which was used to assess the Aftercare Program at Williamson County Juvenile Services. The four components of the model aftercare program include: community supervision, mental health aftercare, school involvement and family involvement.

SUMMARY OF MODEL

Table 3.1 lists the components and subcomponents of the practical ideal type and links them to the literature. The components include:

- Community Supervision
- Mental Health Aftercare
- School Involvement
- Family Involvement

Along with their subcomponents, these components make up the model aftercare program, which will be used to assess the aftercare program in Williamson County.

The components and subcomponents evolved after a thorough review of the literature, and were closely modeled after the Intensive Aftercare Program Model developed by Altschuler and Armstrong. As Gies (2003) stated, this model can serve as a blueprint for any agency seeking to implement a successful aftercare program. The components are ideal to assist youth with mental health needs and those designated to work with them during the transition from a correctional setting back into the community.

Table 3.1 Summary of Conceptual Framework Linked to the Literature

Ideal type categories	Literature
Community Supervision <ul style="list-style-type: none"> ▪ Transition Planning ▪ Intensive Supervision & Treatment ▪ Officer Training ▪ Interagency Collaboration 	Gies 2003 ; Josi 1999; Coccozza 2000; Foster 2004, Howell 2004; Kaplan 2004; Trupin 2004; SNDP 2004; Byrnes 2002; Boesky 2002; Abadinsky 2003; Armstrong 1991; Rosenblatt, J.A. 2000; Kamradt 2000; Travis 1998
Mental Health Aftercare <ul style="list-style-type: none"> ▪ Interagency Collaboration, Systems of Care, & Wraparound Services ▪ Assessment & Screening ▪ Funding 	Gies 2003; Josi 1999; Coccozza 2000; Kamradt 2002; Bullis 2002; Atkins 2003; Bullis 2004; Foster 2004; Howell 2004; Kaplan 2004; Trupin 2004; Boesky 2002; Spriggs 2003; Travis 1998; Armstrong 1991; Ashcroft 2003; Rosenblatt, J.A. 2000; Byrnes 2002; Eber 2002; Ruffolo 2004; Rawal 2004; Kamradt 2000
School Involvement <ul style="list-style-type: none"> ▪ Alternative Education ▪ Specialized Services for Learning Disabled Youth ▪ Mental Health Services through Multisystemic Therapy & Positive Attitude Toward Learning in Schools (PALS) Programs ▪ Interagency Collaboration & Wraparound Services 	Atkinks 2003; Atkins 1998; Bullis 2004; Bullis 2002; Ruffolo 2004; Howell 2004; Trupin 2004; Stephens 2000; Byrnes 2002; Eber 2002; Travis 1998; Boesky 2002; Ashcroft 2003; Rosenblatt, J.A. 2000; Josi 1999
Family Involvement <ul style="list-style-type: none"> ▪ Family Intervention & Training ▪ Wraparound Services 	Gies 2003; Howell 2004; Trupin 2004; Josi 1999; Boesky 2002; Travis 1998; Ashcroft 2003; Byrnes 2002; Eber 2002; Ruffolo 2004; Kamradt 2000

COMMUNITY SUPERVISION

Community Supervision, the first main category, includes four subcomponents including transition planning, intensive supervision and treatment, officer training and interagency collaboration, and is an important component to the aftercare model.

According to Michele Byrnes, Daniel Maccallair and Andrea D. Shorter (2002), young offenders face similar challenges upon returning to their communities. In numerous interviews done with parole officers and service providers in the California Youth Authority, researchers found that youthful offenders face barriers such as limited opportunities for education, lack of skills, mental health problems and lack of community support (Byrnes et al. 2002, 9).

Transition Planning

Howard Abadinsky (2003, 99) considers juvenile probation officers the core of juvenile courts. Aftercare and probation supervision are similar however the main goal of the aftercare officer is to arrange services for the release of a juvenile offender (Abadinsky 2003, 165). Thus, juvenile probation officers serving as aftercare officers would therefore be the center of aftercare programs as well. Lisa M. Boesky, Ph.D. (2002, 227) concluded that when supervising staff in the community have knowledge about prior treatment, the referral process is much easier. Other strategies that have been successful include probation and parole supervision with “multiple services” (Kaplan 2004, 8).

Intensive Supervision and Treatment

According to Boesky (2002), supervision officers in the community should monitor a youth’s progress in various settings including school, at home or with friends. As a matter of fact, increased supervision can deter criminal activity (Boesky 2002, 282). A major premise behind this program includes weekly meetings with parole officers as well as counseling for specific issues (Josi & Sechrest 1999, 60).

An ideal continuum of care includes proper supervision techniques such as electronic monitoring and intensive supervision to keep a close watch on youth in the community as well as suitable requirements like community service (Byrnes et al. 2002, 25). The Electronic Monitor (EM) program can help officers enforce curfews or house arrest, which requires the youth to stay home at all times unless they are school, work or other activities which require permission (Abadinsky 2003, 448).

Yet, according to Travis (1998), research showed several discouraging statistics among offenders. First, the more intensive supervision was, the more likely a youth was

to return to a correctional facility because of technical violations. Second, the offenders categorized as low-risk did not do as well under intensive supervision as opposed to regular supervision (Travis 1998, 1-2). Gies (2003) argues that staff and offender contact is essential and effective treatment.

On the other hand, “the most effective treatment programs provide larger amounts of meaningful contact with offenders over a longer treatment period” (Gies 2003, 3). Systematic barriers exist including staff turnover, unstable operating environments, and competing agency priorities (Gies 2003, 3).

Increasing the supervision level of offenders reduces their abilities to commit crimes and therefore prevents the occurrence of criminal activity. However, while supervision alone does not reduce recidivism when coupled with treatment it offers promising results (Gies 2003, 4).

Individual treatment has been customary as opposed to family or group therapy that “engages parents and incorporates all aspects of a youth’s environment (family, school, community, parole, etc.)” (Trupin, Turner, Stewart & Wood 2004, 607). Intervention strategies include counseling, probation, and/ or vocational and academic programs that seek to change behavior and prevent delinquency (Gies 2003, 3).

According to Gies (2003), intervention strategies should have several characteristics. They should target both dynamic and criminogenic factors such as age, gender, or criminal history that are associated with criminal activity yet cannot be changed by treatment. Thus, rehabilitative efforts must focus on dynamic characteristics that are open to change such as attitudes, relationships and even education and peers (Gies 2003, 3).

Intervention strategies favor the use of structured treatment techniques as opposed to less structured ones. They should focus on multimodel methods and behavioral and skills-oriented treatment. In fact, treatment provided in the community has shown greater reduction in recidivism as opposed to treatment in correctional settings (Gies 2003, 3).

As far as supervision strategies go for dealing with certain youth with mental health disorders, as an officer it is best to explain precisely what is expected of the youth. Just as well, consistency is essential for these youth who typically were raised in inconsistent environments. According to Boesky (2002, 54), successes should be reinforced and officers dealing with youth should treat them with respect in order to get respect.

Additionally, Boesky (2002, 58) maintains that officers involve family members in treatment by teaching them effective strategies as well as informing them of progress and barriers. Conditions for successful treatment should be concise, but at the same time should not be overburdening (Boesky 2002, 275).

Boesky (2002, 275) adds that consequences for non-compliance from the youth should be communicated and enforced among the various agencies. Good practice for supervising officers is to discuss what type of positive incentives as well as negative sanctions would be motivational to youth and their families (Boesky 2002, 276).

Officer Training

Of equal importance is the issue of staff training. Gies (2003) argues it is imperative that trained staff strictly adheres to intervention strategy plans. Research shows weak programs implemented by untrained staff will be unsuccessful in reducing recidivism, which is the ultimate goal (Gies 2003, 3).

Boesky (2002, 230) agrees that juvenile justice staff and mental health professionals should work together and have proper training to supervise youth in the juvenile justice system with mental health needs. In order for staff to work effectively with juvenile offenders with mental health problems, officers should receive sufficient, hands-on training, not just training from manuals (Boesky 2002, 277).²¹ Training in the area of developmental issues, interpersonal skills, identification of disorders and proper treatment interventions are ideal (Boesky 2002, 277).

Interagency Collaboration

Interagency collaboration is a recurring theme throughout the literature regarding aftercare, coordination of services, and continuum of care. The preferred method for delivering services across agencies consists of cross training and collaboration (Cocozza & Skowrya 2000, 11).²²

According to Boesky (2002, 235), assessments conducted in both the mental health and juvenile justice systems have similar objectives and both should pool resources to share information in order to coordinate services in the best interest of the child.

MENTAL HEALTH AFTERCARE

The next main category of a model aftercare program, Mental Health Aftercare, includes three subcomponents: interagency collaboration, systems of care, and wraparound services; assessment and screening; and funding, and is an important component to the aftercare model for the following reasons. James C. Howell, Marion

²¹ According to Byrnes et al. (2002, 18), parole officers receive very little training even though they must play several roles including enforcer, referral agent and community liaison. All too often, trainings are reserved for only the basic policies and procedures.

²² Incidentally, in the California Youth Authority, policies frown upon the sharing of information among different agencies (Byrnes et al. 2002, 20)

R. Kelly, James Palmer and Ronald L. Mangum (2004) stresses the compelling need to merge several systems including the juvenile justice system, education system and mental health system. According to research conducted by the National Adolescent and Child Treatment Study (NACTS), only a small amount, 6 percent of seriously emotionally disturbed (SED) youth receive services from one of these systems yet “4 out of 10 received services from three systems” (Howell et al. 2004, 144).

Howell et al. (2004, 144) maintains the agency providing most services is the mental health system (93 percent) followed by 80 percent of youth receiving services from the juvenile justice system and 71 percent receiving special education services in the school system.

Howell et al. (2004) found services to be inadequate, particularly for seriously emotionally disturbed youth. In fact, “75% were either readmitted to a mental health placement or committed to a juvenile correctional facility” (Howell et al. 2004, 44). The NACTS found “short-term interventions targeting a specific problem are not likely to be effective with the SED population” (Howell et al. 2004, 144). Researchers of NACTS concluded that “comprehensive, integrated services” were needed over an extended amount of time to achieve success (Howell et al. 2004, 144).²³

Interagency Collaboration, Systems of Care, & Wraparound Services

Joseph J. Cocozza & Kathleen Skowrya (2000) argue that juvenile justice officials are challenged with meeting the needs of youth with serious mental health problems and face many barriers. One barrier is deciding which of the many systems, juvenile justice

²³ Due to the disproportionate amount of youth with mental health disorders involved in the juvenile justice system, several substantial intervention programs have been implemented. The two most notable to date are Multisystemic Therapy and Functional Family Therapy, which call for early intervention (Trupin et al. 2004, 600).

or mental health, is responsible for providing care. Another is the “lack of training, staffing, and programs necessary to deliver mental health services within the juvenile justice system” (Cocozza & Skowrya 2000, 7).

Denise C. Herz (2001) argues that when a juvenile is involved in more than one system, for instance, the juvenile justice and mental health system, the two rarely coordinate services. Instead, the youth typically goes to the system that has the most resources (Herz 2001, 172). According to Cocozza and Skowrya (2000, 7), new strategies or models of care must enforce collaboration across systems. “The field is beginning to understand that the needs and issues surrounding individuals with mental health disorders cannot be placed at the doorstep of any single agency or system.” On the contrary, many agencies have to coordinate services in order to effect change (Cocozza & Skowrya 2000, 7).

Foster et al. (2004, 859) believes the type of service varies from strategic planning, budgeting, assessments, case management and staff training. Furthermore, Lucille Eber et al. (2002, 172) affirms that positive behavioral interventions and supports (PBIS) and wraparound promote positive change in behavior “across the range of student life domains.” This continuum of care requires support, commitment and consistency from the time of incarceration throughout successful release to the community (Byrnes et al. 2002, 22). Foster et al. (2004) adds that by using the system of care approach, involvement in the juvenile justice system would lessen.

According to Boeksy (2002, 238-239), professionals in both the MH (Mental Health) and juvenile justice systems should have knowledge about how the other field operates. In order to develop “a better understanding of how to coordinate services

between MH and juvenile probation is as much an essential component of addressing the problem of juvenile delinquency as it is of treating the needs of youth with severe emotional disturbance” (Rosenblatt, J.A., Rosenblatt, A. & Biggs 2000, 235).

According to Boesky (2002, 237), “referring youth to mental health/ medical professionals is one step in the possible prevention of significant mental health issues.” Rosenblatt et al. (2000, 238) insists, “a community-based component is essential for altering the environment to fit the needs of the particular child.” These needs should be examined from a “socioecological perspective” focusing on a youth in regards to his or her family, peer group, school, and community (Rosenblatt et al. 2000, 235).

While collaboration between agencies definitely has its strong points, Eber et al. (2002, 172) claims it is difficult to accomplish. For youth receiving aftercare treatment from multiple agencies, coordinating services among them is important to avoid repeating services. Agencies must also communicate with one another about the services they are providing (Boesky 2002, 274). One of the first steps to integrating services is sharing information. According to Howell et al. (2004, 149), planning, funding, and delivery of services to create an interorganizational infrastructure are necessary.

Howell et al. (2004) emphasizes another major step towards integration includes appointing a team of community members to plan and make decisions. Suggested members from the community include but are not limited to the following systems: education, mental health, law enforcement, private organizations, courts, religious organizations, parents and the youth in the community (Howell et al. 2004, 149-150).

The goal of the team is to assess the needs of the youth and family. The next step is to communicate their needs with other agencies by way of referrals (Howell et al.

2004, 149-150). “Important mental health information should follow youth as they move through the juvenile justice continuum-with new treatment approaches integrating assessment information and intervention strategies that have come before” (Boesky 2002, 274). Boesky (2002, 284) adds, “...it is beneficial to designate one professional as the coordinator of the many services that youth receive, and with whom everyone communicates.” Yet, Boesky (2002, 285) argues that one system alone is not equipped to handle the burden of dealing with the care of youth with mental health disorders and therefore it is crucial for multiple agencies to work together.

Assessment & Screening

Certain symptoms of mental health disorders can change over time and youth may outgrow some symptoms. Therefore, assessments are necessary every few years (Boesky 2002, 95). Aftercare providers should monitor treatment progress or set backs and make changes when necessary (Boesky 2002, 269).

Boesky (2002, 248) discusses Community Assessment Centers (CAC’s), which are actual centers developed across the country to “more effectively and efficiently screen and assess youth involved with the juvenile justice system.” Boesky (2002, 248) maintains that CAC’s help coordinate services between various agencies including juvenile justice, mental health, and educational systems in order to assist youth who need their services.²⁴

CAC’s have many benefits including 24-hour services, mental health staff on site, immediate screening and assessment, individualized treatment plans, collaboration

²⁴ One goal of the CAC’s is to prevent youth involved in the juvenile justice system from future criminal activities by identifying and meeting their treatment needs effectively (Boesky 2002, 248).

among agencies, and ongoing case management services. Furthermore, Boesky (2002, 248) asserts that CAC's offer a "consistent and coordinated response to juvenile crime."

Funding

As previously stated, Abadinsky (2003, 169) argues that aftercare is under funded despite its importance. Of the astonishing number of youth with mental health needs, many do not receive treatment. Bruce Kamradt (2000, 1) argues that several barriers exist but none more prevalent than funding.

Byrnes et al. (2002) agrees that funding is insufficient to provide youth with the treatment they need. Many programs remain under funded and eligibility criteria are often very strict.²⁵ Furthermore, confusion exists among agencies and which systems, juvenile or mental health, are responsible for funding. According to Kamradt (2002, 1), "economics play a decisive role in whether or not a youth gets timely and significant mental health support."

Still, options for funding mental health services do exist (Kamradt 2000, 1). Rehabilitative efforts from the government include federal funding (Josi & Sechrest 1999, 54). Public insurance programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) are available to provide services to children and adolescents with long-term mental health needs (Kamradt 2002, 2).²⁶

State Children's Health Insurance Programs offer low cost insurance to working families who make too much to qualify for Medicaid but are unable to afford private

²⁵ In fact, Byrnes et al. (2002) found the lack of available resources was a main reason youth with only the most serious mental health needs were given priority in the California Youth Authority.

²⁶ Medicaid provides a majority of services to youth but restrictions exist for detained juveniles or those in correctional institutions. Federal law prohibits States from providing Medicaid services to incarcerated youth but that does not terminate their eligibility, just postpones it (Kamradt 2002, 2).

health insurance. Through SCHIP's, youth can receive mental health services, but they vary from state to state (Kamradt 2002, 2).

Private insurance also serves the mental health needs of juveniles including hospitalization, outpatient treatment, and medication, but require co-payments and there is usually a limit on the amount of services, which can lead to costly out of pocket payments for which parents are responsible (Kamradt 2002, 2).²⁷

As in any other field, money plays a big factor in the dispensation of services. All too often, cuts are made when it comes to the exact programs that help the transition process such as job placement and intensive supervision. In fact, Byrnes et al. (2002, 21) found in a budget report from the California Youth Authority, that these were labeled as “non-critical parolee services, which will not affect parolee oversight or public safety.” On the contrary, Byrnes et al. (2002, 21) argues these services have proven effective in reducing recidivism.

According to Boesky (2002, 229), “when agencies/ facilities try to procure funding for mental health services, providing objective data about the complex needs of these youthful offenders can be very educational, as well as persuasive.”²⁸ For instance, the data gathered can be sent to policy makers to show an increased need for funding of mental health services (Boesky 2002, 227).

SCHOOL INVOLVEMENT

School Involvement is the third main category of a model aftercare program and includes the following four subcomponents: alternative education, specialized services

²⁷ Other mental health funding sources include Title IV-E Waivers and grants from the Federal Government that are given to social service, mental health and juvenile justice agencies (Kamradt 2002, 2).

²⁸ Information gathered at screening can also assist in areas that are not so obvious, such as funding (Boesky 2002).

for learning disabled youth, mental health services through Multisystemic Therapy & Positive Attitude Toward Learning in Schools (PALS) Programs and interagency collaboration & wraparound services, is equally important to the aftercare model. Among the many responsibilities a school system must deal with, recently they have been given yet another major task, dealing with young offenders returning from confinement (Stephens & Arnette 2000, 1). Ronald D. Stephens and June L. Arnette (2000, 1) maintain schools must coordinate services and provide support and structure for juvenile offenders to be successful upon their release from juvenile correctional facilities.

The transition alone can be extremely difficult for youth accustomed to intense supervision and structure in the correctional setting. The school environment is less structured and therefore neither the school system nor the juvenile is ready to handle the problems that arise in this transition period (Stephens & Arnette 2000, 2).

According to Lucille Eber et al. (2002, 175), instead of being punitive and reactive, schools must promote prosocial behaviors, which also creates a safer school environment. The type of behavior delinquent youth display in the school environment can lead to unfavorable choices like dropping out or forcing the school system to punish delinquent youth because of their behavior. This can lead to feelings of abandonment and frustration, which is counterproductive. "Next to the family, school is perhaps the most formative influence in a child's life" (Stephens & Arnette 2000, 2-3).

Education has a huge impact on a child's life; then again lack of education can lead to further involvement in the juvenile and adult prison systems. There are many reasons to promote education besides the obvious, but one area of interest is economics. The cost to educate a student for one year is approximately \$7,000 whereas the cost to

incarcerate a youth could be anywhere from \$35,000- \$60,000 annually (Stephens & Arnette 2000, 2-3).

Alternative Education

According to Travis (1998, 1-2), many youth are unable return to their regular school upon release from a correctional setting. Byrnes et al. (2002, 26) and Stephens and Arnette (2000, 8-9) agree these youths should have suitable educational options such as alternative schools where there are smaller student ratios and the lessons are flexible. Stephens and Arnette (2000, 8-9) add that transitional centers and alternative schools are smaller and teachers are able to interact on an individual level with more students, which helps with the transition process. Alternative schools can provide the right amount of supervision along with support in order to help a youth gradually progress to a level they are comfortable with.

In addition, providing initial assessments is important for these youths to evaluate their needs and provide them with adequate services to help the transition into regular school (Stephens & Arnette 2000, 8).

Specialized Services for Learning Disabled Youth

Stephens and Arnette (2000, 5) argue that youth diagnosed with learning disabilities are at risk of failing in school and becoming involved in the juvenile justice system. Eber et al. (2002) found students with emotional and behavioral disorders do poorly in public schools and are most likely to receive their education in a restricted

placement. Their ability to succeed academically is lower and dropout rates are higher in the public school system.²⁹

Additionally, Bullis et al. (2004, 91) found incarcerated youth diagnosed with a learning disability were less likely to be involved in school or work upon returning to the community.

Mental Health Services

Because schools are found in any community and because of their accessibility, they are one of the best and last available resources to offer mental health services to youths in need. Schools have access to youth and their families and can reach many underserved families that might experience barriers otherwise. “Schools also offer the opportunity to decrease fragmentation of services by serving a coordinating function for mental health services” (Atkins et al. 1998, 65). Therefore, Marc S. Atkins, Patricia A. Graczyk, Stacy L. Frazier and Jaleel Abdul-Adil (2003, 509) maintain that schools are the most logical places to implement mental health services because of the “easy access to children.”

According to Atkins et al. (2003, 504), a desire exists to help children and youth receive improved benefits and access to mental health providers in the community.³⁰

Atkins et al. (2003, 503) sought to introduce alternative means to get families involved, to give teachers the desire to help children with disorders such as ADHD, and to collaborate with officials from two different agencies to develop a model to last long-term.

²⁹ Students with EBD are more likely to be poor, unemployed, or involved in the criminal justice system after spiraling through the various juvenile justice, mental health and child welfare agencies (Eber et al. 2002, 172).

³⁰ The rate of “no-show” appointments at community mental health clinics is 50 percent or more (Atkins et al. 2003, 504).

Another reason to focus on MH services in schools is to “assess the effect of services on multiple indicators of children’s functioning such as academic performance, peer relations, and classroom behavior” (Atkins et al. 2003, 504).³¹ Furthermore, “... the linkage between schools and community social service agencies encourages a consideration of the best use of social service resources on behalf of children’s mental health. The ultimate goal is to develop a new standard of care for the delivery of effective services for children and families...” (Atkins et al. 2003, 510).

Multisystemic Therapy (MST) was developed as a model to assist children with multiple behavior problems by coordinating assistance at multiple levels. MST “involves simultaneous interventions in multiple settings” (Atkins et al. 1998, 68). According to Arline Kaplan (2004, 7), “Multisystemic Therapy provides community-based clinical treatment for violent and chronic juvenile offenders...”

Kaplan (2004) and Atkins et al. (1998) concludes MST has been effective in reducing recidivism or out-of-home placement. While MST has been effective, it is hard to implement such an extensive model of intervention for the large number of youths in need of mental health services. Of major concern is that mental health resources are improperly allocated to the large number of children in need (Atkins et al. 1998, 68).

Another model somewhat more conducive to the school environment is known as Parents and Peers as Leaders in School (PALS). Since PALS is implemented in schools it enhances the opportunity to serve more youth because of the amount of time they spend in school (Atkins et al. 1998, 68).

³¹ Interventions should be apt to look at various factors such as “homework completion, participation in classroom discussions,” and “problem-solving disputes with peers” which the authors describe as “measures of daily life functioning” (Atkins et al. 2003, 504).

Atkins et al. (2003, 505), maintains that PALS is designed to “(a) minimize barriers and maximize service accessibility; (b) improve children’s academic, behavioral, and social functioning; and (c) develop the capacity of classrooms, schools, and families to sustain positive change.”³²

According to Atkins et al. (1998), PALS is intended to improve mental health services based in schools to promote positive activities for children. The goal is to increase the coordination of services among the community resources that are most easily accessible. Services should not be restrictive; they should be flexible and cater to the individual needs of the children they intend to serve and parental involvement is a must (Atkins et al. 1998, 72).

Both MST and PALS have notable similarities and differences. The major difference between MST and PALS is that MST coordinates services for youth with multiple problems that are involved in multiple systems whereas PALS offers services to youths in schools (Atkins et al. 1998, 68).

While both models seek to “coordinate services to prevent the occurrence of more serious problems that would require more intensive interventions,” MST seeks to prevent the removal of a child from their home to other more serious placements including juvenile detention (Atkins et al. 1998, 68). According to Atkins et al. (1998, 68), “MST and PALS represent a natural continuum of services.”

A school-based program is not without problems. Even though school-based programs provide accessible services to children, research indicates parents are not taking

³² PALS is “based on an engagement framework” drawn from a critical need to get more effective services for families. Parents are consulted so they could give their personal insight and experiences to clinicians to offer “a window into the cultural world of families” (Atkins et al. 2003, 505).

full advantage of them, which is counterproductive to the goal of enlisting family involvement (Atkins et al. 1998, 66).

Atkins, et al. (1998, 67-68) insists that in order to create a better overall environment at school, a mental health service delivery model should allow for both parents and children to have a say in the services they receive and emphasize “positive opportunities for parents and children to participate in school activities...”

Another problem with implementing school-based services occurs when a youth in need of mental health services is expelled or suspended from school. Therefore “linking mental health services to schools may not always be helpful for this population” (Ruffolo, Sarri, & Goodkind 2004, 243).³³

Overall, “well-organized and successful schools have considerable mental health benefits for all students, and additional social services” should “then be targeted to children and families with the greatest needs” (Atkins et al. 2003, 509).

According to Stephens and Arnette (2000, 14), “several challenges continue to face schools and communities as they attempt to deal with problems of crime and violence among youth.” Stephens and Arnette (2000, 14) argue that educators must first be prepared to work with these youths and training and communication is the key. Community officials, whether in the schools, with probation departments, aftercare providers or law enforcement can no longer afford to put up walls of resistance or “turf battles” when dealing with juvenile offenders (Stephens & Arnette 2000, 14).

³³ Additionally, added responsibility leads teachers to be somewhat resistant and unwilling to cooperate with the process, which creates another barrier to effective mental health services (Atkins et al. 1998, 65).

Interagency Collaboration & Wraparound Services

The first step to mainstreaming delinquent youth back into the school system is to help them successfully “reconnect” (Stephens & Arnette 2000, 3). Problems arise for youth transitioning back to mainstream schools because of incomplete information regarding their personal and academic history and teacher prejudice regarding their status as a juvenile offender. Providing successful strategies for delinquent youth returning to the school system is critical because it plays a role in the success of other students as well (Stephens & Arnette 2000, 2).

Failure to share information with educators about youth returning from secure facilities often creates numerous problems for both the youth and the school system. Often times, educators are left wondering about treatment received while in the institution, family information, probation requirements and required aftercare (Stephens & Arnette 2000, 3). “The time it takes to obtain all the information needed often leads to unnecessary referrals, duplicate services, inaccurate information, and service delays. Inefficiencies in information sharing complicate the reintegration of juvenile offenders into school settings, often hindering the education process or rendering it ineffective” (Stephens & Arnette 2000, 3).

The same idea behind the Intensive Aftercare Program can also be used for reintegrating juvenile offenders back into the school system especially in regards to providing ongoing services and supervision (Stephens & Arnette 2000, 4). “ ‘Cold turkey’ reentry into public schools is often a formula for failure” (Stephens & Arnette 2000, 8). These juveniles often feel overwhelmed because there is less structure than in the correctional setting and can often lead to disruptive behavior (Stephens & Arnette 2000, 8).

According to Stephens and Arnette (2000, 9), “many students leaving incarceration do not have access to specialized transitional educational placements and must reenter the school environment immediately after their release.” Without help, this is a difficult, if not impossible task. Moreover, youth returning to school during the middle of a semester face even more academic hardships especially if they were not previously exposed to the curriculum (Stephens & Arnette 2000, 9).

Stephens and Arnette (2000, 9) insist that juvenile officials and school officials should communicate about the needs of the student’s returning to mainstream campuses and juvenile officials should provide the schools with background information about the youth’s needs and requirements. In turn, the schools should also assist the juvenile officials with monitoring (Stephens & Arnette 2000, 9).

Ideally, schools should conduct an initial interview with a returning youth and their parents in order to gain valuable information on the parent-child relationship, the student’s goals, and any information about treatment, particularly mental health concerns. This is also a good time for the school officials to go over rules and school policies with the youth and their parents as well as disciplinary procedures (Stephens & Arnette 2000, 10).

Stephens and Arnette (2000) believe it is very important for a youth to identify academic and vocational goals upon reentry and schools should assist by developing an Individual Service Plan. Youth with special education needs should receive an Individual Education Plan, which outlines behavioral and academic objectives and requirements

(Stephens & Arnette 2000, 10-11).³⁴ Not only is there limited opportunity for young offenders returning to school from incarceration, many find they cannot return to school because of their age, opposition from school administrators, and many of the “administrative hurdles” that go along with reenrollment and transferring credits (Byrnes et al. 2002, 11).

The Federal Government recognized the need for innovative strategies for dealing with delinquent youth returning to schools and has put several programs into action. The Youth Out of the Education Mainstream (YOEM) program is a joint venture set forth by the Office of Juvenile Justice and Delinquency Prevention, the U.S. Department of Justice, the Safe and Drug-Free Schools Program, and the U.S. Department of Education (Stephens & Arnette 2000, 1). The purpose of the YOEM is to provide strategies to help reintegrate delinquent youth back into the mainstream educational system (Stephens & Arnette 2000, 2).

In addition, the California Youth Authority utilizes Transition Coordinators who help students prepare their educational and career goals upon release to the community. The coordinators help fill in the gaps where parole officers are unable to assist in the educational transition either due to limited time or abilities (Byrnes et al. 2002, 16).

According to Eber et al. (2000, 173), “wraparound is a philosophy of care with a defined planning process for creating a unique plan for a child and family that is designed to achieve a set of outcomes that reflect their voices and choices.” Wraparound requires a blending of outlooks from family members and a team of professionals who can provide interventions focusing on the needs of all involved (Eber et al. 2000, 173).

³⁴ For many youth, education is the key to future success and has been a factor in reducing recidivism. However, according to the Office of Juvenile Justice and Delinquency Prevention, many juveniles over 15 years old who are released from incarceration do not return to school or graduate from high school (Byrnes et al. 2002, 15).

Application of wraparound services can help the transitional process for youth in many ways including school completion, and job performance, which Eber et al. (2000, 173) labels as indicators for success. But, it is up to the child, the family, and other professionals whom they come into contact with because of their particular circumstance to describe their needs, which are then linked to service providers who can help them (Eber et al. 2000, 173).

Wraparound can also be incorporated into the school system for students with specialized needs. Schools can facilitate such a program because of their ability to reach a large amount of students that other agencies in the community cannot. Schools provide daily structure and routine, support services such as counseling, nursing, and special education services, and they have the ability to communicate with families regularly (Eber et al. 2000, 174).

According to Eber et al. (2000, 174) implementing the wraparound process in schools will lead to better outcomes in other settings as well. “The wraparound process is a tool for building constructive relationships and support networks among youth with emotional and behavioral disorders (EBD) and their families, teachers, and other caregivers” (Eber et al. 2002, 171). Eber et al. (2002, 171) states the purpose for the wraparound process is to “increase the likelihood that appropriate supports and interventions are adopted, implemented and sustained, thereby leading to improved behavior functioning for a given youth.” Eber et al. (2002, 171) argues that schools promoting positive behavioral interventions and supports (PBIS), or a consistent method of proactive discipline procedures for students and staff members in any school setting will be most effective.

“The wraparound process brings teachers, families, and community representatives together to commit unconditionally to a way of conducting problem solving and planning that gives equal importance and support to the child and his or her family, teachers, and other caregivers” (Eber et al. 2000, 173).

The Cluster Group Model developed in the New Jersey Gateway Academy uses a cluster group to help manage coordination of services across agencies including juvenile probation departments, school systems, and mental health providers. These groups meet regularly to share information, provide services, and prevent replication of services.³⁵ According to Arnette and Stephens (2000, 6-7), ideally the cluster group should be established prior to a youth’s release in order to have services ready upon release.

Another way for school officials and probation departments to work together is for schools to implement school-based probation. This helps both school and probation officials whose goal is “helping young people acquire knowledge and develop skills that lead to positive and productive lifestyles” (Stephens & Arnette 2000, 12-13).

Probation officers working in the schools have easy access to youth, which makes supervision easier and they can assist in many other ways (Stephens & Arnette 2000, 12-13). School-based probation officers can quickly distribute confidential information as well as coordinate the needs and aftercare services of these youth with school officials. In addition, school-based probation officers can monitor behavior and attendance and provide immediate intervention when necessary. Such teamwork would only encourage stronger relationships, while being more helpful to the youth they serve (Stephens & Arnette 2000, 12-13).

³⁵ Typically, one group member from the school system acts as the leader and distributes necessary information to each agency (Stephens & Arnette 2000).

Wraparound also complements the Individualized Education Plan (IEP) by designating support systems in the community in addition to the school. Instead of trying to fit a student into a program, wraparound services allow the student's needs to take precedence (Eber et al. 2000, 174). According to Eber et al. (2000, 174), "school-based wraparound planning guides the implementation of interventions that develop and support academic and behavioral skills needed for students to succeed at school, at home, and in the community."

FAMILY INVOLVEMENT

Aside from school involvement, Family involvement, which includes two subcomponents, family intervention and training and wraparound services, is the final component included in the ideal aftercare model. According to Ashcroft et al. (2003, 8), "any program that hopes to improve a juvenile's future must include his or her family in the solution."³⁶ Consistency and security is essential for youth in order to be successful upon release to the community. Problem behaviors must be addressed early on because if they are not, it could lead to more serious, often violent and chronic offenses (Howell et al. 2004, 148).

Family Intervention & Training

The continuum of services has a vision of integrating services among public and private organizations to help "build on the strengths of each child and family..." (Howell et al. 2004, 146). The wraparound model is ideal because it promotes planning and delivering services. It encourages families and youth to get involved in the services they need in order to promote strong family and community ties, and it calls for flexible

³⁶ Research shows a relationship between a juvenile's risk of delinquency and the number of times they have moved or any other type of disruption in the family including divorce or parental incarceration (Ashcroft et al. 2003, 8).

funding. The most effective of the wraparound service delivery models “integrate juvenile justice, mental health, child welfare, and other systems in addressing the needs of youth and their families” (Howell et al. 2004, 152).

One main goal “of the comprehensive strategy is to address problem behaviors early with less costly and more effective family-and child-centered treatment interventions ” (Howell et al. 2004, 148). Howell (2004, 148) argues that the juvenile justice system must get involved because the court’s play an extensive role when it comes to making decisions whether or not to remove a youth from home or to order a variety of services, including mental health treatment.

The comprehensive strategy framework discussed in Howell et al. (2004, 146) encourages families to provide guidance, support and moral values. It goes one step further, emphasizing program control in the hands of the local agencies themselves, making “each neighborhood, city, or state” responsible for their own plan (Howell et al. 2004, 148).

Community-based services include: case management, support in the home, medical interventions and family therapy either in the homes or in a clinic.³⁷ Multi-systemic therapy uses a home-based approach including family therapy and parent training as well as cognitive therapies (Byrnes et al. 2002, 28). According to Boesky (2002, 260), “family-focused treatments emphasize communication skills, clarification of family roles and boundaries, conflict resolution/ negotiation, and modification of the family system to improve the behavior of the youth.” Parents are highly involved in

³⁷ The System of Care: Chicago (SOC-C) mentioned in Atkins et al. (2003, 10) provides an example for the structure of agencies to coordinate several services; one of which was waivers for Medicaid for “universal prevention programming.” The initiative was “intended to encourage a systemic awareness of resources and needs...to avoid overidentification of child or family characteristics...” (Atkins 2003, 10).

treatment plans and they receive training on how to develop behavior modification plans that are best for their family (Boesky 2002, 260).

Another good idea in order to increase effectiveness is to blend supports such as childcare and transportation, known as natural supports, with interventions such as therapy and medication as well as social skills training (Eber et al. 2002, 173).

Wraparound Services

Because the family is the center of the youth's life, Kamradt (2000, 16) emphasizes that service systems engage the family in the youth's treatment process instead of trying to remove the youth from the home to try to "fix" them. The Wraparound philosophy consists of individual treatment focusing in on the child and their family in accordance with the communities they come from and considering their cultural background. The core of the wraparound approach is to coordinate service systems for youth with emotional problems that traverse all of these various systems (Kamradt 2000, 15).

When dealing with juvenile justice involved youth, wraparound services should focus on the strength of a child and their family instead of their weaknesses. Kamradt (2000, 15) affirms that support systems within the community are key.

One of the main reasons treatment falls short is because of "failure to listen to what a child and family identify as their needs" (Kamradt 2000, 16). According to Kamradt (2000, 16), treatment goals must cater to the child's and families needs in order to be effective.

As previously stated by Eber et al. (2002, 173), wraparound is a planning process that requires a blending of outlooks from family members and a team of professionals who can provide interventions focusing on the needs of all involved. This team should

look “outside the box” to create services based on the families unique needs (Eber et al. 2002, 173).

Eber et al. (2002, 173) encourages families and professionals to see each other differently in a wraparound process, “instead of being told what services and supports professionals will provide, the family members and the child are asked...” According to Eber et al. (2002), families should even choose team members who will help them prioritize their needs.

Before starting wraparound services, it is important to engage in conversation with families to get their ideas, values, goals and even frustrations in order to develop a level of trust with providers (Eber et al. 2002, 176). Eber et al. (2002, 176-177) insists the agency must implement a clear and concise mission statement and the facilitator must be trained in order to implement effective strategies. The wraparound philosophy is guided by values that call for commitment and flexibility when listening to families about their needs. The process of assigning blame should be left at the door (Eber et al. 2002, 178).

CONCLUSION

Purva Rawal, Jill Romanowsky, Michael Jenuwine, Ph.D., and John S. Lyons (2004, 253) concludes that youth with mental health needs involved in the juvenile justice system are not utilizing services. Additionally, there is a difference in mental health needs according to race (Rawal et al. 2004, 253).

According to Jeanette M. Jerrell, Ph.D. (1998, 35), the “costs of providing psychiatric... services for children and adolescents have increased dramatically.” Over ten years of research indicates that children’s mental health needs should be based on

integrated treatment in the community, which are available for as long as the youth and their families need. Jerrell (1998, 35) insists these services should cater to the individual needs of a youth and their family to be most effective.

The overall consensus of the literature concludes that youth released from correctional facilities back into the community do not perform well unless they are engaged in some type of work or school program. Bullis et al. (2004, 92) maintains that “intervention programs focused on structured learning, school achievement, and job skills can cut recidivism among incarcerated youths.” Kamradt (2000, 19-20) found that since the Wraparound Milwaukee Program was implemented, recidivism rates were lowered, the amount of youth being placed outside of their homes decreased 60 percent and the cost of care dropped over \$2,000 per child.

Kamradt (2000) insists that Wraparound Milwaukee has proven to be a successful model that other communities should replicate, however several challenges do exist. For example, trying to coordinate a system of collaboration can be difficult but with a little training across agencies, this problem could be solved. Sharing information is a big challenge but options to overcome this exist such as setting up databases, sharing agency contact information, and regular attendance at cross-agency meetings (Kamradt 2000, 22).

According to Foster et al. (2004, 864), most research conducted centers around the mental health needs of youth already involved in the juvenile system, however further research should focus on “whether system integration can reduce such involvement.” While much research has been done to predict recidivism, or the return to prison, little has been researched from the time of release to recidivism (Josi & Sechrest 1999, 56).

Further research should also focus on whether it would be beneficial in terms of cost-effectiveness to implement a “public health-oriented strategy” to deter “youths with emotional and behavioral problems” from the juvenile justice system as opposed to the detention of such youth (Foster et al. 2004, 864). Bullis et al. (2004) found more research is needed regarding the transition of incarcerated youth from the juvenile correctional facility back into the community.

Furthermore, an efficient intervention program needs to be in place that will effect change; even though policymakers might be reluctant to spend money on this type of research regardless of how valuable it would be to create efficient interventions (Bullis et al. 2004, 92). Bullis et al. (2004, 92) suggests further research should focus on the “intensity of services” or “dosage” of treatment and interventions.

Howell et al. (2004, 147) suggests states and communities implement a guide to deal with research and practice in order to implement prevention and treatment strategies. Additionally, Rawal et al. (2004, 253) adds future research should assess the differences in needs and provide more effective and culturally acceptable “treatments to serve these needs.”

Jack Powell (2004, 27) declares if “our present is the sum of past events, our future will be the sum of present efforts.” This statement could be translated to the state of the rising number of youth with mental health needs involved in the juvenile justice system. If current efforts determine the future of our youth and the way we deal with them, how can we make changes to better serve the population for the future? Providing adequate aftercare services for youth involved in the juvenile justice system is one place to start.

CHAPTER 4

THE RESEARCH SETTING

PURPOSE

The purpose of this chapter is to provide an overview of the research setting, Williamson County Juvenile Services. The department of Williamson County Juvenile Services was established in 1981 as an extension of the Juvenile Court. Director of Juvenile Services, Charly Skaggs has been employed as the Chief Probation Officer since April 22, 1986.

WILLIAMSON COUNTY JUVENILE SERVICES

Williamson County is located in Central Texas, north of Austin, the capitol of Texas. The estimated population of Williamson County in July 2004 was 317,938. Williamson County Juvenile Services serves several larger cities including Round Rock, Cedar Park, and Georgetown, as well as several smaller communities including Taylor, Hutto, and Granger.



The organization consists of six divisions including: Central Administration and Business Office, Probation Services, Court Services, Detention Services, Juvenile Justice Alternative Education Program (J.J.A.E.P), and Academy Residential Services. At the

time of this study, the new budget for 2005 had not yet been approved, however the annual budget of the department in 2003 was approximately \$7 million.

Today, Williamson County Juvenile Services has approximately 128 full and part-time employees including: Certified Probation Officers, Administrative Personnel, Certified Detention Officers, Drill Instructors, and Medical Personnel.

There are a total of four facilities within the department of Juvenile Services. The main building, known as the Juvenile Justice Center, located in Georgetown, Texas houses the Juvenile Detention Center, J.J.A.E.P, Residential Academy, Juvenile Court, Administration, and Probation Services. Three satellite offices serve clients in Round Rock, Taylor and Cedar Park and the surrounding municipalities.³⁸

Aftercare, or transition services have been in place in Williamson County for approximately two years. Aftercare services are provided for all youth released from post-adjudication residential facilities, both secure and non-secure, in Texas who must complete the remainder of their probation in the community, with the exception of youths released from the Texas Youth Commission (TYC).

Williamson County Juvenile Services has maintained a contract with TYC since April 1998 and employs one Parole Officer to supervise all youths released from TYC. In addition to supervising all youth released to parole in Williamson County, the Parole Officer is also responsible for coordinating aftercare services for TYC youth. However, the TYC youth released to parole will not be included in the scope of this study.

PROFILE OF RESIDENTIAL PROGRAMS

During the 2004- 2005-year, approximately 123 youths were released to Williamson County from post-adjudication facilities. Approximately 20 of those youth were

³⁸ Information obtained from the Williamson County Website (www.wilco.org).

subsequently committed to TYC; therefore excluding TYC commitments, a sample of 103 youths released from post-adjudication facilities in Texas was included in this study.

In order for a youth to be sent to a post-adjudication facility from Williamson County, they must have been adjudicated in the Juvenile Court and received disposition to a residential placement facility. According to the Texas Juvenile Probation Commission, there are approximately 40 post-adjudication facilities in Texas and 266 Title IV-E approved residential placement facilities.³⁹

Williamson County Juvenile Services has its own Residential Academy, which was established in 1991. The Academy incorporates a military- style component in addition to providing constant supervision, academic programs including the J.J.A.E.P. and GED services, and counseling and medical services. The Academy currently has 36 male beds and 12 female beds. While the majority of youths in Williamson County were placed in the Academy, youth were also sent to the following placement facilities in Texas during 2004- 2005: Hays County Boot Camp, Brookhaven Youth Ranch, Pegasus Schools, North Texas State Hospital, Pathfinders Camp, New Life Children's Treatment Center, Phoenix House, Nexus, Rockdale Regional Juvenile Justice Center, Sandstone Health Care, Shoreline Residential Treatment Center, Good Shepherd Residential Treatment Center, Garza County Regional Juvenile Center, St. Jude's Ranch for Children, Coastal Bend Youth City Inc., Therapeutic Family Life, Vernon State Hospital, Hannah's House, Krause Children's Residential Center, and Cedar Ridge.

In order to obtain permission to conduct this research project, Juvenile Board approval was required. On June 15, 2005, a prospectus outline was presented to the

³⁹ Information obtained from the Texas Juvenile Probation Commission Website (www.tjpc.state.tx.us).

Juvenile Board and the researcher was approved to conduct the case study (**See Appendix A** for the prospectus outline).

The next chapter discusses the methodology employed to conduct the study.

CHAPTER 5

RESEARCH METHODOLOGY

PURPOSE

This research project evaluates how closely the aftercare program in Williamson County compares to the ideal model developed in Chapter 3. The techniques used in this case study include structured interviews, document analysis and archival data analysis. In addition, the ideal model is operationalized and used as a template for data collection.

CASE STUDY RESEARCH

The case study research method was used to assess the Aftercare Program at Williamson County Juvenile Services against a model aftercare program developed from the review of the literature. Robert K. Yin (2003, 1) defines case study research as a “research strategy...used in many situations to contribute to our knowledge of individual, group, organizational, social, political, and related phenomena.” Since one of the goals of this research is comparing the aftercare program in Williamson County to an ideal aftercare model, the case study method was preferred.

According to Earl Babbie (2004, 113), triangulation involves “the use of several different research methods to test the same finding...” Triangulation is important because every method of research has strengths and weaknesses, which may have an effect on the findings (Babbie 2004, 113). Yin (2003, 98) concurs that “any finding or conclusion in a case study is likely to be much more convincing and accurate if it is based on several different sources of information...” In fact, using multiple sources of evidence is one of the strengths of case study research (Yin 2003, 97).

Therefore, several data collection mechanisms were used in this study. First, structured interviews were used to gather data on the aftercare program for juveniles released from post-adjudication facilities in Williamson County, Texas. Second, document analysis of the Williamson County Juvenile Services policy and procedure manual was used. Finally, archival data such as case plans and chronological notes were used to supplement the structured interviews.

STRUCTURED INTERVIEW

According to Babbie (2004, 263), an interview is a method of collecting data that can be conducted in person or by phone. This method requires an interviewer to ask questions of the desired respondent. Babbie (2004, 263) asserts that interviews usually have a “higher response rates than do mail surveys.” The Chief Probation Officer, Director of Field Services, and Assistant Director of Field Services in Williamson County were all asked which method they would prefer based on their schedules and all stated they would favor a phone interview.

Fourteen employees of Williamson County were selected for interview due to their positions within the County: two administrative staff (Chief Probation Officer and Director of Field Services) and 12 Aftercare Officers (8 Field Officers and 4 Court Placement Officers). In order to obtain the sample of employees to interview, the Director of Field Services and four office supervisors were asked which employees were responsible for providing aftercare services to youth in Williamson County. The 8 Field Officers who work with an aftercare caseload also have other cases not pertaining to youth released from residential placement. The 4 Court Placement Officers are only involved in the supervision of youth released from placement as well as youth in

placement or in the J.J.A.E.P. For the purposes of this study, however all 12 are considered Aftercare Officers and will be referenced as such. Administrative staff were not asked all questions that Aftercare Officers were asked simply because the questions were directed to the front line officers dealing with day to day supervision. (See **Appendix B** for the Interview Questions)

DOCUMENT ANALYSIS

According to Yin (2003), document analysis is pertinent to case study research because documents are accessible and typically offer precise information. Furthermore, inferences can be made from some findings. While Yin (2003, 87) reports that document analysis may not be the most accurate source of information, it should be used “to corroborate and augment evidence from other sources.” One weakness of document analysis is on the part of the researcher, who could mistake the information as absolute truth (Yin 2003, 87). As previously stated, the documents used in this study were certain policies from the policy and procedure manual of Williamson County Juvenile Services and was analyzed in this research study as a supplement to the structured interviews. (See **Appendices C** and **E-I** for the policies and procedures that were used).

ARCHIVAL DATA

Archival records include service and organizational records such as charts, budgets, and “clients served over a given period of time” (Yin 2003, 89). Archival records can also be used as a supplemental data collection method in case study research (Yin 2003, 89). Yin (2003, 89) maintains that the importance of archival information depends on the research project and warns, “most archival records were produced for a specific purpose

and specific audience (other than the case study investigation), and these conditions must be fully appreciated in interpreting the usefulness and accuracy of the records.”

The units of analysis in this case study included records such as case plans and chronological notes. (Since the case plans and chronological documentation used in this study pertained to juveniles, the information was strictly confidential and the researcher was granted permission to view them by the Juvenile Board- See **Appendix A** for the prospectus submitted for approval).

The sampling technique used in this study is known as systematic sampling with a random start. According to Babbie (2004, 203), systematic sampling is “a type of probability sampling in which every *k*th unit in a list is selected for inclusion in the sample—for example, every 25th student in the college directory of students.” Systematic sampling with a random start requires the researcher to choose the first unit randomly, for example by randomly choosing a number between one and ten. Whichever number is randomly selected is where the researcher would start and in the above example would select every tenth selection after that (Babbie 2004, 204).

Babbie (2004, 205) maintains that systematic sampling is very similar to a simple random sample and in fact may be preferred solely because systematic sampling is more convenient. One problem Babbie noted was in regards to the order of the list as it could cause bias. Babbie (2004, 205) contends that if the list is in any kind of order, the researcher should decipher any bias the order would create and “take steps to counteract any possible bias...”

The placement list was obtained from the online policy and procedure manual, maintained on the Williamson County Juvenile Services network. These youth were

systematically sampled in order to review the archival data contained in their file as a supplemental method to the structured interviews.

In this study, the number that was randomly selected was two. Therefore, the first case used was number two on the list, and every fifth youth was selected for inclusion in the sample. The list of youth was in no particular order, except that youth were separated according to which year they were in placement (2004 and 2005) and whether or not they were in placement or out of placement.

Twenty-one youth were randomly selected from a total of 103 youth sent to or released from post-adjudication facilities in Williamson County, during the 2004- 2005 year, excluding those committed to TYC. Additionally, several youth were placed more than once, however only one placement was counted in this study. As previously stated, the purpose of randomly selecting these youth was to review the archival data contained in their file as a supplemental method to the structured interviews.

POPULATION

According to John Posey, Research Specialist for the Texas Juvenile Probation Commission, there are four categories of counties in Texas. The four categories are established by the juvenile population size based on the juvenile age range of 10-16, not the amount of referrals the county received. The four categories are:

- 1) 0-1,000
- 2) 1,001- 7,000
- 3) 7,001- 70,000
- 4) 70,001- 390,000

These numbers were figured in 2000, as estimates for the 2003 census regarding juvenile population. Williamson County falls into the third category, as the estimated juvenile population size in 2000 was 34,810.

There were several reasons for narrowing the sample to a case study of Williamson County Juvenile Services that allowed for enhanced research opportunities. First of all, the sheer size of Williamson County offered more accessibility than larger metropolitan counties in Texas, which was ideal for conducting structured interviews. As stated in Chapter 4, Williamson County is located in Central Texas, north of Austin, the capitol of Texas. The estimated population of Williamson County in July 2004 was 317,938.

There are several larger cities in Williamson County including Round Rock, Cedar Park, and Georgetown as well as several smaller towns such as Taylor, Leander and Hutto.⁴⁰

Secondly, Williamson County Juvenile Services is beginning to develop new programs and other initiatives that are in their early stages, including a web site, which gives access to the Juvenile Services Policy and Procedure manual online. Furthermore, Williamson County Juvenile Services is in the early stages of implementing a Mental Health Assessment Team consisting of mental health counselors to conduct the Minnesota Multiphasic Personality Inventory (MMPI) screenings of all youth detained in Williamson County. The purpose of this initiative is to serve the juvenile population better and to help identify their needs early on. Offering Williamson County an innovative aftercare model is ideal, as implementing the model would be very beneficial with these new programs. In addition, implementing a new model in Williamson County would seem less daunting than it would in larger counties.

⁴⁰ Information obtained on the Williamson County Website (www.wilco.org).

Second, accessibility was a priority. All officers interviewed were easily accessible either in person or by phone or e-mail. The interviews were done in person, with the exception of two, one officer responded by e-mail and another officer was provided the interview questions and returned hand written responses.

The purpose of using several research methods, allowed supplemental data to the structured interviews to analyze whether or not the Williamson County Juvenile Services Aftercare program adheres to the practical ideal type. As previously stated by Yin (2003), using several research methods makes the findings in a case study more acceptable.

OPERATIONALIZING THE CONCEPTUAL FRAMEWORK

Operationalizing links the practical ideal type categories to the data collection methods. **Table 5.1** indicates how the conceptual framework is linked to these data collection methods: document analysis, archival data and the structured interview. For example, the interview questions are constructed using the concepts found within the categories. Each of the interview questions was developed precisely to fit the components of the ideal aftercare program categories. (See **Appendix B** for the interview questions).

Table 5.1. Operationalization of the Conceptual Framework

CATEGORY	DOCUMENT ANALYSIS	ARCHIVAL DATA	INTERVIEW QUESTION	POSITION
COMMUNITY SUPERVISION				
<ul style="list-style-type: none"> ▪ Transition Planning 	<p>Policy & Procedure</p> <p>Policy & Procedure</p>	Case Plans	<p>1. Is there a departmental policy requiring transition case plans for youth released from residential placement?</p> <p>2. Who is involved in developing the transition case plan and how long does it stay in effect?</p>	<p>Chief Probation Officer, Director of Field Services, Aftercare Officer</p> <p>Aftercare Officer</p>
<ul style="list-style-type: none"> ▪ Intensive Supervision and treatment 	<p>Policy & Procedure</p>	Case Plans, chronological notes	<p>3. What is the average caseload of an Aftercare Officer??</p> <p>4. What kind of supervision and treatment is provided?</p> <p>5. How many contacts are required per week?</p>	<p>Aftercare Officer</p> <p>Chief Probation Officer, Aftercare Officer</p> <p>Aftercare Officer</p>
<ul style="list-style-type: none"> ▪ Officer Training 			6. Do Aftercare Officers receive specialized training?	Chief Probation Officer, Director of Field Services, Aftercare Officer
<ul style="list-style-type: none"> ▪ Interagency Collaboration 		Chronological notes	7. What outside agencies assist in supervision?	Chief Probation Officer, Director of Field Services, Aftercare Officer
MENTAL HEALTH AFTERCARE				
<ul style="list-style-type: none"> ▪ Interagency Collaboration, Systems of Care, & Wraparound 			<p>8. What agencies are involved in MH Aftercare?</p> <p>9. How are services coordinated for youth with MH needs?</p>	<p>Chief Probation Officer, Director of Field Services, Aftercare Officer</p> <p>Aftercare Officer</p>
<ul style="list-style-type: none"> ▪ Assessment & Screening 	<p>Policy & Procedure</p>	Case plans	<p>10. What type of screening and assessment tools are used?</p> <p>11. How often are youth screened?</p> <p>12. How often is the case plan updated?</p> <p>13. Are MH services required in the case plan?</p>	<p>Director of Field Services, Aftercare Officer</p> <p>Director of Field Services, Aftercare Officer</p> <p>Aftercare Officer</p> <p>Aftercare Officer</p>

<ul style="list-style-type: none"> ▪ Funding 	Policy & Procedure		<p>14. How is MH funding secured?</p> <p>15. What is the annual budget for aftercare?</p>	<p>Chief Probation Officer, Director of Field Services, Aftercare Officer</p> <p>Chief Probation Officer</p>
SCHOOL INVOLVEMENT				
<ul style="list-style-type: none"> ▪ Alternative Education 		Case Plans, chronological notes	16. Where does a youth return to school upon release?	Aftercare Officer
<ul style="list-style-type: none"> ▪ Specialized Services for LD youth 			17. Who coordinates services for LD youth at school?	Aftercare Officer
<ul style="list-style-type: none"> ▪ MH services in schools- MST & PALS 			18. Do schools provide additional MH services?	Chief Probation Officer, Director of Field Services, Aftercare Officers
<ul style="list-style-type: none"> ▪ Interagency Collaboration & wraparound services 			19. What is a CRCG and how is it beneficial?	Chief Probation Officer, Director of Field Services, Aftercare Officer
FAMILY INVOLVEMENT				
<ul style="list-style-type: none"> ▪ Family Intervention 			20. How are parents involved in Aftercare and what services does the agency offer to help them?	Chief Probation Officer, Aftercare Officer
<ul style="list-style-type: none"> ▪ Wraparound Services 			21. What services does the agency offer to help parents and youth with MH disorders adjust to life back in the community?	Chief Probation Officer, Director of Field Services, Aftercare Officer

CHAPTER 6

RESULTS

PURPOSE

As previously stated, the purpose of this study was to assess the aftercare program in a case study of Williamson County Juvenile Services as compared to the components of an ideal aftercare program. The purpose of this chapter is to summarize data used to assess the Aftercare Program in Williamson County.

Overall, Williamson County's Aftercare Program adheres to the following categories of a model aftercare program: Mental Health Aftercare, School Involvement and Family Involvement. However, Williamson County's Aftercare Program could use significant improvement in the Community Supervision Category in regards to Officer Training and Intensive Supervision and Treatment.

COMMUNITY SUPERVISION RESULTS

Community Supervision is the first component of an ideal aftercare program. According to the model, community supervision contains the following elements: Transition planning, Intensive supervision and treatment, Officer training and Interagency collaboration.

TRANSITION PLANNING- INTERVIEW

Transition planning was the first subcategory of the Community Supervision component of a model aftercare program. Of the 14 Administrative/ Aftercare Officers interviewed, all knew there was a departmental policy requiring transition case plans for youth released from residential placements and knew that it could be found in the department's Policy and Procedure manual. This evidence is key to transition planning because as found in the literature, among other reasons, mental health services provided

upon release from institutions can play a major role in decreasing recidivism rates (Trupin et al. 2004, 600).

Both Administrative Officers added that the policy has been in place for approximately two years and was developed for several reasons. The Chief Probation Officer noted an increase in the caseload and funds spent in placement (approximately \$600,000) and the Director of Field Services added that the policy developed out of the need to integrate youth back into the community, both as a proactive and reactive approach.

All 12 Aftercare Officers interviewed indicated that the Court Placement Officer was involved in developing the transition case plan, and 8 Aftercare Officers additionally identified the child and parent as being involved in the transition case plan. In regards to the follow up question about how long a transition case plan stays in effect, there were several different answers. One officer did not provide an answer, 2 officers said the transition case plans stayed in effect until the end of probation, 3 officers said it stayed in effect for 30 days and 6 officers said the transition case plan stayed in effect for 90 days. While the officers knowledge of the policy and procedure documentation requiring transition case plans was sufficient, these findings show there are inconsistencies among Aftercare Officers in regards to the length of time a case plan stays in effect.

DOCUMENT ANALYSIS

Document analysis was used to supplement the interview questions in order to determine the clear objectives for the policy. The policy and procedure was referred to as Placement Aftercare Supervision, making it easily identifiable. The policy reads as follows, “it is the policy of Williamson County Juvenile Services that all juveniles that have been court ordered into an alternative residential setting for more than 90 days,

receive specialized aftercare supervision in their home once released from placement” (See Appendix C for the Placement Aftercare Supervision policy and procedure). Nine procedures for aftercare supervision are clearly outlined as well as who is responsible for ensuring the procedures are followed. Additionally, there was reference to an attached Exit Interview/ Transition Plan form, however one was not attached nor was there an active link provided for any relevant forms. Furthermore, there was not a clear time indicated in the policy and procedure regarding the length of time the transition case plan remains in effect. While the Aftercare policy and procedure clearly outlines the procedures, it does not set out a clear guideline about the length the transition case plan should stay in effect.

ARCHIVAL DATA

Archival data in the form of case plans and chronological notes was used to supplement the interviews and document analysis. The following results describe responses and adherence to criteria:

Table 6.1- Transition Case Planning Archival Results

Criteria	# Meeting Criteria (N = 21)	Consistent w/ Criteria
Parental Involvement in Case Plan	20	Yes
Development mentioned in chronological notes	17	Yes

This archival data clearly supports the policy as to who is involved in case planning and shows that information is documented adequately.

INTENSIVE SUPERVISION AND TREATMENT- INTERVIEW

The overall consensus of the 12 Aftercare Officers interviewed agreed that the average caseload varies. Six officers reported supervising less than 5 youth in aftercare during the 2004-2005 year. Three officers reported supervising between 5-10 youth and

only 1 officer reported supervising more than 10 youth in aftercare during the 2004-2005-year. Two officers did not report an exact number and responded that the average caseload in a year varies.

Of the 13 Administrative/ Aftercare Officers interviewed, the evidence supports that officers knew several programs that provide supervision along with treatment: Electronic Monitor/ Intensive Supervision Program, Curfew Calls, the PROMPT (Probation Resource Officer and Mental Health Professional Team) Program, Family Preservation Program, counseling, and MHMR services. For example, the officers assigned to the PROMPT and Family Preservation Programs reported that they are grant-funded programs that require intensive supervision in the home 3-5 times per week in addition to providing treatment such as family and individual therapy. Both programs require an initial screening and youth eligible for PROMPT must have at least one Axis I Diagnosis. Youth eligible for Family Preservation must be at risk of removal from the home and present some type of need such as a substance abuse need. The PROMPT Program was the most common program identified for providing treatment and supervision among 7 of the 13 officers interviewed.

In regards to required contacts the evidence somewhat supports the findings as there were several different responses from the 12 Aftercare Officers interviewed. Two officers reported that youth are seen twice a week on aftercare supervision. Eight officers said that youth were seen once a week and 2 officers reported that youth were seen 3-5 times per week. The officers reporting that youth were seen 3-5 times per week were the PROMPT and Family Preservation Officers, whose grant-funded programs work

differently than the others. However, there were minor inconsistencies between the other Aftercare Officers in reporting requirements.

DOCUMENT ANALYSIS

According to the departmental policy and procedure regarding Placement Aftercare Supervision, the fifth and sixth step provides an accurate description of the amount of contacts required per week as well as the types of contacts required (**See Appendix C** for the Placement Aftercare Supervision policy and procedure). According to P&P, Aftercare Officers must see a youth with their parent every five working days while on aftercare supervision and at least one visit must be in the home. Other visits such as school and office visits can be made in addition to the home visit. A majority of the Aftercare Officers interviewed were correctly aware of the amount of weekly contacts required.

ARCHIVAL DATA

Chronological notes were used in addition to the interviews and document analysis in regards to the amount and type of contacts required per week. The following results describe responses and adherence to criteria:

Table 6.2- Intensive Supervision & Treatment Archival Results

Criteria	# Meeting Criteria (N = 21)	Consistent w/ Criteria
Appropriate contacts required per week	13	Somewhat

Thirteen youth received weekly home visits in addition to office, school, and field visits, whereas 2 received weekly visits but they were not home visits but a combination of office and school visits. Additionally, 5 youth were transferred to another jurisdiction for

supervision and data was not available on their contacts. One youth was released from probation shortly after release from placement.

Therefore, this evidence somewhat supports the findings as the majority of officers knew how often youth were to be seen and more than half of the youth were seen as required, however not all contacts were made in the home as required in P&P.

OFFICER TRAINING- INTERVIEW

Ten of the 14 Administrative/ Aftercare Officers interviewed said that Aftercare Officers did not receive any specialized training. In fact, 4 officers identified that they became aftercare officers based on their title either as a Supervisor or Juvenile Probation Officer II title. Two officers identified they were previously designated case managers and then were given the title of Aftercare Officer. One officer identified that training came through policy and procedure and on the job training and one officer stated that training came in the form of Case Management Standards. Therefore, since the majority of officers admitted the lack of specialized training, the evidence does not support the subcategory requiring the need for officer training.

INTERAGENCY COLLABORATION- INTERVIEW

Of the 14 Administrative/ Aftercare Officers interviewed, 10 officers reported the local Mental Health and Mental Retardation department (MHMR) as an outside agency that assists with supervision. Although other agencies were mentioned, MHMR was the one reported by a majority of officers. Therefore, the evidence obtained in the interview supports the need for interagency collaboration with this population.

ARCHIVAL DATA

Chronological notes were used in order to supplement the interview responses. The following results describe responses and adherence to criteria:

Table 6.3- Interagency Collaboration Archival Results

Criteria	# Meeting Criteria (N = 21)	Consistent w/ Criteria
Outside agencies mentioned in chronological notes	9	Somewhat

Five youth were transferred to courtesy supervision out of the county and therefore, outside agencies assisting in their supervision were unknown. This information shows that nearly half of the officers utilizing outside agencies are also mentioning them in chronological notes, which somewhat lends support to the subcategory of the community supervision component of the practical ideal type.

Table 6.4 Community Supervision- Overall Results

Community Supervision	Archival Data	Document Analysis	Interview	Overall
Transition Planning	Case Plans & chronological notes support the data and policy as to who is involved in case planning and shows that information is documented adequately.	While Policy & Procedure adequately outlines the procedures, it fails to indicate the length of time a case plans stays in effect.	All officers knew there was a policy requiring transition case plans (N=14); and all officers knew who was involved in case planning (N=12)	Somewhat
Intensive Supervision & Treatment	Chronological notes somewhat lends support to the interview data showing that while officers knew the amount of contacts required, not all required contacts were made.	P&P accurately describes the amount and type of contacts required of youth on Aftercare.	All Officers identified a variety of services within the department that provided treatment and supervision (N=13); However there were inconsistencies in regards to the type and amount of required weekly contacts. (N=12)	Somewhat
Officer Training			10 Officers interviewed indicated they did not receive specialized training. (N=14)	No
Interagency Collaboration	Chronological notes somewhat lend support to the interview by showing that officers were using outside agencies and most were also referencing them in the archival data.		10 Officers identified MHMR as an outside agency. (N=14)	Somewhat

MENTAL HEALTH AFTERCARE

The second category of an ideal aftercare program, based on a review of the literature was Mental Health Aftercare and according to Gies (2003, 24-25) is crucial in facilitating the transition from a correctional institution to the community. The following subcategories were included in the mental health aftercare category because of their importance: Interagency collaboration, Systems of Care, and Wraparound Services, Assessment and Screening, and Funding.

INTERAGENCY COLLABORATION, SYSTEMS OF CARE & WRAPAROUND SERVICES- INTERVIEW

Of the 14 Administrative/ Aftercare Officers interviewed, 11 primarily identified MHMR as the agency involved in mental health aftercare. While other services within the department such as the Family Preservation and PROMPT Programs were identified as well, MHMR was mentioned by a majority of the officers.

When asked how services were coordinated for youth with mental health needs, 8 of the 12 Aftercare Officers interviewed said that agency referrals were how services were coordinated. It is important to note that the two additional county programs that offer assistance to youth with mental health needs (Family Preservation and PROMPT) coordinate services differently. For example, the Family Preservation Program enlists weekly staffings that consist of the Family Preservation staff (a probation officer and a Licensed Professional Counselor), Probation Officers, a weekend therapist, and the Director of Counseling to discuss needs and services of each youth enrolled in the program each week. This evidence shows strong support for this subcategory of the practical ideal type in that not only could a majority of officers identify outside agencies that assist with mental health needs but also that they knew how to coordinate services.

ASSESSMENT AND SCREENING- INTERVIEW

Six of the 13 Administrative/ Aftercare Officers interviewed reported using the MAYSI (Massachusetts Youth Screening Instrument) most often with this population. Additionally, officers identified the SASSI (Substance Abuse Subtle Screening Inventory), and psychological and psychiatric assessments most often used with this population.

When asked how often youth were screened, 7 of 12 Aftercare Officers said that youth were screened on an as needed basis after an initial screening was conducted. Additionally, 3 of 13 Administrative/ Aftercare Officers stated that MAYSI screenings were done each time a new offense occurred. According to the literature, proper screening and assessment can help compile important mental health data and assist in the transition process (Boesky 2002, 227). Therefore, this evidence supports the practical ideal type subcategory in that half of the officers interviewed knew of assessment tools and how often youth were screened.

Six of 12 Aftercare Officers interviewed said that the case plans were updated every six months. In the Family Preservation and PROMPT Programs, officers reported that they updated case plans on a monthly basis. Four officers identified that case plans were updated every three months; however there is a clear distinction here in regards to placement case plans and field case plans. Of the 8 Field Officers interviewed, only 2 officers incorrectly stated that case plans were updated every 3 months, however they are required every 6 months. Three of the 4 Court Placement Officers said that case plans were conducted every three months, and this is correct with placement case plan reviews.

Eleven of 12 Aftercare Officers interviewed said that mental health services are required in the case plan. Two officers stated that mental health needs is a domain in and of itself in the case plan (See **Appendix D** for the Transition Plan).

DOCUMENT ANALYSIS

The policy and procedure manual was used to supplement two interview questions (#12 and 13) in order to clearly identify the objectives for the policy. There were three policies regarding case planning, which were referred to as Case Planning and Management (See **Appendix E**). The policies were further narrowed down to Field Supervision, Residential Placement and Residential Placement Review (See **Appendix F-H**). In the Field Supervision policy, definitions were given and procedures were clearly outlined in detail. Additionally, links to the case planning forms were provided.

According to the policy and procedure manual, field case plans are required every 6 months. Case plan reviews for youth in residential placement are required to be updated every 3 months. Therefore, it appears that a distinction was made depending on which officers, Field or Court Placement, were interviewed.

ARCHIVAL DATA

Case plans were used to supplement information given in the interview regarding mental health services required in the case plan. The following results describe responses and adherence to criteria:

Table 6.5- Assessment & Screening Archival Results

Criteria	# Meeting Criteria (N = 21)	Consistent w/ Criteria
Mental health needs listed in case plan	10	Yes

It is important to note that of 21 youth sampled, only 4 did not have mental health needs whatsoever. That is not to say they did not have other needs, only that they did not have specific mental health needs. Mental health needs were not mentioned in 4 case plans and of the 5 youth transferred to other jurisdictions for supervision, 3 did not have any mental health information contained in their transition case plans. The number of youth with mental health needs sampled in Williamson County clearly agrees with the research stating that this population is increasing and requires more precise aftercare attention.

FUNDING- INTERVIEW

The most common response of the 14 Administrative/ Aftercare Officers in regards to securing mental health funds was parents or private insurance. Ten of 14 officers reported that parents secured funding or private insurance. Additionally, 6 officers identified Medicaid or State Funds responsible for mental health funding.

Only the Chief Probation Officer was asked about the annual budget for aftercare and he responded that there was no set budget for an Aftercare program, only professional contracts. This evidence clearly supports the funding subcategory of the practical ideal type indicating that a majority of officers knew who was responsible for funding or how to acquire funding for mental health services.

DOCUMENT ANALYSIS

The policy and procedure manual was used to supplement the interview question regarding the budget. The policy was located under the Department Administration Policy and Procedure and it was titled Contracted Services for Juveniles (**See Appendix I** for the Contracted Services for Juveniles policy and procedure). The policy clearly outlined the procedures and responsible party for maintaining funds for contracted

services and even provided an example of a contract for services. While there is no set budget for aftercare services, funds are available for services when necessary.

Table 6.6 Mental Health Aftercare- Overall Results

Mental Health Aftercare	Archival Data	Document Analysis	Interview	Overall
Interagency Collaboration, Systems of Care & Wraparound Services			MHMR was identified by a majority of officers interviewed. (N=14); and over half of the officers were able to identify how services were coordinated for youth. (N=12)	Yes
Assessment & Screening	Case plans identified mental health needs adequately in almost half of the cases sampled.	P&P adequately identifies how often case plans are updated and makes distinctions as to the types of case plans.	Over half of the officers were able to identify the types of screening and assessment tools used most often with this population (N=13); In addition over half of the officers knew how often screening tools were used with this population. (N=12)	Yes
Funding		P&P adequately identified the responsible party for maintaining funds for contracted services.	A majority of officers identified how funding for mental health services was secured. (N=14)	Yes

SCHOOL INVOLVEMENT- INTERVIEW

School Involvement is the third category of an ideal aftercare program and research indicates it is very important for schools to be involved in the transition of a youth from placement back to an educational setting. School involvement contains the following subcategories: Alternative Education, Specialized Services for Learning Disabled Youth, Mental Health services in schools- Multisystemic Therapy and PALS, and Interagency Collaboration and Wraparound Services.

All 12 Aftercare Officers asked about where a youth returns to school upon release from placement stated that youth return to their home campus, or regular public

school. Eleven of 12 Aftercare Officers identified the school being the responsible party to coordinate services for learning disabled youth and additionally 8 officers identified either the special education coordinator or an ARD committee. Ten of 12 Aftercare Officers stated that the schools they work with do provide additional mental health services including school counselors, PALS, Communities in Schools, and wraparound programs. This evidence supports the need for school involvement in regards to transition planning as a majority of the officers interviewed knew where a youth returned to school and who to contact to help coordinate services. Additionally, officers were able to provide examples of mental health services available in schools.

When asked about Community Resource Coordination Groups (CRCG's), 11 of 14 Administrative/ Aftercare Officers could identify what a CRCG does. Of the officers who could identify a CRCG, most stated that it was a multi-agency group that came together to provide services for youth and families. The Chief Probation Officer summed it up stating that a CRCG is a "group of mandated agencies (multi-agencies) who take the team approach to meeting the needs of kids who might fall through the cracks of one agency." Seven officers found CRCG's to be beneficial. Two officers reported that CRCG's were no longer in existence and 1 officer felt CRCG's needed work. This evidence again shows support in that the majority of officers could identify what agencies they could collaborate with in order to provide services for youth in need.

ARCHIVAL DATA

Case plans and chronological notes were used to supplement information given in the interview regarding where youth return to school upon release. The following results describe responses and adherence to criteria:

Table 6.7- School Involvement Archival Results

Criteria	# Meeting Criteria (N = 21)	Consistent w/ Criteria
Chronological notes and case plans indicate where a youth returns to school upon release.	10	Yes

Five youth returned to the J.J.A.E.P, or alternative school and 2 youths obtained their GED while in placement. Of the 5 youth that were transferred for courtesy supervision, no information was provided regarding school for 3 youth.

Table 6.8 School Involvement- Overall Results

School Involvement	Archival Data	Document Analysis	Interview	Overall
Alternative Education	Case plans and chronological notes adequately identify where youth return to school upon release, supporting the data obtained from the interviews.		All officers identified appropriately where a youth returns to school upon release. (N=12)	Yes
Specialized Services for LD Youth			A majority of officers were able to identify the responsible party for coordinating LD services for youth at school. (N=12)	Yes
MH Services in schools- MST & PALS			A majority of officers could identify additional mental health services that schools provide. (N=12)	Yes
Interagency Collaboration & Wraparound Services			A majority of officers could identify a Community Resource Coordination Group (CRCG) in providing services to youth and families. (N=14)	Yes

FAMILY INVOLVEMENT- INTERVIEW

Family involvement is the final category for an ideal aftercare program. As previously stated by Ashcroft et al. (2003, 8), “any program that hopes to improve a juvenile’s future must include his or her family in the solution.” The following

subcategories are included in family involvement: Family Intervention and Wraparound Services.

When asked how parents are involved in aftercare and about services provided, 11 of 13 Administrative/ Aftercare Officers reported that parents are involved in aftercare by attending meetings and providing transportation. Seven of 13 officers identified parenting classes as a program the agency offers to help families.

When asked about services specific to mental health needs, 9 of 14 Administrative/ Aftercare Officers identified the PROMPT and Family Preservation Programs. This information supports both the family intervention and wraparound services subcategories of the Family Involvement component of the model aftercare program in that a majority of officers knew how parents were involved in aftercare and what services the county provided to help those with mental health needs.

Table 6.9 Family Involvement- Overall Results

Family Involvement	Archival Data	Document Analysis	Interview	Overall
Family Intervention			A majority of officers were able to identify how parents were involved in aftercare and the types of services the agency offered to help them. (N=13)	Yes
Wraparound Services			A majority of officers identified the types of services the agency provided for youth with mental health needs.	Yes

CONCLUSION

In conclusion, this chapter provided information obtained from structured interviews, document analysis and archival data about the Aftercare Program in Williamson County. The data collected through the above-mentioned methods indicates that overall, Williamson County’s aftercare program meets the ideal aftercare model

developed through the literature review. However, Williamson County's Aftercare Program could use significant improvement in the Community Supervision Category in the following areas:

- Officer Training, first and foremost was the only subcategory that Williamson County did not meet the criteria for an ideal aftercare program, and is vitally important to the success of any program.
- Intensive Supervision and Treatment- while a majority of the officers interviewed knew the types and amount of contacts required, not all youth were seen adequately.

The next chapter will offer conclusions of the findings and overall recommendations to improve the aftercare program in Williamson County in order to adhere to the model aftercare program.

CHAPTER 7

CONCLUSIONS & RECOMMENDATIONS

PURPOSE

The purpose of this research was to: (1) describe the ideal characteristics of an effective mental health aftercare program based on a review of the literature; (2) assess the aftercare program in Williamson County, Texas using the ideal characteristics; and (3) to make recommendations to assist all juvenile probation departments in Texas to supervise youth with mental health needs in a more effective manner.

Chapter 3 described the ideal characteristics of a model aftercare program and developed a conceptual framework to assess Williamson County's aftercare program based on the literature review. Chapter 6 presented the results of the assessment based on the structured interviews, document analysis and archival data analysis.

This chapter presents conclusions of the research project and recommendations for improving the aftercare program in Williamson County, Texas. These results are the basis for the final purpose of this project, which is to make recommendations for improving the aftercare program in Williamson County, Texas.

RECOMMENDATIONS

The conceptual framework of this study presents ideal categories for a model aftercare program for youth with mental health needs. Table 7.1 on the following page identifies the overall evidence that the aftercare program in Williamson County supports each portion of the model.

In short, the following recommendations are made:

1. Provide set guidelines in Policy and Procedure.
2. Provide specialized training for Aftercare Officers.
3. Develop a specialized Aftercare Team.
4. Provide staff development through ongoing training and evaluation.

Table 7.1 Williamson County Aftercare Program Recommendations Summary

Ideal Type Categories	Evidence Supports	Recommendation
<p>Community Supervision</p> <ul style="list-style-type: none"> ▪ Transition Planning ▪ Intensive Supervision & Treatment ▪ Officer Training ▪ Interagency Collaboration 	<p>Somewhat</p> <p>Somewhat</p> <p>No</p> <p>Somewhat</p>	<ul style="list-style-type: none"> • Provide clarification and guidelines in written policy and procedure manual and conduct routine audits to ensure compliance with all requirements. • Provide specialized training for Aftercare Officers as well as ongoing training for officers working with this population, in order to ensure officers have the information and tools they need to work successfully with this population.
<p>Mental Health Aftercare</p> <ul style="list-style-type: none"> ▪ Interagency Collaboration, Systems of Care & Wraparound Services ▪ Assessment & Screening ▪ Funding 	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<ul style="list-style-type: none"> • Develop a specialized Aftercare Team staffed with specially trained officers. • Continue supporting and working with all other agencies involved with this mental health population. • Conduct routine audits for compliance of standards.
<p>School Involvement</p> <ul style="list-style-type: none"> ▪ Alternative Education ▪ Specialized Services for LD youth ▪ Mental Health Services through MST & PALS Programs ▪ Interagency Collaboration & Wraparound Services 	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<ul style="list-style-type: none"> • Continue supporting and working with schools in order to develop successful transition planning for youth returning to regular schools. • Designate an officer from the Aftercare Team to maintain contact with schools to gain information on programs in schools and designate the officer to disseminate information to others on a routine basis.
<p>Family Involvement</p> <ul style="list-style-type: none"> ▪ Family Intervention & Training ▪ Wraparound Services 	<p>Yes</p> <p>Yes</p>	<ul style="list-style-type: none"> • Continue providing services to youth and families in need and make all families as well as staff aware of all programs available to them. • Provide ongoing staff development through training opportunities and routine evaluation of programs for effectiveness.

COMMUNITY SUPERVISION RECOMMENDATIONS

Clear, written guidelines are important for many reasons but mostly to communicate with staff about expectations. Policy and procedure manuals are one way of providing set procedures and guidelines as to how an organization wants something done. In this case, Williamson County has a policy and procedure in place to deal with the aftercare population. The policy and procedure provides step-by-step guidelines for supervising youth in the aftercare program and even details who is responsible for following each procedure. However, there was no written standard as to how long a transition case plan should stay in effect. Furthermore, there was confusion among Aftercare officers as to the length of time a case plan stays in effect. This minor problem could easily be remedied by adding this information into the procedures for aftercare supervision.

While research does not indicate how long transition case plans should stay in effect, Boesky (2002, 282) concluded that transition case plans should start upon a youth's entrance into placement. Furthermore, because the ongoing efforts to coordinate services require extensive communication and collaboration (Stephens & Arnette 2000, 5), transition plans should have a specific start and end date, which should be communicated with a youth and their family.

Providing specialized training for officers would be the most important recommendation for Williamson County to implement, as the issue of training could eliminate several of the minor inconsistencies among Aftercare Officers (Field versus Court Placement) in regards to case management requirements and more importantly

could improve the overall effectiveness of the Aftercare Officers, which would improve the effectiveness of the agency.

As stated in the literature, weak programs implemented by untrained staff will not be successful in reducing recidivism, which is the ultimate goal (Gies 2003, 3). In order for officers to work effectively with juvenile offenders with mental health problems, they should receive sufficient, hands-on training, not just training from manuals (Boesky 2002, 277). Particularly, specialized training should include training on mental health diagnoses and their characteristics, whether or not those characteristics can change over time, and especially effective communication skills so that officers can feel comfortable explaining characteristics of the diagnoses in a way the youth can understand them. Furthermore, ongoing training about medications, side effects, as well as other treatment options should be communicated through ongoing training. These trainings should not only be offered, they should be mandatory for all probation officers since approximately 80% of the juvenile population they work with have mental health needs.

While policy and procedure helps communicate supervision requirements, training could help drive home the issue so that all officers are on the same page and know what is expected of them, and more importantly, why the required contacts are crucial for the aftercare population. As the literature states, community supervision must include several components of counseling and treatment, but also requires intensive supervision to hold youth accountable to ensure they are following their treatment plan (Gies 2003, 15).

As previously stated, youth and their families should know what is expected of them, which should be in written form on a case plan. There were minor inconsistencies

among officers interviewed in Williamson County regarding time requirements for case plans. Again, effective training could help reduce this inconsistency. Furthermore, ongoing training is crucial for officers working with the aftercare population, specifically youth with mental health needs because officers must have the most current information and tools they need to work successfully with this population.

MENTAL HEALTH AFTERCARE RECOMMENDATIONS

The second most important recommendation for Williamson County to implement, which would show great initiative, would be to develop a specialized Aftercare Team. This team could draw upon components of other programs Williamson County is already implementing such as the Family Preservation and PROMPT Program combining intensive supervision, therapy and staffing requirements to communicate needs. As opposed to weekly staffings similar in the Family Preservation Program, a monthly staffing would suffice and should include members from the Aftercare Team, treatment providers, school officials, and other local community agencies when possible. The importance of these monthly staffings would support interagency collaboration and show youth and their families that these various agencies have a vested interest in their success.

The Aftercare Team should be staffed with specially trained and experienced officers showing a strong desire to work with the juvenile population with mental health needs. Many of the officers interviewed said they were appointed Aftercare Officers either because of their title as a Supervisor or Juvenile Probation Officer II, or previous case manager title. The officers comprising the Aftercare Team should not necessarily be appointed because of their title, but more so because of their experience and willingness

to work closely and effectively with the aftercare population. While not all youth in aftercare programs have mental health needs, as evidenced in the sample drawn from Williamson County, a vast majority did have mental health needs. Additionally, ongoing training on mental health diagnoses, medication, and other counseling and treatment options should be sought out by the Aftercare Team.

Chapters Two and Three introduced successful Intensive Aftercare Programs in several states including Colorado, Nevada, and Virginia. All models excluded youth with mental health needs, however the premise behind them could be used, as a model for youth with mental health needs. In addition, the Wraparound Milwaukee Program showed promising results in the reduction of recidivism rates. These programs should be investigated further and it would show great initiative for Williamson County to send a representative to observe these successful programs in order to implement similar strategies.

Finally, developing and maintaining successful programs requires a system of checks and balances. Implementing these programs alone will be ineffective if routine monitoring is not done. Therefore, Williamson County should conduct routine audits to ensure compliance of all standards.

SCHOOL INVOLVEMENT RECOMMENDATIONS

While evidence supported Williamson County's adherence to the school involvement component of the model aftercare program and its subcategories overall, several recommendations are still offered. Williamson County should continue to encourage and support collaboration with the schools in order to develop successful transition planning for youth returning to public school upon release from placement. As

evidenced in the sample drawn from Williamson County, a majority of youth returned to public schools upon release. Stephens and Arnette (2000, 2) indicated that problems arise for youth transitioning back to mainstream schools because of incomplete information and teacher prejudice regarding their status as juvenile offenders. Therefore, it is critical to provide successful strategies for delinquent youth returning to the school system because it plays a role in the success of other students as well (Stephens & Arnette 2000, 2).

Interagency collaboration is a recurring theme throughout 3 of the 4 ideal components of a model aftercare program, indicating its overall importance. According to Boesky (2002, 238-239), professionals working with the juvenile population, specifically with mental health needs, should have knowledge about how the other field operates. While coordinating services between agencies is difficult to accomplish (Eber et al. 2002, 172), collaboration avoids repetition of services (Boesky 2002, 274).

Howell et al. (2004, 149-150) suggested a community team to plan for and make decisions for youth returning to the community. Designated members of the suggested Aftercare Team would be ideal to maintain contacts with schools so that information about programs and services is current and distributed to others on a routine basis.

FAMILY INVOLVEMENT RECOMMENDATIONS

Evidence suggested that Williamson County adheres to the subcategories of the family involvement component, by providing family intervention and training and wraparound services, yet in order to maintain its effectiveness the County should continue to provide services to youth and their families and officers should be armed with accurate information to distribute to the families about the programs available to them.

And, as mentioned throughout this chapter, Williamson County should provide staff development through ongoing training and routine evaluation of programs to ensure effectiveness.

CONCLUSION

The increase of youth with mental health needs involved in the juvenile justice system is a growing problem. Even more disturbing is the role the juvenile justice system has had to play for providing services to these youth. Success is determined in different ways, however in regards to the juvenile population, one way to measure success is to measure recidivism. Thus reducing recidivism should be the ultimate goal not only for juvenile probation departments and the youth they serve, but also for the future of all communities. Therefore, providing efficient aftercare services to adequately serve the increasing population of youth involved in the juvenile justice system with mental health needs is vitally important.

The aftercare program categories discussed in this applied research project identifies the effective components of an ideal aftercare program. The Aftercare Program in Williamson County overall adheres to the ideal aftercare program, while measures could be taken to improve certain aspects of the program, particularly in regards to community supervision. Williamson County Juvenile Services as well as other juvenile probation departments can build upon the recommendations outlined in this study in order to provide a successful community transition for youth, their families and their communities.

Bibliography

- Abadinsky, H. 2003. *Probation and parole theory and practice*. New Jersey: Upper Saddle River.
- Armstrong, T.L. 1991. *Intensive interventions with high-risk youths: promising approaches in juvenile probation and parole*. New York: Criminal Justice Press.
- Ashcroft, J., Daniels, D.J. & Flores, J.R. 2001, May. OJJDP research 2000. *Office of Juvenile Justice and Delinquency Prevention: 1-37*.
- Atkins, M.S., McKernan McKay, M., Arvanitis, P., London, L., Madison, S., Costigan, C., Haney, P., Zevenbergen, A., Hess, L., Bennett, D., & Webster, D. 1998, February. An ecological model for school-based mental health services for urban low-income aggressive children. *Journal of Behavioral Health Services & Research*, 5 (1): 64-75.
- Atkins, M.S., Graczyk, P.A., Frazier, S.L., & Abdul-Adil, J. 2003. Toward a new model for promoting urban children's mental health: accessible, effective, and sustainable school-based mental health services. *School Psychology Review*, 32 (4): 503-514.
- Babbie, E. 2004. *The Practice of Social Research*. California: Thomson Wadsworth.
- Bilchik, S. 1999, December. Juvenile justice: A century of change. *Office of Juvenile Justice and Delinquency Prevention 1999 National Report Series, Juvenile Justice Bulletin: 1-4*.

- Boesky, L. M. 2002. *Juvenile offenders with mental health disorders: who are they and what do we do with them?* Maryland: American Correctional Association.
- Bullis, M., Yovanoff, P. Mueller, G., & Havel, E. 2002, Fall. Life on the “outs”- examination of the facility-to-community transition of incarcerated youth. *Exceptional Children*, 69 (1): 7-22.
- Bullis, M., Yovanoff, P., & Havel, E. 2004. The importance of getting started right: further examination of the facility-to-community transition of formerly incarcerated youth. *The Journal of Special Education*, 38 (2): 80-94.
- Byrnes, M., Macallair, D., & Shorter, A.D. 2002, August. Aftercare as afterthought: reentry and the California Youth Authority. *Center on Juvenile and Criminal Justice*: 1-40.
- Cocozza, J.J. & Skowrya, K. 2000, April. Youth with mental health disorders: issues and emerging responses. *Juvenile Justice*, 7 (1): 3-11.
- Eber, L., Sugai, G., Smith, C.R. & Scott, T. 2002, Fall. Wraparound and positive behavioral interventions and supports in the schools. *Journal of Emotional and Behavior Disorders*, 10 (3): 171-180.
- Foster, E.M., Qaseem, A., & Connor, T. 2004, May. Can better health services reduce the risk of juvenile justice system involvement? *American Journal of Public Health*, 94 (5): 859-865.
- Gies, S.V. 2003, September. Aftercare services. *Office of Juvenile Justice and Delinquency Prevention, Juvenile Justice Bulletin*: 1-31.

- Herz, D.C. 2001, Fall. Understanding the use of mental health placements by the juvenile justice system. *Journal of Emotional and Behavioral Disorders*, 9 (3): 172-181.
- Howell, J.C., Kelly, M.R., Palmer, J. & Mangum, R.L. 2004, March/ April. Integrating child welfare, juvenile justice, and other agencies in a continuum of services. *Child Welfare League of America*, LXXXIII (2): 143-156.
- Jerrell, J.M. 1998, February. Utilization management analysis for children's mental health services. *The Journal of Behavioral Health Services & Research*, 25 (1): 35-42.
- Josi, D.A. & Sechrest, D.K. 1999, March. A pragmatic approach to parole aftercare: evaluation of a community reintegration program for high-risk youthful offenders. *Justice Quarterly*, 16 (1): 51- 80.
- Kamradt, B. 2000, April. Wraparound Milwaukee: aiding youth with mental health needs. *Juvenile Justice*, 7 (1): 14-23.
- Kamradt, B. 2002, December. Funding mental health services for youth in the juvenile justice system: challenges and opportunities. *National Center for Mental Health and Juvenile Justice, Research and Program Brief*: 1-5.
- Kaplan, A. 2004, December. Youth violence prevention conference explores risk factors, interventions. *Psychiatric Times*, 21 (14): 3-8.
- O'brien, J., Newton, J., Zinnecker, A., & Parr, B. 2005, January. Statewide criminal justice recidivism and revocation rates. *Legislative Budget Board*: 1-15.

- Powell, J. 2004, Spring. Five stages to responsible human behavior. *International Journal of Reality Therapy*, 23 (2): 27-30.
- Puzzanchera, C., Stahl, A.L., Finnegan, T.A., Tierney, N. & Snyder, H.N. 2003, July. Juvenile court statistics 1999. *Office of Juvenile Justice and Delinquency Prevention, National Center for Juvenile Justice*: 1-103.
- Rawal, P., Romansky, J., Jenuwine, M., & Lyons, J.S. 2004, July/ September. Racial differences in the mental health needs and service utilization of youth in the juvenile justice system. *The Journal of Behavioral Health Services & Research*, 31 (3): 242-254.
- Rosenblatt, J.A., Rosenblatt, A., & Biggs, E.E. 2000. Criminal behavior and emotional disorder: comparing youth served by the mental health and juvenile justice systems. *Journal of Behavioral Health Services & Research*, 27 (2): 227-237.
- Ruffolo, M.C, Sarri, R. & Goodkind, S. 2004. Study of delinquent, diverted, and high-risk adolescent girls: implications for mental health intervention. *Social Work Research*, 28 (4): 237-245.
- Shields, P. 1998. Pragmatism as a philosophy of science: a tool for public administration. *Research in Public Administration*, 4: 195-225.
- Shields, P. 2003. A pragmatic teaching philosophy. *Journal of Public Affairs Education*, 1: 7-12.

Special Needs Diversionary Program (SNDP).

[http://www.tjpc.state.tx.us/about_us/divisions/federalprograms.htm#Special%20Needs%20Diversionary%20Program%20\(SNDP\)](http://www.tjpc.state.tx.us/about_us/divisions/federalprograms.htm#Special%20Needs%20Diversionary%20Program%20(SNDP)), (accessed March 14, 2005).

Spriggs, V. 2003, February. Identifying and providing services to Texas' juvenile offenders with mental health needs. *Corrections Today*, 65 (1): 64-66.

Stephens, R.D. & Arnette, J. L. 2000, February. From the courthouse to the schoolhouse: making successful transitions. *Office of Juvenile Justice and Delinquency Prevention, Juvenile Justice Bulletin*: 1-15.

Travis, J. 1998, December. Reintegrating juvenile offenders into the community: OJJDP's intensive community-based aftercare demonstration program. *National Institute of Justice, Research Preview*: 1-2.

Trupin, E.W., Turner, A.P., Stewart, D., & Wood, D. 2004. Transition planning and recidivism among mentally ill juvenile offenders. *Behavioral Sciences and the Law*, 22: 599-610.

Yin, R.K. 2003. *Case Study Research Design and Methods, Third Edition*. California: Sage Publications