# THE COLLABORATIVE FAMILY INITIATIVE

**The New York City**
**Department of Juvenile Justice**
**with**
**The Research and Evaluation Center &**
**The Prisoner Reentry Institute**
**John Jay College of Criminal Justice, CUNY**

**Interim Report**
**April 2008**

# Acknowledgements

Those of us at the Research and Evaluation Center and the Reentry Institute, John Jay College, CUNY, are indebted to many people for helping to create a strategy-focused learning community. We have benefited from and been inspired by leaders of New York City's Department of Juvenile Justice and many community-based service providers. Many of these leaders created change from within their organizations to generate the rich experiences and client-related successes that we describe in this Interim Report.

In addition to our organizational collaborators, we wish to acknowledge our appreciation for the evaluation assistance received from Drs. Lila Kazemian and Jeff Mellow from John Jay College's Departments of Sociology and Law and Police Science, respectively. Without their assistance, the insights necessary to the improved performance of organizations and clients alike would remain but a vision.

# Table of Contents

# Executive Summary

## National Context

Media portrayal of youth who are involved in the criminal justice system typically sensationalizes both the indifference of youth and the quality of their crimes. It is this viewpoint, unfortunately, that helps shape public perception. However, this depiction ignores a worrisome component shared by many youth involved in the criminal justice system: their mental health problems and learning disorders indicate they are more in need of treatment than punishment. Moreover, these youth, estimated to be from 30 to 60 percent of the adolescent offender population (Snyder, 2004; Bullis, Yovanoff, and Havel, 2004; Grisso, 2004), are very often without family and/or the community resources necessary to improve their situations.

Without question, courts must uphold their primary responsibility to effectively and appropriately address challenges to public safety. In doing so, however, judges are becoming increasingly aware that sentencing options, as they currently exist for youth in general and for youth with mental health problems in particular, may fulfill judicial responsibility in the short run, but may further compromise a young person's chances for a successful and productive return to the community in the not-so-distant future. This increasing sensitivity to the problems inherent in sentencing options has come about as more and more people who are involved with the juvenile justice system, as currently designed, recognize that it is neither equipped nor philosophically driven to effectively address the mental health needs of adolescent offenders (Cocozza and Skowyra, 2000; Soler, 2002; Tolan and Gorman-Smith, 1997).

While entitlement to mental health treatment in New York State is legislatively clear, the juvenile justice system lacks the resources, coordination, and training to provide what has been identified as "effective" treatment. Crucial components of effective mental health services, such as comprehensive assessments, individualized interventions and targeted psychiatric treatment when indicated; family-based services and capacity-building support; and adequate follow-up, have not, until the present, been practically considered in the context of detainees. Heretofore, planners and decision-makers have felt constrained by the relatively limited amount of time a young person spends in detention and the transitory nature of the detainee population. However, the necessary components of effective interventions are too often inadequate or missing in longer-term placement facilities as well (Steinberg, Chung, and Little, 2004), confounding informed judicial decision-making as well as long-range policymaking.

Research on best practice regarding adolescent and juvenile reentry has been, in the main, limited to the transition from placement settings back into the community. While not generally encouraging in terms

of their outcomes, they are considered inconclusive because they are derived from non-random assignment to interventions. Nonetheless, when thoughtfully considered, findings collectively suggest that successful transition programs are those that provide chances for young people to apply the social skills they learned in a specially designed program in natural, community-focused settings (frequently their home neighborhood). Such findings are particularly encouraging with respect to young detainees and prospects for the Collaborative Family Initiative (CFI). As discussed below, this new initiative was conceptualized and planned as a specially designed program to be implemented in neighborhood settings.

Just as encouraging, recent studies have demonstrated that family, school, and peer environments, the broad domains that encompass the most significant risk factors associated with delinquency and adolescent offending, can, indeed, be improved through programmatic interventions (Henggeler, 1997; Kumpfer, 1994). When effective, interventions can substantially decrease the likelihood of delinquent behavior, provided they are grounded in the characteristics of empirically identified program components resulting from meta-analyses of the most reliably effective (Lipsey, Wilson, and Cothern, 2000) reentry efforts.

However, even in the face of encouraging research, one of the most prominent challenges to effective community-based services for a juvenile delinquent with a mental health problem returning from detention (or even a placement facility) is the lack of community-based, systematic adolescent mental health services. Exacerbating the general paucity of adolescent mental health services, youth with behavioral and mental health problems are increasingly concentrated in communities already experiencing enormous disadvantage (Mears and Travis, 2004). Moreover, changes in public health policy nationally may be increasing the flow of youth with mental health disorders into the juvenile justice system, particularly in these disadvantaged communities. For example, when families moving from welfare-to-work lose public health insurance benefits that cover mental health counselors and psychiatric treatment (and replacement insurance does not provide such benefits), involved youth lose access to critical mental health services, increasing the likelihood of justice system involvement (Snyder, 2004). Thus, while youth in Department of Juvenile Justice (DJJ) custody are being well served during detention, a disparity becomes evident when considering post-release continuity of care.

## New York City's Challenge

In New York City, it has often been the case that juveniles diagnosed with treatable mental health problems while detained in a DJJ facility who are released to the community, often return to detention within several weeks for an infraction. Sadly, but not uncommonly, when youth have been prescribed medication for their mental health problems, the supply of prescribed medication is used and depleted shortly after the youth is released. Further, access to community-based psychiatric services is often several months in the future. Families in distress simply lack the resources to negotiate complicated social service systems or to cope with yet another crisis, particularly if they feel stigmatized by acknowledging a mental health problem.

Within this context, one of New York City Mayor Michael R. Bloomberg's visions for his second administration included the reform of the juvenile justice system. Complementing the mayoral vision of juvenile justice reform, the Deputy Mayor for Health and Human Services, Linda Gibbs, foresaw the coordination of the DJJ and other juvenile justice agencies as a priority. The commitment from Sara M. Gonzalez, Chair of the Juvenile Justice Committee of the New York City Council, to support the needs of discharge planning for adolescents with mental health problems (and their families) provided the context and the wherewithal for DJJ to conceptualize its approach to enlightened juvenile justice reform.

DJJ planners were keenly aware that New York City youth with identified mental health issues were over-represented in the detainee population. Moreover, they were found to have longer lengths of stay and, when they were released, they were remanded with greater frequency, and within a shorter period of time, than others who were not encumbered with mental health problems. It also was noticed that youth with mental health issues were more apt to be sent to state placement because of the lack of community services, options, and alternatives, and to have more negative outcomes when returning from such placement.

## The Development of the Collaborative Family Initiative

Strategic planning within the Department focused first on this population. Agency decision-makers began by identifying a need for enhanced discharge planning for adolescents with mental health problems and their families, laying the groundwork for the creation of the Collaborative Family Initiative (CFI). Planning was premised on the latest research, program evaluations, and an intuitive understanding that young people who came to detention with untreated, or under-treated, mental health problems could be better transitioned to a productive lifestyle if they remained in their communities, firmly connected to ancillary services for family strengthening, targeted adolescent mental health treatment, and educational development.

Seeking to develop a program that would address gaps in current practice and traditional thinking, DJJ engaged the Prisoner Reentry Institute and the Research and Evaluation Center at John Jay College, CUNY, to review best practice and the latest research, and to collaborate with DJJ to prepare possible programmatic options for review by practitioners with a promising track record.

With a concept paper and options in hand within two weeks, additional subject matter experts, potential

service providers, psychiatrists, and educators were invited to a facilitated discussion to obtain additional input. By January 1, 2007, just six weeks after the initial meeting between John Jay College stakeholders and DJJ, program components were in place. All agreed on the new program's basic tenets, which were to encompass:

- Formal agreement from a parent or guardian to actively participate in required program activities;
- A family-focused schedule of services and support that included siblings;
- Family engagement and program enrollment initiated while the young person is still in detention;
- Immediate availability of services upon release, including psychiatry if needed; and,
- Home visits and case management.

CFI began enrollment on February 6, 2007. During the eleven weeks of gestation, it had become a learning community and a partnership as well as a type of unique discharge planning and reentry program — unique because it served families and their adolescent children with mental health issues who were returning to their communities from *detention* rather than a placement assignment, and unique because it ensured immediate services in the community regardless of judicial disposition.

In order to ensure that data would be collected promptly, and that the program was growing as a whole rather than as a series of individualized interventions, a "learning community" was created that required the participation of all Community Based Organizations (CBOs), DJJ and John Jay. The learning community aspect of the CFI was also consistent with the City Council's request for an "outcome" assessment. As a result, a key effort during this period was to ensure the quality, completeness and timeliness of the data and its collection process. The intensity of the outcome requirements, the fact that only four months separated the stakeholders from June 1, and the desire of the participating service providers to demonstrate their expertise within a context where accountability was measured and feedback constant combined to facilitate the utility of bi-weekly meetings. Stakeholders used these meetings to discuss progress and challenges, to adjust a program model when indicated, and to share insights and concerns. All, including DJJ, were enthused about the opportunity provided by the CFI to improve on the discouraging outcomes that were the hallmark of so many prior reentry efforts (Frederick, 1999).

## Early Outcomes and Lessons Learned

By June 1, CFI partners were fully enmeshed in developing new methods of engaging difficult to reach parents and guardians, the most effective means of sustaining youths' involvement in their education, and in methods of financing families and youth who remained active in the CBO activities for longer than the three months that could be sustained with existing CFI funding. This report is a snapshot of

early learning and the outcomes of the first four months of participant activities.

In brief, CFI was tasked with engaging 100 youth and their families, referring them to CBOs for outreach and engagement in family strengthening activities, post-detention mental health services, education, and life skill support for their youngsters released to the community. Outreach to families for consent to participate was the most time consuming and demanding part of the enrollment process. There were 154 in-person contacts and 120 completed phone contacts with a family member, with a net result of 62 enrolled families. Significant attrition (due in part to difficulties in reaching families, youth no longer eligible, parental refusal to participate, youth remaining in detention or becoming placed with the State or another program) brought the final pool to **21 youth who were actively participating in the community by the end of the trial period, June 1, 2007.**

**All 21 participating youth were enrolled in school. Seventeen of the 21 participating youth (81 percent) were NOT arrested on new charges during the 90-day post-release period.** Eight of the seventeen had successfully completed 30-, 60-, and/or 90-day program benchmarks for attitudinal and behavioral improvement established by the DJJ within the four-month time frame. Only three youth were remanded to DJJ custody for violations of their conditions of release. Two youth were hospitalized for psychiatric treatment and one ran away from home.

Behind these numbers are the remarkable efforts of the CFI stakeholders, who have created a system of service delivery that is positioned to address issues in the referral process, to meet the mental health needs of a most vulnerable population, and to become a valued resource in the community.

## Next Steps

The experiences of the initial five months of the CFI program led to several considerations that will need to be addressed as the program continues. Among them:

- CFI provided accessible and critical community-based psychiatric services, counseling, and family support that participants would have been unlikely to secure if not for their program participation. It is important to know the nature and duration of the services provided and the characteristics of those who benefited most. What was the value of the discharge plan developed by DJJ? To the extent that improvements in the discharge plan are required, what is the consensus of service providers regarding such improvements?

- That the CFI families are hard-to-reach, hard-to-engage, and hard-to-treat was palpably demonstrated. The evaluation team identified several elements of the DJJ referral process that will be explored in an effort to facilitate family/youth engagement and reduce the amount of unproductive time spent by CBOs in pursuit of parent engagement and the community release of youth.

- CFI benefited from the substantial resource commitment and dedication of all stakeholders. The evaluation team has begun work with service providers to translate client and family assessments and progress reports into behavioral terms that are unambiguously understood by the interested public. Clarity and consistency internally and among providers will help establish benchmarks and behavioral outcomes that can be standardized among service providers and are meaningful to policymakers.

- Remand, hospitalization, and violations of conditions of release will be explored for patterns and recommendations relevant to program issues and needs assessments.

- Young women and their families have not participated in the CFI at the expected rate. Qualitative data from young women and their families will be gathered in an effort to empirically determine the explanations for lower-than-anticipated rates of female participation.

- Program successes — those youth who remain actively engaged in CFI for at least 90 days, return to an educational program, demonstrate pro-social behaviors and remain in the community for at least six months subsequent to completing CFI participation — will be studied for the personal and contextual patterns that may account for their "success."

# THE COLLABORATIVE FAMILY INITIATIVE

**The New York City**
**Department of Juvenile Justice**
**with**
**The Research and Evaluation Center &**
**The Prisoner Reentry Institute**
**John Jay College of Criminal Justice, CUNY**

**Interim Report**
**April 2008**

# Introduction

This interim report describes the development, implementation, and initial outcomes of the Collaborative Family Initiative (CFI) during its first five months — from January through June 1, 2007. The report first describes the program's planning phase, when the parameters for eligibility, service provision, and community-based organization (CBO) selection were determined and a "learning community" created that included the New York City Department of Juvenile Justice (DJJ), the CBOs selected to provide program services, and evaluators and technical assistance providers.

The second section of the report discusses program implementation. Contained within the discussion is an analysis of the attrition rate for the pool of eligible youth and the relationship between attrition, court case processing time, and the family characteristics of DJJ-identified youth.

In the third section, criminal history and mental health profiles of the DJJ pool of CFI-eligible youth are discussed and differentiated from those eligible youth who actually participated in the program.

Lastly, as part of the third section, the report reviews outcomes for early CFI participants. The outcomes section of the report reviews youth progress and performance in CFI at intervals of 30, 60, and/or 90 days of participation. For a smaller number of cases, more detailed synopses provide a profile of their circumstances, characteristics, and status.

## Department of Juvenile Justice Background

DJJ has in its custody, on any given day, between 400 and 450 alleged juvenile delinquents and juvenile offenders housed in secure detention facilities or (non-secure) group homes. Somewhere between 65 and 85 percent of these youth are identified by DJJ at intake as having a mental health needs. For all youth with a mental health diagnosis — either a behavioral problem requiring supportive services (such as anger management) or a clinical diagnosis (such as bipolar disorder) — DJJ provides counseling services, psychiatric services for those with indicated disorders, and transitional planning in anticipation of the youth's possible release to community. This results in an individualized discharge plan, which is shared with the youth's parent(s) or guardian. The discharge plan is viewed as the means by which a youth who is not sentenced to residential treatment or further incarceration can be supported in his/her effort at successful community reentry. Often, the plan recommends mental health treatment in the community and DJJ provides a week or so of medication when appropriate.

It is not uncommon, however, for youth with mental health needs to remain in custodial care longer than others detained in a DJJ facility. The lack of adequate community-based mental health services for

adolescents is an acknowledged reality among members of the New York City criminal justice community. Youngsters in general, and those with mental health problems in particular, are not able to navigate the systems crucial to their success without the assistance of a supportive adult. Yet, in the stressed communities to which these youngsters most often return, their families, too, are often over-extended and in need of help themselves.

At the time that the CFI was conceptualized, DJJ staff was aware that youth identified with mental health needs were returned to DJJ custody more quickly than their peers, either with new charges or due to violations of the conditions of their release. Additionally, staff reported that youth often stopped taking their medication upon release, once the medication provided ran out. Given extraordinarily long waiting lists for psychiatric services, youth were often bereft of psychiatric services for an appreciable amount of time, precluding the possibility of timely refills.

An additional concern centered on youth who tried to return to school, but found the reentry process impossible to negotiate. Those who did manage to re-enroll were often far from welcome and were given to repeating the aggressive behaviors that landed them in custody in the first place.

In short, the written discharge plan alone was not sufficient to ensure youngsters with mental health problems had enough support for a successful return to their communities.

# Part I: The Planning Phase

## Formation of the Collaborative Family Initiative (CFI)

Despite the fact that there was no clear model for the successful community reentry from detention of youth with mental health problems, staff at the Department of Juvenile Justice (DJJ) were determined to better the chances of success for this group. Taking into account what they knew about best practice, DJJ administrators outlined the key components of an approach that would become the model for CFI. The approach would include:

1) Improved transitional planning, based on an assessment of clinical, social, and educational needs;

2) Support for the families or caretakers of the youth so they could assume a more central and constructive role in reentry;

3) Collaboration with community-based organizations (CBOs), located in close geographical proximity to youths' homes, that could provide culturally appropriate services and that had the capacity to address the mental health needs identified in youth discharge plans; and

4) Coordination of the transition from DJJ to CFI through enrollment in services prior to release so that those youth and families who wanted to participate could do so with relative ease.

CFI is a direct result of this DJJ-proposed approach. Its goal is to meet the needs of detained adolescents whose mental health issues are barriers to successful community reentry. The program name reflects its emphasis on collaboration among DJJ, the courts, and CBOs and its focus on family as the most critical support to successful reentry for participants.

DJJ received initial funding for the CFI pilot from Sara M. Gonzalez, the Chair of the Juvenile Justice Committee of the New York City Council, and invited the John Jay College Prisoner Reentry Institute and the Research and Evaluation Center (the Center) to join its effort to ensure that the program would incorporate an outcome evaluation from its inception.

## Creation of a Learning Community of Agencies, CBOs, and Evaluators

The Center's evaluation staff and the Reentry Institute assisted DJJ early on with program and evaluation design. Among the issues discussed between the Center and DJJ were the development and enhancement of databases for tracking individual youth (both pre- and post-release); methods of maintaining accountability for the performance of CBOs under contract; and plans for engaging family members or caretakers in the proactive support of their very high-risk youth.

Also discussed at this point were the program components that CBOs would need to have in place in order to provide CFI services.[1] Since CFI was not a "linkage" program, it was essential that potential service providers have a comprehensive package of services available on-site, including mental health professionals already on staff and a psychiatrist readily available to provide or adjust medication. The need to refer a youngster to another community-based agency to comply with a discharge plan or to satisfy commonly agreed-upon needs for positive youth outcomes was sufficient to disqualify a CBO from consideration as a CFI provider.[2]

These early discussions helped to identify a pool of CBOs from each borough with the capacity to deliver CFI services for the number of eligible youth that DJJ estimated would be referred. Workshops for the pool of CBOs were held in the fall of 2006. By the end of the year, CBOs without the organizational capacity or motivation to participate in CFI, as well as those who did not have specific program components considered by program planners to be critical, either self-identified or agreed that participation for them would be impractical. That left seven committed CBOs ready for implementation in January 2007.

The seven CBOs that were implementation-ready in January included:[3]

- Coalition for Hispanic Family Services, serving Queens & North Brooklyn
- Friends of Island Academy, serving Manhattan
- Full Circle Health, serving the Bronx
- Good Shepherd Services, serving South Brooklyn
- Staten Island Mental Health Association, serving Staten Island

---

[1] *See Appendix A for logic models depicting the programmatic services of each CBO.*

[2] *Steering clear of linkage models became important enough to consider engaging the services of a mobile medical unit to make scheduled trips to participating CBOs. Pursued vigorously in the early stages of program planning, this particular idea was set aside because of staffing changes at the provider and other logistical concerns that went against the need for a quick start-up.*

[3] *The seven CBOs reduced to five by June 2007. One CBO with a focus on medical services became an untenable contributor, and another, more focused on substance abuse than mental health, chose not to continue participation. For simplicity, however, this report will refer to the number of CBOs as seven.*

- Steinway Children and Family Services, serving Queens
- Project Stay, providing mobile health education services city-wide

The working group, with representatives from DJJ, the Center, and the selected CBOs, met three times in January 2007 (six weeks after the first contact between DJJ and the Center). The January meetings allowed for discussion and brainstorming of program implementation issues that included effective discharge planning, strategies for outreach to and consent from families that are traditionally difficult to engage, effective family strengthening practices, and the importance of tracking activities and outcomes.

Despite the intense level of commitment required of CBOs and the limited funds available to supplement their program services, all of the CBOs in attendance at the January meetings were enthusiastic about CFI participation. CBOs were particularly enthused about creating a "learning community" where they could explore approaches to working with this traditionally difficult group of adolescents and were amenable to adapting their programs and their models as necessary. They felt it was extremely valuable to share their experiences and concerns with like-minded service providers, as well as directly with the city's juvenile justice agency. Bi-monthly meetings were planned to facilitate these conversations.

## *Early Implementation Challenges*

In order to begin implementation, a substantial amount of administrative work was required. Although often challenging, those involved managed to successfully complete this work within the required time frame.

CBOs learned to trust that the evaluation team could document CFI's accomplishments without compromising each organization's unique character and method of delivering services. To address the issue of multiple service delivery models, the evaluation team worked with the CBOs to develop agency-specific logic models that reflected the individual approach of each participating CBO. A logic model is a succinct, developmentally sequenced series of statements that link the problem a group is trying to resolve with 1) the activities and strategies used to address it; and 2) the immediate, intermediate, and final outcomes the group expects, should the program be "successful."

The agency-specific logic models have the capacity to differentiate among the CBO approaches. However, with only 100 anticipated program participants, who would be unevenly distributed among the service providers, the decision was made to examine the final outcomes as a product of the intervention as a whole. The individual logic models were expected to be useful in formulating hypotheses about the relative importance of different approaches to outcomes. The general CFI logic model, although based on the individual models (See Appendix A for logic models), reflects the elements common to all of the CBOs.

These early discussions were important to the CFI. They allowed the group to work through early issues, to agree on project goals, to understand the theories driving the program strategies, and to buy into the long- and short-term purposes of the evaluation. Bi-monthly meetings were planned in order to provide a forum for addressing any unforeseen challenges to implementation, to continue program development as the reality of youth and family needs were identified, and to encourage communication as the project was implemented.[4] These meetings were particularly valuable given the quick program start-up and the short duration of the pilot phase of the project.

[4] *While the bi-monthly meetings were productive, some unexpected issues did surface over time. Communication between CBO project directors and their frontline staff was not consistent, and questions and concerns of staff were not always shared with project directors, or directors did not feel free enough to discuss those concerns with the rest of the group at the meetings. After becoming aware of this issue, the evaluation team scheduled focus groups with caseworkers, staff from DJJ, and all of the CBOs. Information from these focus groups is embedded in the discussions that are presented in later segments of this report.*

# Part II: Participant Selection and Program Implementation

## Developing a Pool of Eligible CFI Participants

Based on DJJ estimates, it was initially anticipated that 100 eligible youth, at least 25 of whom would be female, would participate in CFI by the end of April 2007. For evaluation purposes, this would ensure a minimal number of participants from whom credible outcomes could be obtained.

To be considered eligible for a CFI referral, DJJ youth had to:

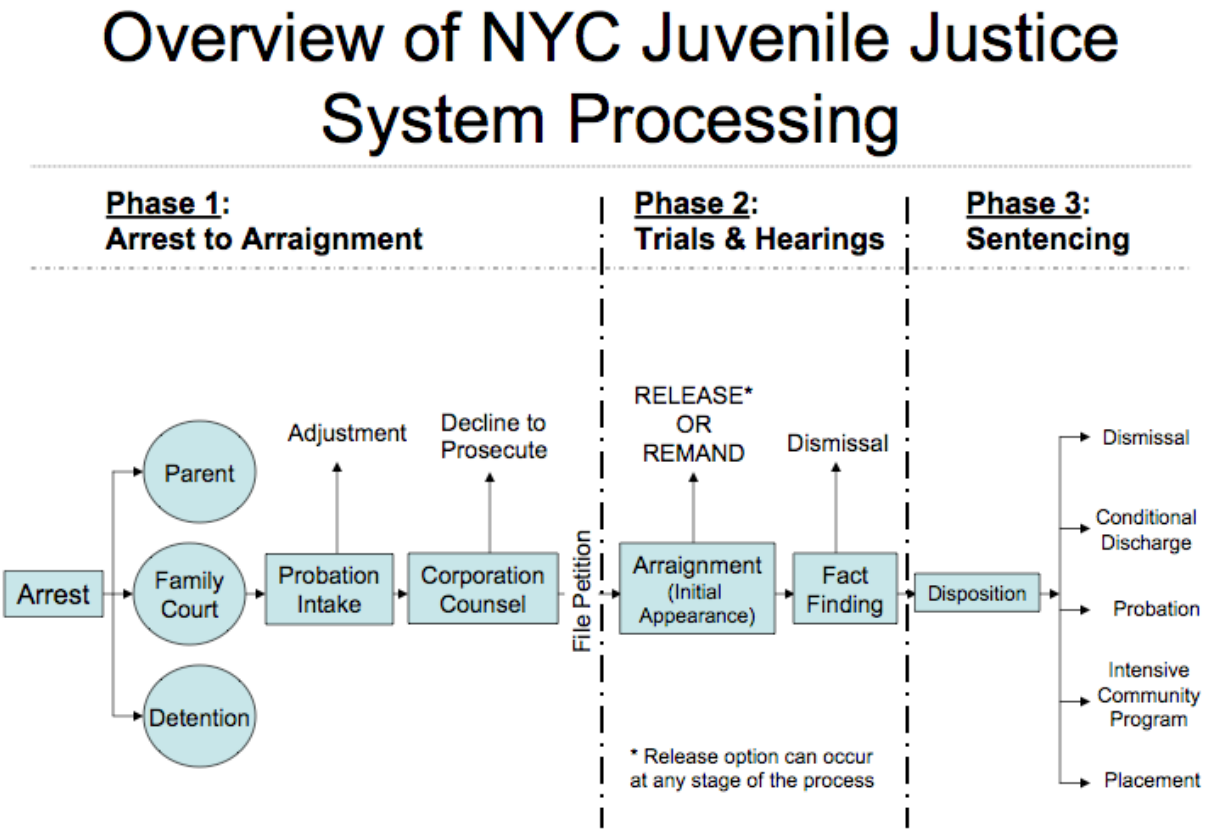
- Be identified with a mental health need by a clinician or, in more serious cases, by a psychiatrist at DJJ. This could happen at any time during their stay. A youth could be referred to mental health by self-referral, caseworkers, discharge planners, law guardians, a judge, or juvenile counselors;
- Have an identified family resource in the community (parent or guardian), who would be able and willing to participate in the project;
- Provide consent, along with a family member or guardian, to participate in the project; and
- Not be assigned to, or have consented to participate in, any other family-focused therapeutic intervention.

Not all eligible youth were referred to CFI, however. DJJ discharge planners screened the pool of eligible youth — a much larger pool than were referred — for those most likely to be released in the near future. At best, this was only a "guesstimate."

Between February (when CFI officially enrolled the first youth) and June 1, 2007, DJJ discharge planners referred 150 eligible youth to CFI. The difficulty of turning these referrals into actual enrollments is evidenced by the fact that just 21 of the referred youth were released and actively participated in CFI during the study period.[5] The data presented in this report will clarify the reasons that the number of initial CFI participants was fewer than expected.

[5] *There were initially 22 active participants, but one CFI-referred youth was released and participated in both CFI and another program. As a result, he was dropped from the research sample. This report will therefore refer to the number of CFI participants as 21.*

*Figure 1. Overview of NYC Juvenile Justice System Processing*



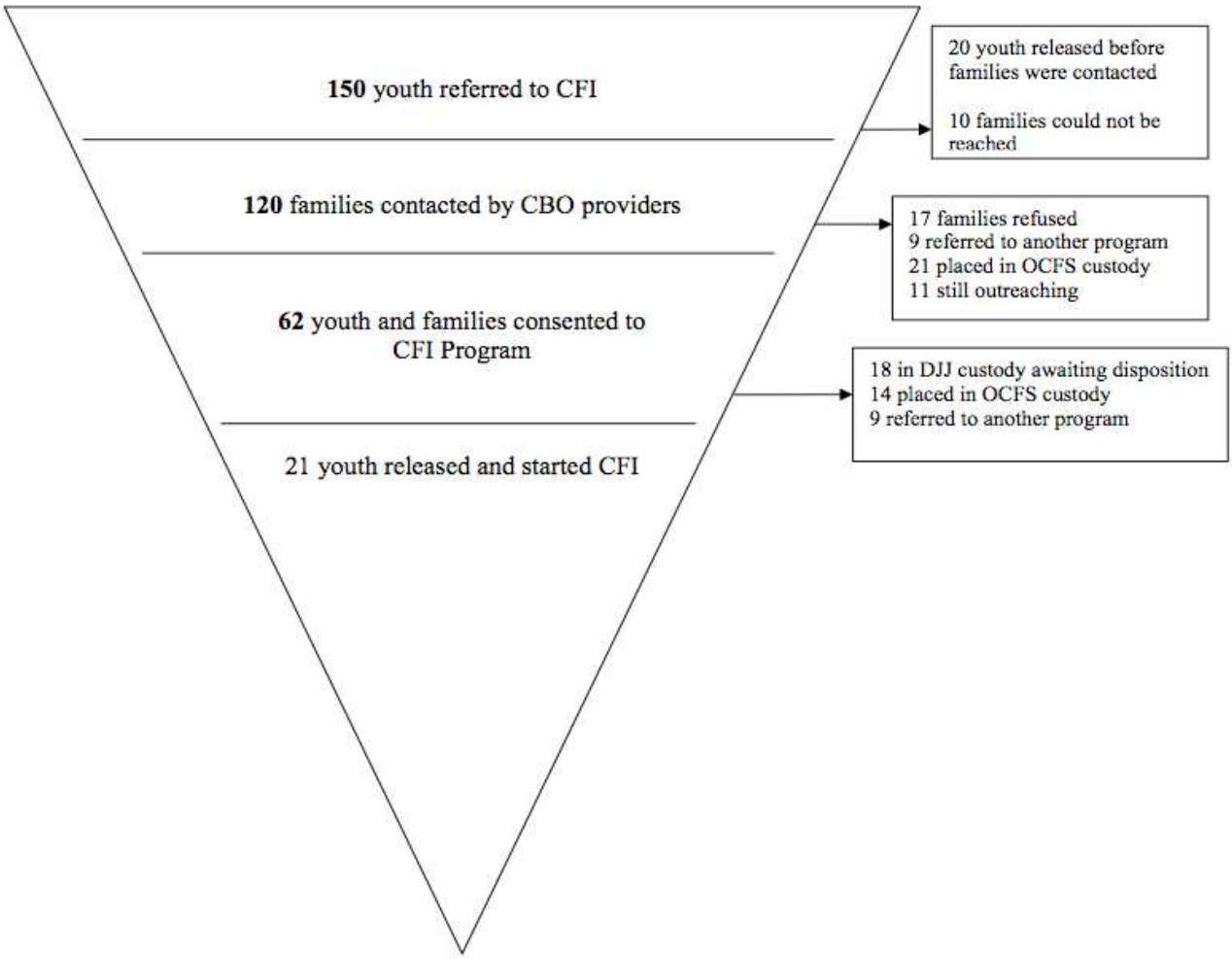

## *Referral and Enrollment Challenges: The Participant Funnel*

Figure 2 on page 19 shows the flow of youth through the stages of adjudication in New York City Family Court. Explanations for case attrition are identified at each stage of the process. As mentioned previously, DJJ discharge planners referred 150 eligible youth to CBOs for family outreach between February and June 1, 2007. CBOs successfully contacted 120 (80 percent) of the 150 referrals. Of the 30 referrals not contacted, 20 had been released back to the community before CBOs could contact a family member or guardian, and 10 families could not be reached at all. Thus, 20 percent of the families who were initially eligible could not be included in the pool.

There were several reasons why families could not be contacted. Phones were often disconnected, phone numbers were often incorrect, and phone calls often went unanswered despite creative calling patterns. DJJ has noted that many of these families move frequently, making it difficult to secure accurate phone numbers.

Of the 120 families remaining in the participant pool, 62 youth and their families consented to participate in CFI (a 52 percent consent rate). Fifty-eight members of this group (48 percent of the pool) were not able to participate because they remained in detention or were assigned to New York State Office of Child and Family Services (OCFS) custody (21 youth). Nine youth were referred by the court to another program, and 17 had families who refused CFI services at the time data collection for this Interim Report ended (June 2007).

### *Figure 2. Flow of Youth in the CFI Program, from Referral to 90 Days*



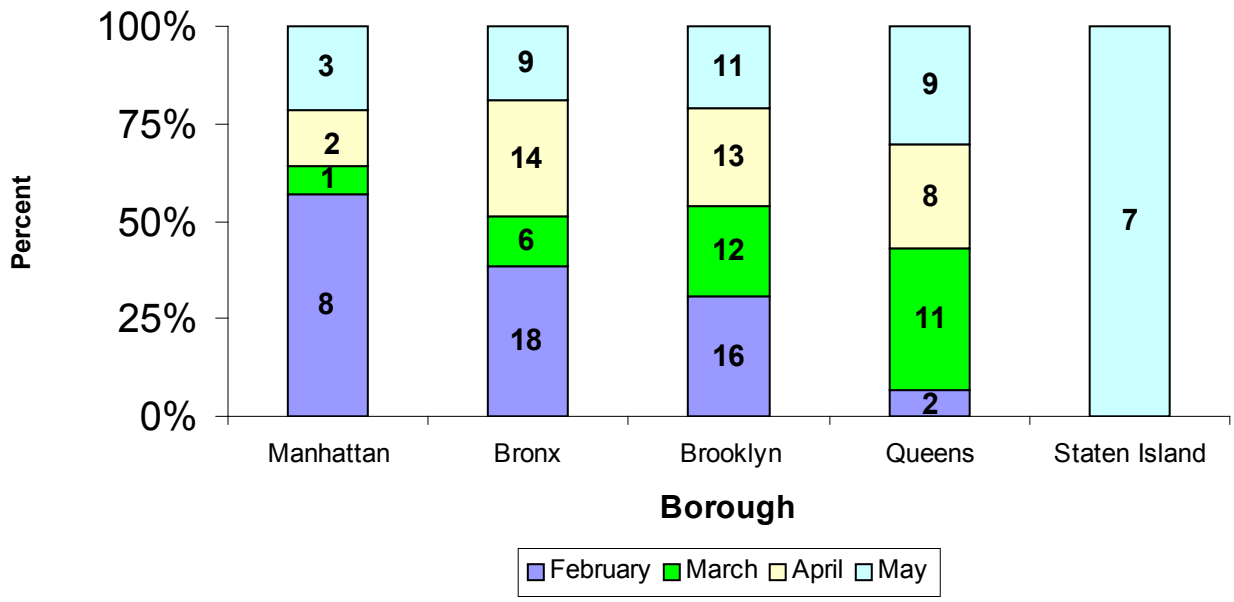

There were a variety of reasons for parental refusal to participate in CFI. Some parents felt that they were not equipped to cope with the child and expressed reluctance to accept the youth back home. These were often families who preferred residential or long-term treatment for their child, as opposed to the short-term services offered by CFI. In other instances, parents did not like the services offered by CFI or did not grasp the purpose of the program. Still others resisted the program because of the stigma associated with a mental health diagnosis for their child.

Among youth from the 62 families who agreed to participate, 21 were released from detention and actively participating in CFI by June 1, 2007. Forty-one of the consenting youth were either still in DJJ custody, placed in OFCS custody, or were referred to another program[6]; eighteen of which were still in DJJ custody awaiting disposition at the end of this study period. Among the 21 who were released and began the program, all were still active at 30 days, with smaller numbers at the 60- and/or 90-day benchmarks (see the last section for a more detailed discussion of youth progress).

## *CBO Outreach Efforts*

Figure 3 shows the distribution of referrals by borough from February through May. The largest number of referrals occurred in February (nearly 40 percent), a result of DJJ's efforts to identify eligible youth in advance of program implementation. Referrals to the Brooklyn, Bronx, and Queens CBOs occurred steadily over the next three months, although referrals to Manhattan dropped off over time. (Note that the Staten Island provider did not become active until spring 2007 and ceased participation altogether in June 2007.)

### *Figure 3. Referrals by Borough*




[6] *At the same time that DJJ introduced CFI, the Administration for Children's Services began its Juvenile Justice Initiative (JJI), intended to serve youth who were placement bound to private placement and to work with youth already ACS involved at the time of remand. For those youth who were eligible for both programs, DJJ and ACS worked closely together to ensure the best possible outcome for youth and families.*

As soon as the CBO received a referral, staff would reach out to the youth, who was still in detention, and to the family. This family outreach was done through telephone calls and home visits, at which time the CBO counselor would explain the program and ensure that the youth and family were appropriate candidates for participation. Contact with families was vital, not only because family participation was a key component of the model, but also because written parental consent was a legal requirement. Individual and family assessment information and case-related data crucial to a CBO's ability to develop a prescriptive plan could not be released without this consent.

CFI stakeholders learned quickly that outreach to the youth and their families was the most time-consuming part of the process. Because of the vulnerable and often unstable situations of the families of eligible youth, contact information changed frequently, frustrating outreach efforts. Often, especially in single-parent families, parents were at work and difficult to reach. In some cases, weeks were spent trying to make the initial contact.

Table 1 shows the number of pre-release in-person contacts that were made by all five CBO providers for the 120 referrals. In total, 154 in-person contacts were made (either at home, at DJJ, or at court). Initial contact was more frequently made with families (111) than with youth (43) because of the intentional emphasis of the CFI model on connecting with the families first and gaining their consent, before the youth's release. Family contacts most commonly occurred in court (42 percent), with about a third occurring at the home and 25 percent occurring in the CBO office. Youth contacts, on the other hand, occurred most often in a DJJ facility. A total of 665 attempted phone calls were made, with about 60 percent resulting in an actual contact (397).

### *Table 1. In-person Pre-Release Contacts*

| Visit Type | Family | Youth | Total |
|---|---|---|---|
| Home | 31% (34) | -- | 22% (34) |
| CBO Office | 25% (28) | -- | 18% (28) |
| Court | 42% (47) | 26% (11) | 38% (58) |
| DJJ Facility | 2% (2) | 74% (32) | 22% (34) |
| **TOTAL** | 100% (111) | 100% (43) | 100% (154) |

Figures 4 and 5 provide more information on the reduction in the pool of eligible youth. Figure 4 is specific to the 88 youth and families who did not consent to participate in CFI, illustrating that of these youth, nearly 25 percent were released by the court before contact could be made, and more than a third were placed or referred elsewhere. Nearly 20 percent refused the program, and of the remaining 24 percent, 11 percent of the families could not be reached and 13 percent were still inaccessible at the close of the pilot period.

### *Figure 4. Referral Pool Attrition: Non Consent*

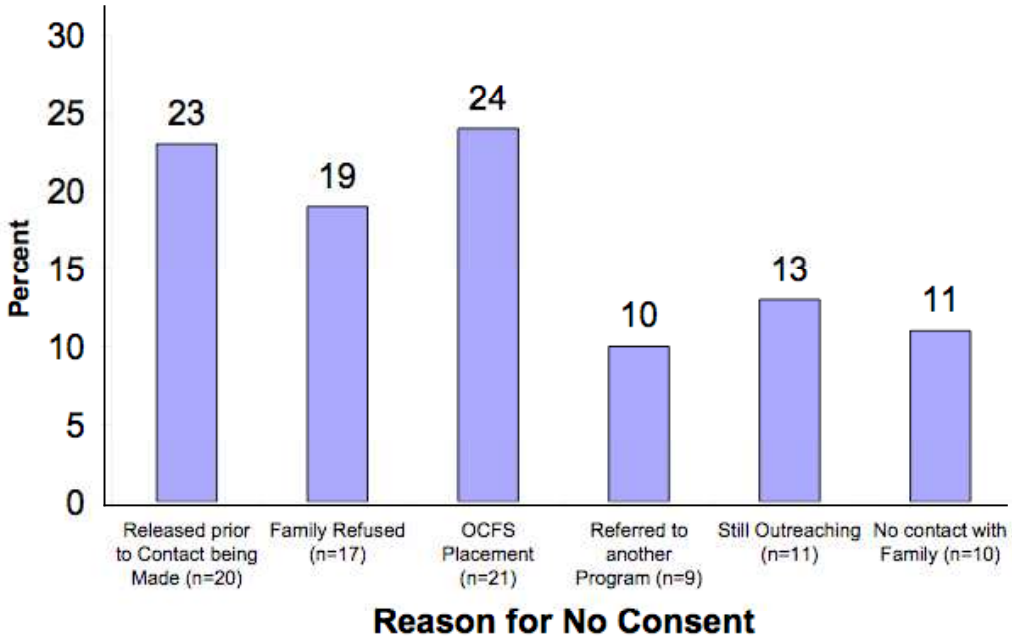
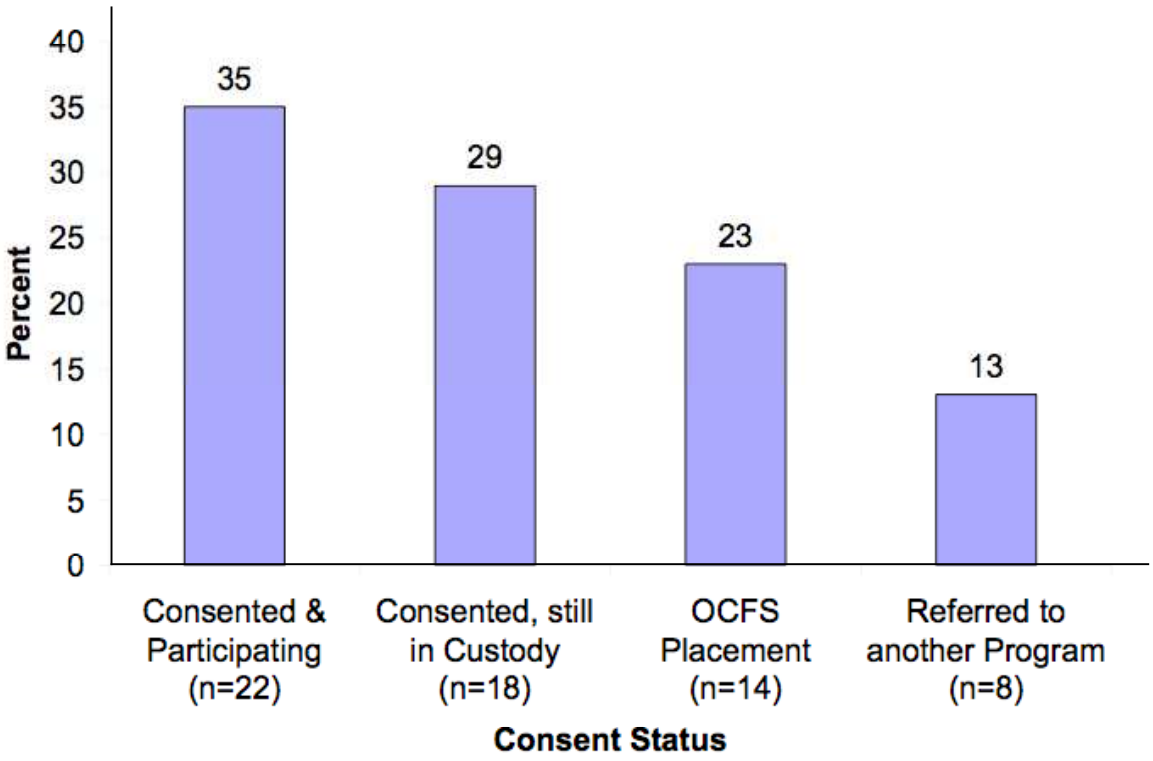



Figure 5 illustrates attrition in the pool of consenting referrals. Only 35 percent of those who agreed to participate were actually doing so by the end of the study period, but a closer look at the reasons for this "funnel effect" is revealing. Almost a third of the consenting pool was still in DJJ care in June. The remaining 36 percent had received sentences that precluded CFI participation: 23 percent were placed in an NYS OCFS juvenile facility, and another 13 percent were judicially referred to other programs.

*Figure 5. Referral Pool Attrition: Consent With and Without Participation*




## Characteristics of Referrals

Examining the characteristics of the 150 youth referred to CFI, paying special attention to any systematic differences that may have existed between those who consented and those who did not, is an important exercise. Any patterns discovered between the two groups may suggest reasons that the program appealed to one group over the other and may also help explain its appropriateness for the targeted population. Of the 150 referrals between February and June 1, 119 were boys and 31 were girls (79 percent and 21 percent, respectively). The average age was 15, but ranged from 12 to 17 years old. For reasons that merit further investigation, the rate of female referrals to the program was lower than expected. Given the small female sample, any comparisons will be of limited value.

**CURRENT OFFENSE**

Table 2 shows the most serious charge against youth in the group of 150 referrals. Sixty-two percent of the referred youth were arrested for a violent felony. Robbery and assault represented 52 percent

of the arrests for all cases. Five percent of CFI referrals were charged with murder or manslaughter. Thirteen percent were arrested on a property charge, and 14 percent were charged with other misdemeanor offenses. Two percent were charged with drug offenses. Thirteen referrals (nine percent) had been detained because of a probation violation. The exact nature of the violations remained unknown, and only two probation violators eventually agreed to participate in CFI. It is important to note, however, that DJJ policy does not exclude by charge when referring youth to CFI.

### Table 2. Current Charge among CFI Referrals

| | CONSENT | NON-CONSENT | TOTAL |
|---|---|---|---|
| Violent | 71% (44) | 56% (49) | 62% (93) |
| *Murder/Manslaughter* | 2% (1) | 7% (6) | 5% (7) |
| *Robbery* | 34% (21) | 18% (16) | 24% (37) |
| *Assault* | 32% (20) | 25% (22) | 28% (42) |
| *Weapon Possession* | 3% (2) | 6% (5) | 5% (7) |
| Property | 8% (5) | 17% (15) | 13% (20) |
| *Burglary* | 2% (1) | 7% (6) | 5% (7) |
| *Theft* | 6% (4) | 10% (9) | 8% (13) |
| Misdemeanor | 16% (10) | 12.5%(11) | 14% (21) |
| Probation Violation | 3% (2) | 12.5%(11) | 9% (13) |
| Drug Charge | 2% (1) | 2% (2) | 2% (3) |
| **Total** | **100% (62)** | **100% (88)** | **100% (150)** |

The table shows that there were important differences in the seriousness of charges between those who agreed to participate and those who did not. Specifically, referred youth who consented were more likely than non-consenters to be charged with violent offenses, 71 percent compared to 56 percent respectively. This difference, and its reasons and implications for treatment protocols and policy, will be closely examined during the next phase of the study.

Non-consent centered on the parent. For example:

— 30 families (20 percent) could not be reached for consent (released prior to contact or no contact), which occurred primarily because of telephone difficulties noted above.

— 30 families (20 percent) did not consent because the youth was sentenced or referred to another program.

— 17 families (11.3 percent) refused for multiple additional reasons, including:

- Family believed that the youth needed more structured treatment and were requesting that the court place the youth in residential care (most common reason for refusal);

- Family did not think that youth would be released due to severity of charge (this occurred in one or two cases);

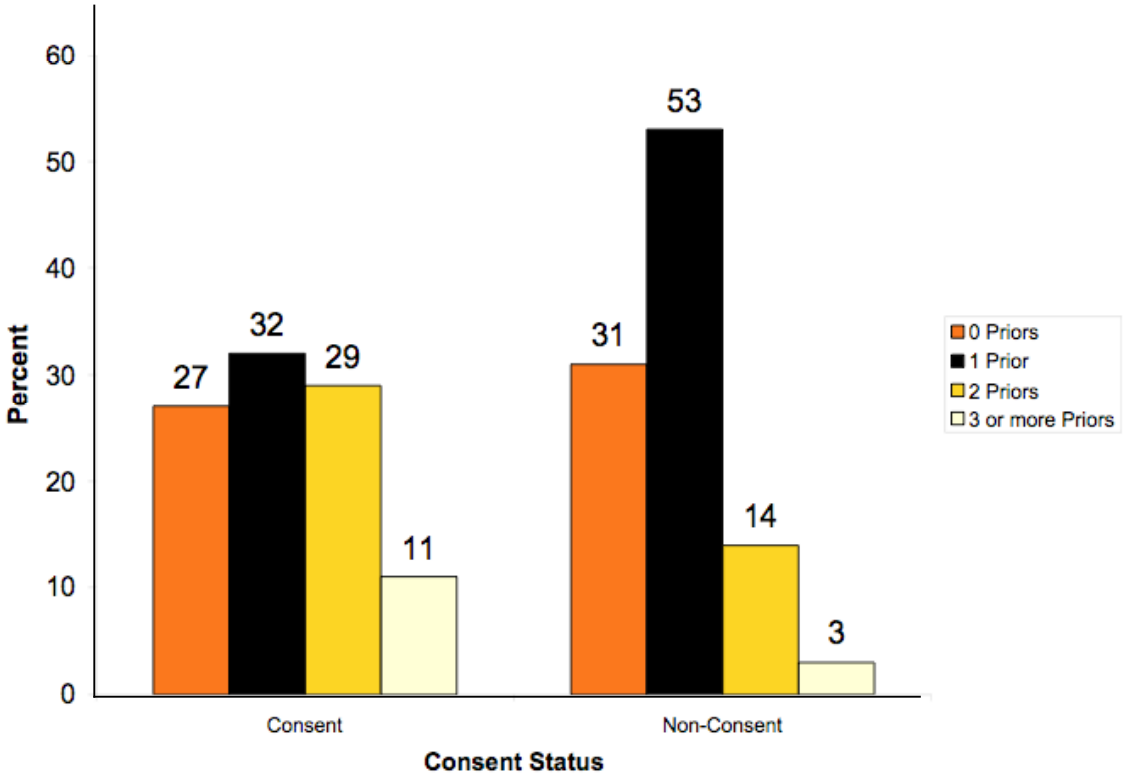
- Family chose not to participate in mental health treatment because they did not accept the mental health problem diagnosis (this occurred only once).

**DETENTION HISTORY**

Figure 6 shows the number of prior stays in DJJ facilities, again looking for systematic differences between consenters and non-consenters. Almost three-quarters of the CFI referrals had prior experiences with DJJ. Many had multiple prior experiences — nearly 27 percent had two or more prior stays in DJJ.

It appears that consenters had more extensive prior histories than non-consenters: 40 percent of those who consented had two or more priors, compared to just 17 percent of the non-consenters. Again, reasons for this may be clarified during the next phase of the study.

## *Figure 6. Priors among CFI Referrals*




**TIME IN DETENTION**

Table 3 shows the amount of time referred youth had been detained in a DJJ facility awaiting a disposition on their current charge. Nearly half (47 percent) of the referral pool had been in detention for less than a month. Another quarter had been detained between 31 and 60 days. Fewer than 10 percent of the youth had been detained for more than five months (sufficient time for the court case to mature) prior to being referred to CFI.

Note as well that consenters appear to have spent more time in detention than non-consenters, suggesting the possibility that defense attorneys may be playing a significant role in encouraging referred youth to consent. Forty percent of those who consented were detained for less than one month, compared to 52 percent of those who did not. Those who spent longer periods in detention

(between 31 and 150 days) made up a larger proportion of consenters (52 percent of the total group of consenters) than they did non-consenters (37 percent of the total group of non-consenters). Recall that most youth were detained on violent offenses.[7]

### Table 3. Time Spent in Detention until CFI Referral

| TIME IN DETENTION | CONSENT | NON-CONSENT | TOTAL |
|---|---|---|---|
| Less than 30 days | 40% (25) | 52% (46) | 47% (71) |
| 31-60 | 31% (19) | 23% (20) | 26% (39) |
| 61-150 days | 21% (13) | 14% (12) | 17% (25) |
| 151-365 days | 6% (4) | 10% (9) | 9% (13) |
| Over 1 year | 2% (1) | 1% (1) | 1% (2) |
| **Total** | **100% (62)** | **100% (88)** | **100% (150)** |

**MENTAL HEALTH ISSUES**

Mental health data from DJJ were explored in two ways. First, the initial assessments conducted by medical personnel under DJJ contract were reviewed. These assessments, administered by DJJ medical contractors at intake, document immediate physical and mental health needs, including severe conditions that require psychiatric medication.

Second, results from the Massachusetts Youth Screening Instrument (MAYSI)[8] administered to youth in detention by mental health clinicians, were reviewed. Results from the MAYSI screening of CFI referrals are shown in Table 4. Although the majority of CFI referrals scored in the normal range across need areas, a substantial portion — about one-third — scored in the "caution" or "warning" range on anger/irritability, depressed/anxious, somatic complaints, and thought disturbances. Scores in the warning range were uncommon, though nine percent were classified as such on anger/irritability and suicidal ideation, and 10 percent on thought disturbance.

[7] *Evaluators also examined time in detention by current offense type. Not surprisingly, CFI-referred youth arrested for violent personal felonies had been detained longer prior to referral than those arrested on other charges.*

[8] *The MAYSI is a 52-question inventory that screens detained juveniles for mental health needs and is given to detained youth within 48-72 hours of admission. The MAYSI, through a self-report instrument, assesses six areas: alcohol/drug use, angry/irritable, depressed/anxious, somatic complaints, suicide ideation, thought disturbance, and traumatic experiences. The MAYSI also documents exposure to trauma and classifies youth into one of three categories: "normal," "caution," and warning." Youth who score outside the normal range are referred to a DJJ clinician for further testing and diagnosis.*

The most common occurrence captured by the MAYSI is the high rate of traumatic incidents (n=105). Seventy-four percent of youth indicated that they had experienced at least one traumatic event and many self-report repeated trauma. Once again, this is an area requiring further exploration. Since treatment approach and underlying trauma are often interrelated, service providers could benefit from additional information.

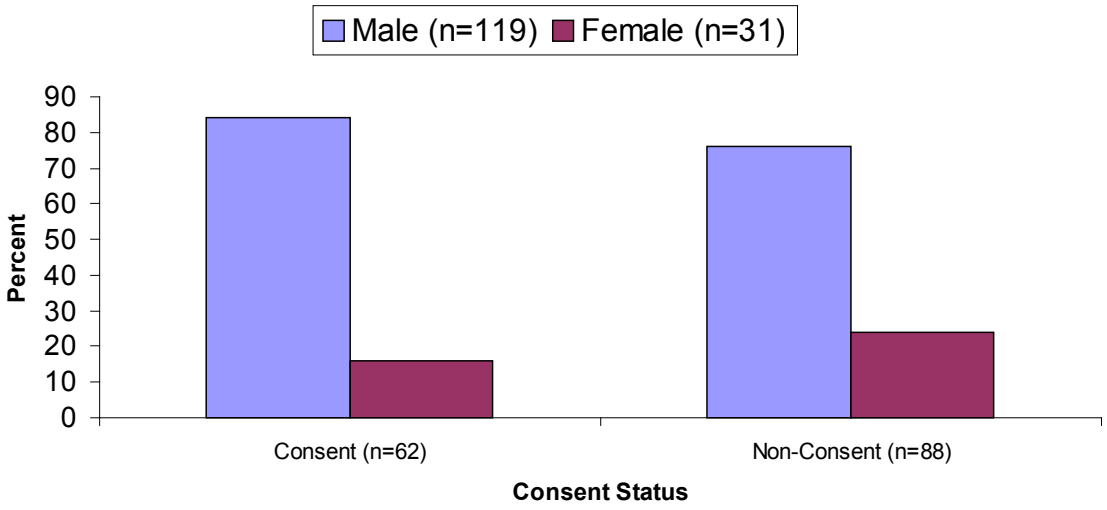
### Table 4. Mental Health Needs of CFI Referrals (n=150)

| NEED AREA | NORMAL | CAUTION | WARNING |
|---|---|---|---|
| Alcohol/Drug Use | 89% | 10% | 1% |
| Angry/Irritable | 63% | 28% | 9% |
| Depressed/Anxious | 62% | 31% | 7% |
| Somatic Complaints | 67% | 28% | 5% |
| Suicide Ideation | 86% | 5% | 9% |
| Thought Disturbance | 63% | 27% | 10% |

### *Comparing Characteristics among Male and Female Referrals*

CFI sought to specifically target females being detained at DJJ facilities, feeling that they were manifesting more severe mental health needs. Only 31 of the 150 referrals were female (21 percent), a finding that will be explored in more detail in the final report. Nonetheless, to better inform the evaluation design for the final report, it is useful to compare the characteristics of male and female youth — keeping in mind that outcomes should be interpreted with caution given the small number of female participants. Figure 8 shows CFI referrals by gender. A higher percentage of females did not consent to participate in the program: 24 percent compared to 16 percent for boys. Parents of females appeared to be more interested in residential treatment.

## *Figure 8. Comparing Consent by Gender*




There were a number of additional differences between male and female referrals that are worth noting:

- A larger percentage of female than male referrals were detained on violent charges: 71 percent (n=22) for females compared to 58 percent (n=69) for males.

- Female referrals tended to have more extensive prior criminal histories than males: 39 percent of females (n=12) had two or more prior DJJ stays compared to 24 percent of males (n=28).

- No female referrals, but 13 percent (n=15) of male referrals, had been detained for more than five months. Additional research during the next phase of the project will examine the positive relationship between longer case processing time and participant consent, and gender-specific issues and consent.[9]

- Females were much more likely than males to be diagnosed by DJJ as suffering from depression/self-harm — 23 percent (n=7) vs. 8 percent (n=10) respectively. Females were also more likely to score in the caution and warning ranges on the MAYSI anger/irritability and somatic complaint scales.

[9] *These results are similar to the results found by Teplin et al. (2002) in their study conducted on youth detained in an Illinois detention center. They identified girls as having higher rates of depression (26.3 percent) than boys (17.2 percent). As with gender-specific issues related to consent, these data raise several questions relevant to a possible gender difference in the mental health needs of the detainee population.*

# Part III: CFI Participant Profiles and Specific Outcomes

This section reviews the background and program experiences for the 21 youth who were released by the Court from DJJ custody and actively participated in CFI during the four months covered by this study.

Behind the numbers are the remarkable efforts of the CFI stakeholders, who have created a system of service delivery that is positioned to address issues in the referral process, to meet the mental health needs of a vulnerable population, and to become a valued resource in their communities.

Several case study narratives, as well as a brief review of each youth's mental health diagnosis and the case that brought them to the attention of CFI can be found in Appendix B.

## General Characteristics of CFI Participants

The released, actively participating youth had roughly the same characteristics as the larger pool of consenting referrals described earlier:

- The average age of participants was 15, with a range of 13-17.
- Sixteen (76 percent) of the CFI program participants were males, 5 (23 percent) were females.
- Fifteen (71 percent) of the participating youth had been arrested for a violent offense.
- Participants, on average, had one prior DJJ admission (58 percent). Thirty-three percent had more than one prior DJJ admission, and 24 percent had two or more prior admissions.
- Youth who were released and became CFI participants spent notably more time, an average of 92 days (median 38), in detention than did the referred youth as a whole. Recall that, as a group, 73 percent of all referrals had spent two months or less in detention. This suggests that case processing is an important factor driving active participation in CFI.
- MAYSI results for the released youth differed from the general pool of consenters. A greater percentage of the released youth scored outside the normal range on five of the six need areas — substance abuse, depressed/anxious, somatic complaints, suicidal ideation, and thought disturbance — than was the case for the general pool of consenters.

## Family & Behavioral History of CFI Participants

For the youth who took part in the program, participation allowed a deeper understanding of their backgrounds, particularly with regard to their family and behavioral histories. This information is summarized briefly below. See Appendix B for case study narratives.

### Family Histories

- Eight youth (38 percent) and their families reported substance abuse within the immediate family.
- Nine youth (42 percent) and their families reported a history of criminal justice involvement, with an incarcerated father as the most frequent issue.
- Nine youth (42 percent) resided in a home with two parents/stepparents present. Two of these youth (9.5 percent) had both biological parents in the home; the other seven (33 percent) lived with a stepfather and biological mother.
  - The biological mother was present in the home for 17 youth (81 percent).
  - In 17 cases (81 percent), the biological father did not reside in the home.

### Behavioral Histories

- Twenty of the 21 participants (95 percent) had school behavioral problems such as truancy, class disruption and fighting in the past.
  - Fourteen of these youth (70 percent) reported fighting with peers either in school or in the community.
  - Sixteen of these youth (80 percent) reported behavioral problems in the home including resisting parental authority and fighting with parents and/or sibling.
- Post-release school enrollment: All youth were reenrolled in school within the first 30 days of release from DJJ. The majority of youth were reenrolled within the first two weeks of release.
- Fourteen of the 21 participants (66 percent) had received counseling or psychiatric services in the past.
  - Seven of the 14 who received psychiatric treatment were also hospitalized in the past.
  - Three others received school counseling.

## CFI Outcomes During the Initial Six-Month Period

Youth performance in CFI was measured at three post-release intervals: 30, 60, and 90 days.

**30-Day Milestone (n=21)**

- Thirteen participants met all of their benchmarks (taking medication, attending school, attending CFI appointments).
- Three participants were meeting some of the benchmarks but not all – missed benchmarks include skipping school or missing an appointment.
- One participant did not meet any of his benchmarks.
- One participant was arrested on a bench warrant for missing court and 2 were remanded to custody for release violations.
- One participant left CFI to participate in another program.

**60-Day Milestone (n=17)**[10]

- Eight participants met all their benchmarks
- One participant was not meeting all of his benchmarks.
- Four participants were arrested.[11]
- One participant was remanded and placed with OCFS because of school truancy.
- One participant was hospitalized due to an inadvertent medication overdose.
- One participant ran away from home.

**90-Day Milestone (n=14)**[12]

- Three participants met all benchmarks.
- One participant met all benchmarks, but was re-arrested shortly after 90 days.
- One participant was placed in a psychiatric hospital.

## A Closer Look at Specific Outcomes

There is little question that CFI's target population faced extreme challenges. They had histories of trauma, prior experience in DJJ custody (in some cases, extensive histories), mental health issues, unstable home environments, and behavioral problems, particularly at school. Given these issues — as

[10] *At the time of this evaluation, two participants did not reach their 60-day milestone.*
[11] *One youth re-arrested was released immediately from custody and continued to participate in CFI.*
[12] *At the time of this evaluation, nine participants did not reach their 90-day milestone.*

well as the small number of cases and short follow-up time — it is useful to examine specific outcomes more closely.

***Recidivism/New Charge***

Seventeen youth were not arrested on new charges during the 90-day post-release period. By this measure alone, the program affected participants in a way that holds potential long-term benefits for individuals, communities, and an extended network of relevant public agencies.

***Other Outcomes***

Three other CFI participants were remanded to DJJ custody at some point during their participation in CFI. These remands involved violations of the conditions of release, such as breaking curfew, missing school, and substance abuse.

Two youth were hospitalized because of severe mental health issues. Another youth ran away from home.

# Considerations for Future Planning

The experiences of the initial five months of the CFI program, as evaluated by John Jay's Research and Evaluation Center, lead to several considerations that will need to be addressed as the program continues. Among them:

- CFI provided accessible and critical community-based psychiatric services, counseling, and family support that participants would have been unlikely to secure if not for their program participation. It is important to know the nature and duration of the services provided and the characteristics of those who benefited most. What was the value of the discharge plan developed by DJJ? To the extent that improvements in the discharge plan are required, what is the consensus of service providers regarding such improvements?

- That the CFI families are hard-to-reach, hard-to-engage, and hard-to-treat was palpably demonstrated. The evaluation team identified several elements of the DJJ referral process that will be explored in an effort to facilitate family/youth engagement and reduce the amount of unproductive time spent by CBOs in pursuit of parent engagement and the community release of youth.

- CFI benefited from the substantial resource commitment and dedication of all stakeholders. The evaluation team has begun working with service providers to translate client and family

assessments and progress reports into behavioral terms that are unambiguously understood by the interested public. Clarity and consistency internally and among providers will help establish benchmarks and behavioral outcomes that can be standardized among service providers and are meaningful to policymakers.

- Remand, hospitalization, and violations of conditions of release will be explored for patterns and recommendations relevant to program issues and needs assessments.

- Young women and their families have not participated in the CFI at the expected rate. Qualitative data from young women and their families will be gathered in an effort to empirically determine the explanations for low rates of female participation.

- Program successes — those who remain actively engaged in CFI for at least 90 days, return to an educational program, demonstrate pro-social behaviors, and remain in the community for at least six months subsequent to completing CFI participation — will be studied for the personal and contextual patterns that may account for their "success."

# Case Synopses

The following brief case synopses provide a sense of the circumstances and characteristics of CFI participants:

- ***"RF" Case 1 (male, ADHD/psychotic disorder):***

  RF was incarcerated for two years on an assault charge (fight with neighborhood boy). This was his second time in DJJ care. He had been hospitalized in the past for hallucinations. He resided with his biological mother. His father passed away when he was younger. After his release from DJJ, RF was compliant with treatment for the entire 90 days of CFI. He did not miss any appointments, was compliant with medication, and attended school regularly.

- ***"AD" Case 2 (male, depressive disorder/PTSD):***

  AD was arrested for robbing someone in the park. This was his first time in DJJ care. He was in care for two months and released on probation. AD resides with his mother and stepfather and has a history of aggressive behavior toward his mother. He was raised by his grandmother, although his mother reentered his life several years ago (family immigrated from Guatemala). AD was compliant during the entire 90 days of CFI treatment. He attended school and did not miss any scheduled appointments. AD and his family received family therapy throughout the 90 days of CFI and plan to continue. He graduated junior high school and planned to attend high school in the fall.

- ***"LC" Case 3 (male, ADHD):***

  LC, 15, has been in treatment since the age of 8 for behavioral problems at school and home. He has been involved in many school fights. He was charged with beating a man on the subway. He had been arrested in the past for marijuana possession, but had no prior stays in DJJ care. His family was very supportive, and LC was compliant with CFI for 90 days.

- ***"NR" Case 4 (male, anger management):***

  NR was incarcerated for assaulting a girl at school with a chair. NR had a total of three assault charges (one for sexual assault) and extensive school issues, including fighting, acting out in class, special education, and teachers not wanting him in the classroom. At the time he resided with his foster mother. He has no contact with his biological mother, and his father is incarcerated. NR was compliant with treatment all 90 days and participated in anger management. He did, however, engage in one fight at school during his treatment.

- ***"BN" Case 5 (female, depressive/conduct disorder):***

  BN was arrested for vandalizing the car of someone who was harassing her. Her prior arrest included the robbery of a neighborhood woman. BN has a history of fighting in school and family problems (parental alcoholism). BN was receiving psychiatric treatment and was on medication

prior to her entry into DJJ, and once released this treatment continued. Throughout her participation in CFI, BN struggled with attending school regularly due to harassment by peers. She was compliant with the rest of her treatment and completed 90 days in CFI.

- ***"VJ" Case 6 (male, disruptive behavior disorder):***

  VJ was arrested and spent two months in DJJ care for not attending court dates for a trespassing violation. This was VJ's first DJJ involvement. VJ was in foster care for several years as a child because his family was homeless. He currently lives with his biological mother and stepfather. VJ has a solid history of attending school, but his academic performance is poor. During his participation with CFI, VJ attended school regularly and participated in other program requirements.

- ***"KW" Case 7 (male, conduct disorder):***

  KW was in DJJ for a robbery charge that involved six of his peers robbing a 6th grade boy. He was on probation prior to this charge for selling crack cocaine. KW resides at home with his parents; however, his father just came home from prison after serving seven years. He reports a history of smoking marijuana, getting into fights in the neighborhood, and frequently being late to school. KW has completed 60 days of CFI successfully, except for missing several probation appointments. He is currently working toward his 90-day benchmarks.

- ***"HE" Case 8 (male, anger management):***

  HE was at DJJ for a probation violation and disorderly conduct charge. His original probation charge was for robbery. HE has been involved in numerous school suspensions for various incidents (robbery, pulling a chair away from teacher, cursing at teachers, etc.). He lives with his biological mother and siblings. Both his father and brother were killed in separate incidents when HE was younger. He has a close relationship with his family and does not have any major behavioral problems at home. HE was compliant with CFI and participated in anger management.

Despite the positive result for the majority of participants, four CFI youth were arrested during the study period (19 percent of the released youth). Three of these four youth were arrested on relatively minor charges and have continued participation in CFI. One youth was removed from the program because of a new arrest for robbery. These four arrest circumstances are briefly described below:

### Case 1 (male, conduct disorder):

New offense: jumping subway turnstile (occurred 45 days after release).

Youth was compliant with CFI prior to arrest. Youth and parent were experiencing significant conflict at home. Shortly after arrest, the youth ran away from home, and he is no longer actively participating in CFI.

**Case 2 (male, adjustment disorder**):

New offense: throwing rocks at a dog/broke window (occurred 60 days after release).

Youth was compliant with CFI prior to arrest. Youth was released on bail and has since successfully completed his 90-day benchmarks.

## Case 3 (female, bipolar):

New offense: criminal mischief (occurred 60 days after release).

Youth was compliant with CFI prior to arrest. Given the youth's serious mental illness, the court is considering long-term psychiatric placement.

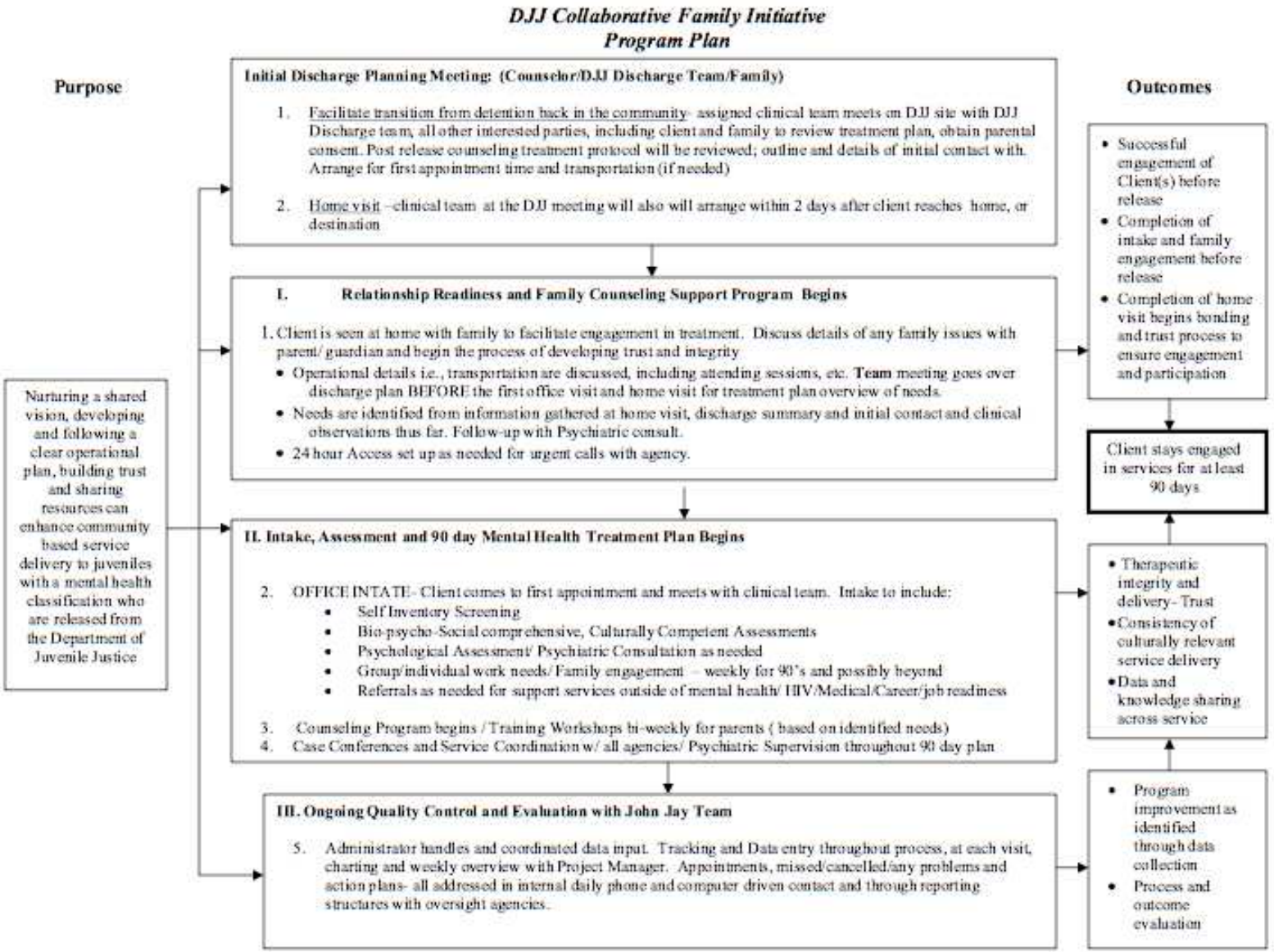
## Case 4 (male, conduct disorder):

New offense: robbery (occurred 40 days after release).

Youth was not compliant with CFI prior to arrest. Youth was not attending school, breaking curfew, and smoking marijuana (drinking alcohol also). The new arrest resulted in the youth's removal from CFI.

# APPENDIX A

# Logic Models


DJJ Collaborative Family Initiative
Program Plan
Purpose
Nurturing a shared vision, developing and following a clear operational plan, building trust and sharing resources can enhance community based service delivery to juveniles with a mental health classification who are released from the Department of Juvenile Justice
Initial Discharge Planning Meeting: (Counselor/DJJ Discharge Team/Family)
1. Facilitate transition from detention back in the community- assigned clinical team meets on DJJ site with DJJ Discharge team, all other interested parties, including client and family to review treatment plan, obtain parental consent. Post release counseling treatment protocol will be reviewed; outline and details of initial contact with. Arrange for first appointment time and transportation (if needed)
2. Home visit –clinical team at the DJJ meeting will also will arrange within 2 days after client reaches home, or destination
I. Relationship Readiness and Family Counseling Support Program Begins
1. Client is seen at home with family to facilitate engagement in treatment. Discuss details of any family issues with parent/ guardian and begin the process of developing trust and integrity
• Operational details i.e., transportation are discussed, including attending sessions, etc. Team meeting goes over discharge plan BEFORE the first office visit and home visit for treatment plan overview of needs.
• Needs are identified from information gathered at home visit, discharge summary and initial contact and clinical observations thus far. Follow-up with Psychiatric consult.
• 24 hour Access set up as needed for urgent calls with agency.
II. Intake, Assessment and 90 day Mental Health Treatment Plan Begins
2. OFFICE INTAKE- Client comes to first appointment and meets with clinical team. Intake to include:
• Self Inventory Screening
• Bio-psycho-Social comprehensive, Culturally Competent Assessments
• Psychological Assessment/ Psychiatric Consultation as needed
• Group/individual work needs/ Family engagement – weekly for 90's and possibly beyond
• Referrals as needed for support services outside of mental health/ HIV/Medical/Career/job readiness
3. Counseling Program begins / Training Workshops bi-weekly for parents ( based on identified needs)
4. Case Conferences and Service Coordination w/ all agencies/ Psychiatric Supervision throughout 90 day plan
III. Ongoing Quality Control and Evaluation with John Jay Team
5. Administrator handles and coordinated data input. Tracking and Data entry throughout process, at each visit, charting and weekly overview with Project Manager. Appointments, missed/cancelled/any problems and action plans- all addressed in internal daily phone and computer driven contact and through reporting structures with oversight agencies.
Outcomes
• Successful engagement of Client(s) before release
• Completion of intake and family engagement before release
• Completion of home visit begins bonding and trust process to ensure engagement and participation
Client stays engaged in services for at least 90 days
• Therapeutic integrity and delivery- Trust
• Consistency of culturally relevant service delivery
• Data and knowledge sharing across service
• Program improvement as identified through data collection
• Process and outcome evaluation

***DJJ Collaborative Family Initiative***
***Coalition for Hispanic Family Services***
***Program Plan***

**Purpose**

Nurturing a shared vision, developing and following a clear operational plan, building trust and sharing resources can enhance community based service delivery to juveniles with a mental health classification who are released from the Department of Juvenile Justice

**PRE ENGAGEMENT**
**Initial Discharge Planning Meetings: CHFS Counselor/DJJ Discharge Team/Family, Pre-Release**

- CHFS (via children's outpatient mental health clinic) will meet with youth and family within one week of referral at DJJ facility to provide them with an overview of services and schedule first appointment.

**ENGAGEMENT**
**Discharge**

- Individual meeting with youth at detention facility or CHFS to begin to identify the youth's future aspirations and goals to encourage independence and self-determination and engage them in the treatment process
- Extensive intake assessment including a psychosocial evaluation and psychiatric evaluation if necessary
- Separate interview with youth's family focusing on goals and dreams they may hold for the youth and how they can facilitate the achievement of these goals

**FULL ENGAGEMENT**
**FOIA 90 day Mental Health Treatment Plan Begins**

- Main thrust of programming focuses on the family and how they can help the youth achieve his/her goals with high expectations of caregivers
- Youth and family receive clinical services from a licensed social worker to help them work together to achieve goals
  - If case management/advocacy services are required, a case manager will be brought in
  - Youth and family will attend at least 85% of appointments

**PROGRAM SUPERVISION**
**To monitor and ensure Full Engagement**

- Progress made toward achievement of future aspirations/goals based on youth's treatment plan (monitored by Jeanette)
- Number of kept weekly appointments by youth, family, youth & family, based on weekly encounter forms (monitored by Jeanette)
- Family member satisfaction with their level of participation in services (Administer Family Participation Measure on a quarterly basis)
- Clinical supervisor oversees clinical services provided by licensed social worker
- Service provider collaborative meetings (minimally bi-monthly)

**Outcomes**

- Successful engagement of Client(s) before release
- Completion of intake and family engagement before release

Client stays engaged in services for at least 90 days

- Therapeutic integrity and delivery- Trust
- Consistency of culturally relevant service delivery
- Data and knowledge sharing across service providers

- Program improvement as identified through data collection
- Process and outcome evaluation

***DJJ Collaborative Family Initiative***
***Friends of the Island Academy***
***Program Plan***

**Purpose**

Nurturing a shared vision, developing and following a clear operational plan, building trust and sharing resources can enhance community based service delivery to juveniles with a mental health classification who are released from the Department of Juvenile Justice

**PRE ENGAGEMENT**
**Initial Discharge Planning Meetings: FIOA Counselor/DJJ Discharge Team/Family, Pre-Release**

1. Facilitate transition from detention back in the community. Meet with youth to introduce service and estimate engagement plan. Agreement to meet and establish dialogue 2 or 3 times before release
2. Home visit – Home visit as quick as possible with DJJ. Engagement through family assessment tool (from FOIA), case history to define challenges and successful strategies in the past. Also introduce services and estimate plan to obtain full engagement. Stress availability case workers 24/7 for support.

**ENGAGEMENT**
**Discharge** (FOIA will arrange pick-up, if required)

- Client is seen at home with family if possible
- First appointment with psychiatrist (never more than three days post-release)
- Operational plan development for short term manageable chunks (e.g., first weekend a benchmark, then three weeks, etc.)
- Dialogue with family about mental health, including a medication list for family

**FULL ENGAGEMENT**
**FOIA 90 day Mental Health Treatment Plan Begins**

- FOIA case manager makes home visits and attends appointments with youth and family as required
- Ongoing mental health treatment
- School issues addressed and resolved
- Active dialogue and strategizing
- On-site group activities with parents

**PROGRAM SUPERVISION**
**To monitor and ensure Full Engagement**

- Case managers meet weekly for supervision and case review with Program Director
- Program Director meets weekly with CFI Psychiatrist to review all cases
- Program Director acts as liaison with Evaluation Team with regard to Program design, implementation, documentation, ongoing feedback, and outcome reporting, as required:

**Outcomes**

- Successful engagement of Client(s) before release
- Completion of intake and family engagement before release
- Completion of home visit begins bonding and trust process to ensure engagement and participation

Client stays engaged in services for at least 90 days

- Therapeutic integrity and delivery- Trust
- Consistency of culturally relevant service delivery
- Data and knowledge sharing across service providers

- Program improvement as identified through data collection
- Process and outcome evaluation

***DJJ Collaborative Family Initiative***
***Full Circle Health Proposed***
***Program Plan***

**Purpose**

Nurturing a shared vision, developing and following a clear operational plan, building trust and sharing resources can enhance community based service delivery to juveniles with a mental health classification who are released from the Department of Juvenile Justice

**Initial Discharge Planning Meeting: ( FCH Counselor/DJJ Discharge Team/Family)**

1. Facilitate transition from detention back in the community- FCH assigned clinical team meets on DJJ site with DJJ Discharge team, all other interested parties, including client and family to review treatment plan, obtain parental consent. Post release counseling treatment protocol will be reviewed; outline and details of initial contact with FCH. Arrange for first appointment time and transportation ( if needed)

2. Home visit –FCH clinical team at the DJJ meeting will also will arrange within 2 days after client reaches home, or destination

**I. FCH Relationship Readiness and Family Counseling Support Program Begins**

1. Client is seen at home with family to facilitate engagement in treatment. Discuss details of any family issues with parent/ guardian and begin the process of developing trust and integrity
   - Operational details i.e., transportation are discussed, including attending sessions, etc. **FCH in Team** meeting goes over discharge plan BEFORE the first office visit and home visit for treatment plan overview of needs.
   - Needs are identified from information gathered at home visit, discharge summary and initial contact and clinical observations thus far. Follow-up with Psychiatric consult.
   - 24 hour Access set up as needed for urgent calls with counselor and FCH service

**II. FCH Intake, Assessment and 90 day Mental Health Treatment Plan Begins**

2. FCH OFFICE INTATE- Client comes to first appointment and meets with clinical team. Intake at FCH to include:
   - Self Inventory Screening
   - Bio-psycho-Social comprehensive, Culturally Competent Assessments
   - Psychological Assessment/ Psychiatric Consultation as needed
   - Group/individual work needs/ Family engagement – weekly for 90's and possibly beyond
   - Referrals as needed for support services outside of mental health/ HIV/Medical/Career/job readiness
3. Counseling Program begins / Training Workshops bi-weekly for parents ( based on identified needs)
4. Case Conferences and Service Coordination w/ all agencies/ Psychiatric Supervision throughout 90 day plan

**III. Ongoing Quality Control and Evaluation with John Jay Team**

4. Administrator handles and coordinated data input- gathered from BAI, BDI, CRAFFT and Psychiatric consult and questionnaire. Tracking and Data entry throughout process, at each visit, charting and weekly overview with Project Manager--
   Appointments, missed/cancelled/ any problems and action plans- all addressed in internal daily phone and computer driven contact and through reporting structures with oversight agencies.

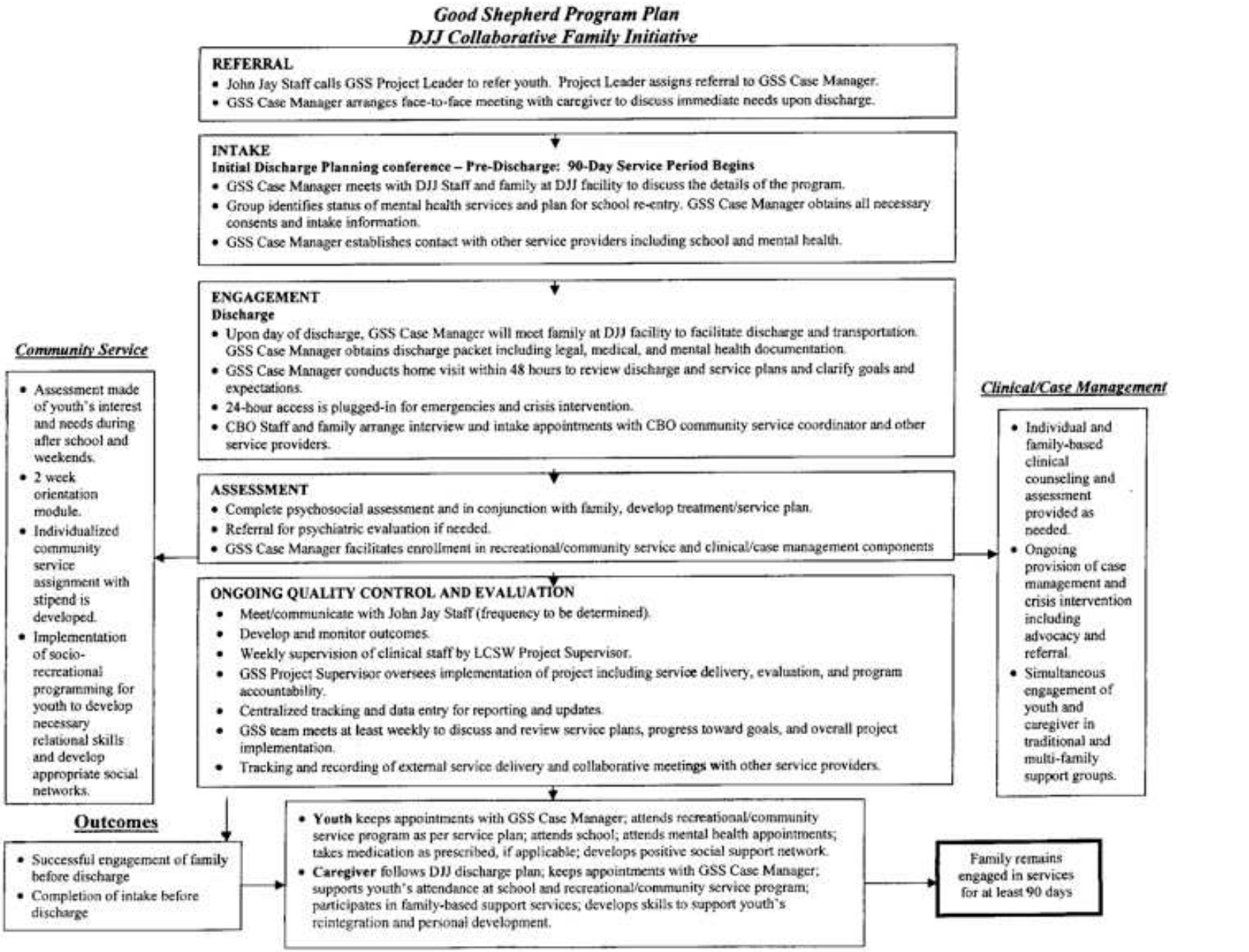
**Outcomes**

- Successful engagement of Client(s) before release
- Completion of intake and family engagement before release
- Completion of home visit begins bonding and trust process to ensure engagement and participation

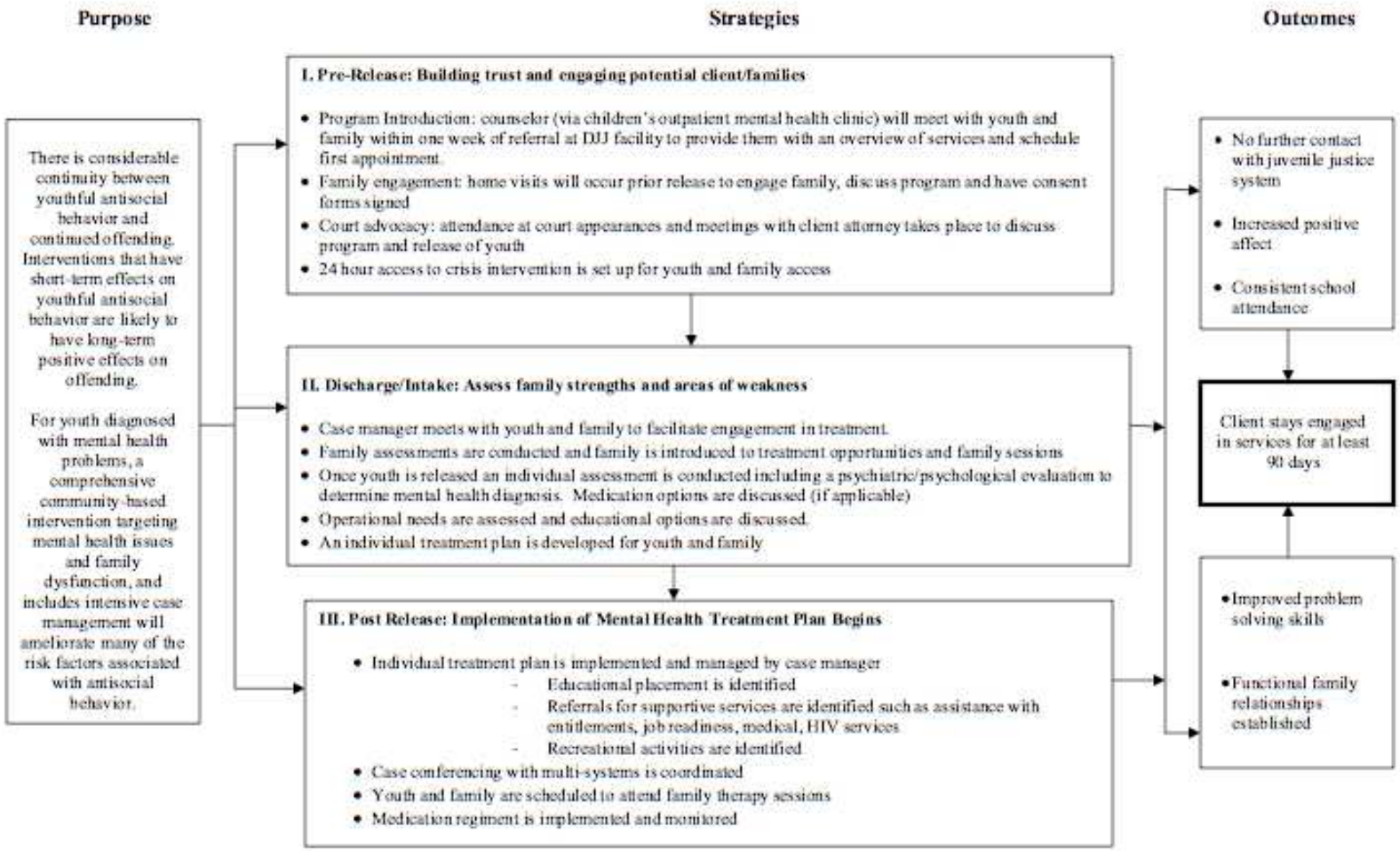
Client stays engaged in services for at least 90 days

- Therapeutic integrity and delivery- Trust
- Consistency of culturally relevant service delivery
- Data and knowledge sharing across service

- Program improvement as identified through data collection
- Process and outcome evaluation


Good Shepherd Program Plan
DJJ Collaborative Family Initiative
REFERRAL
• John Jay Staff calls GSS Project Leader to refer youth. Project Leader assigns referral to GSS Case Manager.
• GSS Case Manager arranges face-to-face meeting with caregiver to discuss immediate needs upon discharge.
INTAKE
Initial Discharge Planning conference – Pre-Discharge: 90-Day Service Period Begins
• GSS Case Manager meets with DJJ Staff and family at DJJ facility to discuss the details of the program.
• Group identifies status of mental health services and plan for school re-entry. GSS Case Manager obtains all necessary consents and intake information.
• GSS Case Manager establishes contact with other service providers including school and mental health.
ENGAGEMENT
Discharge
• Upon day of discharge, GSS Case Manager will meet family at DJJ facility to facilitate discharge and transportation. GSS Case Manager obtains discharge packet including legal, medical, and mental health documentation.
• GSS Case Manager conducts home visit within 48 hours to review discharge and service plans and clarify goals and expectations.
• 24-hour access is plugged-in for emergencies and crisis intervention.
• CBO Staff and family arrange interview and intake appointments with CBO community service coordinator and other service providers.
ASSESSMENT
• Complete psychosocial assessment and in conjunction with family, develop treatment/service plan.
• Referral for psychiatric evaluation if needed.
• GSS Case Manager facilitates enrollment in recreational/community service and clinical/case management components
ONGOING QUALITY CONTROL AND EVALUATION
• Meet/communicate with John Jay Staff (frequency to be determined).
• Develop and monitor outcomes.
• Weekly supervision of clinical staff by LCSW Project Supervisor.
• GSS Project Supervisor oversees implementation of project including service delivery, evaluation, and program accountability.
• Centralized tracking and data entry for reporting and updates.
• GSS team meets at least weekly to discuss and review service plans, progress toward goals, and overall project implementation.
• Tracking and recording of external service delivery and collaborative meetings with other service providers.
Community Service
• Assessment made of youth's interest and needs during after school and weekends.
• 2 week orientation module.
• Individualized community service assignment with stipend is developed.
• Implementation of socio-recreational programming for youth to develop necessary relational skills and develop appropriate social networks.
Clinical/Case Management
• Individual and family-based clinical counseling and assessment provided as needed.
• Ongoing provision of case management and crisis intervention including advocacy and referral.
• Simultaneous engagement of youth and caregiver in traditional and multi-family support groups.
Outcomes
• Successful engagement of family before discharge
• Completion of intake before discharge
• Youth keeps appointments with GSS Case Manager; attends recreational/community service program as per service plan; attends school; attends mental health appointments; takes medication as prescribed, if applicable; develops positive social support network.
• Caregiver follows DJJ discharge plan; keeps appointments with GSS Case Manager; supports youth's attendance at school and recreational/community service program; participates in family-based support services; develops skills to support youth's reintegration and personal development.
Family remains engaged in services for at least 90 days

***DJJ Collaborative Family Initiative***
***Steinway Children and Family Services, Inc.***



# APPENDIX B

# Participant Case Studies

# #1: Jenny

Jenny is a 14-year-old girl who was released from detention in April 2007 after three months (the average stay for CFI participants). She had been arrested for vandalizing a car. According to Jenny, she scratched a car owned by her sister's former boss. She claims he was sexually harassing her sister and making derogatory statements about both of them. This arrest occurred in February, one month after Jenny's only other previous arrest, for robbery. In January, she and some friends had been caught mugging a passerby – although Jenny claims she was just an observer. She was quickly released from detention on this charge. Otherwise, Jenny's main trouble has been fighting at school.

Jenny lives at home with her mother and two siblings; an older sister, who has a child, lives nearby. Jenny sleeps in the living room. She does not have much of a relationship with her father (her parents split up three years ago) and sees him infrequently. The mother has a job, but the family survives with support from public assistance.

A CFI psychiatrist diagnosed Jenny with Depressive Disorder NOS (Not Otherwise Specified) and symptoms of Attention Deficit Hyperactive Disorder (ADHD) and Conduct Disorder. Jenny says she started feeling depressed about six months ago, but didn't say why. In November 2006, Jenny was treated at a child psychiatric clinic for Disruptive Behavior Disorder NOS. It is not known who or what instigated the referral. Her caseworker is encouraging her to resume the individual therapy she had begun before her first arrest. In January, Jenny started taking medication for her depression, which included suicidal thoughts, and says she has felt much better since then.

According to her mother, Jenny's uncle is schizophrenic. She does not know of other family members with psychiatric or legal problems, including her other children and their father. She (the mother) admits abusing alcohol for several years before entering treatment two years ago – but only after ACS was notified by Jenny's school about the problem. The CFI caseworker believes she is still drinking. The mother also says she (the mother) was physically abused by her father (Jenny's grandfather).

Jenny is an average student in school. She says she has not used drugs nor has she been abused. Aside from the fighting, she had difficulty paying attention in class when her mother was drinking. A few years ago ACS was notified a second time by the school because Jenny was truant; the mother was keeping her daughter at home because she thought it was safer. Both ACS cases are now closed.

## #2: Jeffrey

Jeffrey is a 15-year-old boy who was released from detention in March 2007 after five months. He was arrested for assault involving a pair of boys from the neighborhood. Jeffrey gave one boy a broken nose while his 18-year-old friend gave the other boy a broken jaw. Prior to this incident, Jeffrey had no criminal history and no known history of fighting. He says that he is not involved with a gang.

Jeffrey is one of four children; he currently lives at home with his mother and two siblings. His parents divorced when he was 2, and the father has since returned to the family's native country in Africa. Both Jeffrey and his oldest sister (who is 19, living nearby in her own place) have had behavioral problems for the past couple of years, and the mother has been trying unsuccessfully to change their behavior. The sister drinks and smokes pot, and Jeffrey often joins her. The mother is unhappy about their close relationship, believing the sister is a bad influence on her brother. A couple of years ago the mother attempted to get ACS involved, but was rejected; it is not known why. The courts also refused to grant a PINS petition to the family for the sister, because she was too old.

According to his mother, Jeffrey has been troublesome for a while. Some of his problems include chronic truancy, disregard of household rules such as curfew, and drinking and smoking marijuana with his sister and their friends. One condition of Jeffrey's release by the court was his attendance at a drug treatment program.

The CFI psychiatrist diagnosed Jeffrey with Disruptive Behavior Disorder NOS, and reported many symptoms of Oppositional Defiant Disorder, such as externalizing blame, disrespect to authority figures, and active defiance of expected requests. He is not taking medication. Aside from an elderly aunt, the mother knows of no one in the family with mental health problems. She states there is no history of family abuse or legal problems.

Jeffrey's most pressing issue is school, due to truancy and bad grades. He is currently repeating 9th grade. The mother found an after school tutoring program to help him catch up on missed schoolwork, but he is not attending and continues to skip school regularly. He told the CFI caseworker he is behind in every class and feels hopeless about passing any of them, so doesn't feel like bothering. However, the problem may be more serious. Jeffrey has great difficulty even understanding his homework, so the CFI caseworker is having him assessed for special education services. There is no reported history of Jeffrey being aggressive at school, though he says he used to get in trouble frequently for everything; he felt picked on.

Jeffrey has skipped many of his mandated drug treatment sessions. He continues to smoke pot and drink with his sister and stays out after curfew. The CFI caseworker writes that Jeffrey is not motivated to stop using substances or focus on school. He is increasingly disconnected from his mother and is closest to a sister who is a bad influence.

## #3: Thomas

Thomas is a 16-year-old boy who spent six months in detention pending adjudication of assault charges. He says he became involved in a fight when leaping to the defense of a friend who was already in a serious scuffle with a third boy. The fight ended after Thomas and his friend seriously injured the other boy and urinated on him. The family sees it as a case of being in the wrong place at the wrong time, and Thomas says the same; he didn't instigate anything. He admits, however, that he was angry at the time because the victim had insulted him and his family. Thomas has no criminal history and denies any gang affiliation. He does have a serious history of fighting in school.

Thomas lives with his mother, stepfather, and four siblings. His father left the family when he was nine years old, which his mother describes as a traumatic event. Thomas has not had any contact with his father in the past seven years. He says that he likes his stepfather and that they have a good relationship, and sometimes play sports together. Thomas is close to all of his siblings, and enjoys taking care of the younger ones; he says he wants to be a pediatrician. He has always had close friendships, though he has fewer friends now because the family moved to their current apartment a year and a half ago. Neither parent is employed, although the stepfather is in a job-training program after being released from prison on nonviolent charges (the only one besides Thomas with known legal problems). They receive public assistance.

Thomas acknowledges he is quick to anger, that his feelings get "out of control." The CFI psychiatrist diagnosed him with Intermittent Explosive Disorder, based on his difficulty resisting aggressive and destructive impulses, together with his disproportionate response to provocation and stressors. Thomas received counseling from the Children's Aid Society for one month in 2006 when his mother became concerned about his fighting at school. He also attended counseling in detention, and said he was happy to talk to someone about his anger. Regarding the fight that brought him to detention, Thomas says his involvement was not planned. When he thinks about past fights (which he tries to minimize), he knows he has a tendency to act impulsively. He confessed that he is disappointed with his inability to control himself, and is ashamed he was in detention. He has expressed a strong desire to work on his self-control, especially using visualization techniques, and offered ideas as to how he could manage his anger. There is no known family history of mental health issues, substance abuse, or other problems.

Thomas is an average student in school. He says he gets along well with his classmates, and has a long-term girlfriend. However, he has been suspended from school three times in the past due to fighting.

Overall, Thomas is an intelligent young man with good insight into the source of his recent problems. He appears to demonstrate a concerted willingness and desire to change his negative behaviors, understanding their consequences for himself and his family.

# LITERATURE REVIEW

# The Collaborative Family Initiative Theory and Science to Practice: A Literature Review

Over the last decade, the juvenile justice system has focused increasingly on the mental health needs of delinquent youth who come to the attention of family courts (Grisso, 2007). New York City, like other jurisdictions, has witnessed significant efforts to address mental health issues, perhaps best characterized by the development of programs like the Collaborative Family Initiative (CFI), the Juvenile Justice Initiative (JJI), and the Vera Institute's Adolescent Portable Therapy (APT). Grisso (2007) notes that programs like CFI did not emerge in a vacuum, but rather are part of the most recent phase in a larger social movement involving juvenile justice. Grisso's (2007) social movement perspective provides a critically important backdrop for understanding not only the prevailing literature in this area, but also the development and implementation of CFI and similar programs. Using Grisso's (2007) lens, this literature review provides a brief overview of the multiple phases of the social movement in juvenile justice, highlights the state-of-art in research that informs that policy and practice, and offers insights on what Grisso terms the "perils" that threaten this latest phase of the social movement.

## The Phases of the Social Movement in Juvenile Justice

Grisso (2007) states that there have been four phases in the juvenile justice social movement, and that our understanding of the latest phase — characterized by an emphasis on mental health issues involving youth — hinges on recognition of the previous phases. The first phase, typified by the *parens patrie* philosophy, dates to the formal development of the juvenile justice at the turn of the century with its original mission to act in the best interests of the child. The second phase, beginning in the 1960s, was marked by a shift away from *parens patrie* toward due process. Within the context of a larger due process revolution, Supreme Court cases such as In re Gault (387 U.S. 1 (1967) marked an increasing emphasis on procedural fairness, equity, and individual rights for youth involved in the justice system.

The third phase, marked by widespread fears over substantial increases in juvenile crime, reflected a shift toward increasingly punitive responses to youth involved in crime. Concerns arose regarding the proliferation of juvenile "super-predators," who were violent, lacked remorse, and, it was believed, could not be rehabilitated (Migdole and Robbins, 2007). Many states passed laws that facilitated juvenile transfers to adult court, increased penalties for juvenile offenders, and increased the use of detention during pre-adjudication. Migdole and Robbins (2007: 169) note that this phase was also

characterized by the "collapse" of the community mental health system for children, which contributed to the "warehousing" of youth in juvenile detention centers across the country.

The final — and current — phase of the juvenile justice social movement began around 2000 and is characterized by recognition of the growing number of incarcerated youth – both detained and sentenced – with mental health needs. In 1999, the United States Surgeon General issued a report declaring a mental health crisis among youth entering the juvenile justice system. Juvenile correctional administrators across the country echoed this claim, acknowledging that their facilities had become "de facto psychiatric hospitals" (Grisso, 2007: 159).

## The Context for the Current Focus on Mental Health and Juvenile Justice

Researchers have identified a number of factors that facilitated the current focus on mental health needs of juvenile justice-involved youth. Foremost among these factors was the quickly growing body of research that highlighted the prevalence of mental health problems among detained youth, as well as research identifying risk factors for this population.

### *Prevalence of Mental Health Problems*

During the 1990s, a number of researchers began to document the prevalence of mental health problems among delinquent youth in the family court system. In 1992, the National Coalition for the Mentally Ill in the Criminal Justice System published a series of papers edited by Joseph Cocozza that highlighted the huge gaps in our knowledge of the prevalence and treatment of mental health disorders among youth in juvenile justice detention facilities. Since that time, a number of studies have sought to document the prevalence of mental disorders in juvenile justice detention facilities, and Desai et al. (2006) stated that they have all come to the same conclusion: "as many as 65 percent of youths in the juvenile justice system have a diagnosable psychiatric or substance abuse disorder." For example, Teplin et al. (2002) found that 66.3 percent of males and 73.8 percent of females suffered from psychiatric or substance abuse disorders (see also Abram et al., 2003; Dembo, 1996; Halikas et al., 1990). The types of mental health issues commonly found among this population include conduct disorder, hyperactivity and attention disorder, depression, affective disorder, trauma and anxiety disorder and developmental disabilities (Grisso, 1999; and Rogers, Powell, and Strock, 1997).

### *Empirical Research on Risk Factors*

Over the last decade or so, empirical research has begun to examine risk factors for delinquent youth whose cases are heard in family court. Importantly, findings suggest that this delinquent population experiences the same major risk factors as their more seriously involved juvenile offenders counterparts (i.e., youth whose cases are heard in criminal courts). These risk factors include individual-level, family,

and social and community-level characteristics (Wasserman and Miller, 1998; Jessor, 1993). A number of studies examined the prevalence of risk factors and concluded that youth often have overlapping problems of mental illness, drug use, and poor school performance (Cocozza and Skowyra, 2000; Elliott and Huizinga, 1989; Elliott, Huizinga, and Menard, 1989; Huizinga, Loeber, and Thornberry, 1993). A large-scale study of youth carried out in Pittsburgh, Denver and Rochester, sought to identify the "co-occurrence of persistent serious delinquency with persistent drug use, challenges in school, mental health problems, and combinations of these problems" (Huizinga et al., 2000). The most common problem among delinquent males and females was drug use, but the risk of becoming a serious delinquent amplified significantly as the number of problems increased (Huizinga et al., 2000).

There is a clear link between delinquent behavior and school performance. School misbehavior and poor academic performance are common characteristics of juvenile delinquents (McCord, Widom and Crowell, 2001). Those who drop out of school have low aspirations (Elliot et al., 1989), high truant rates, are unsuccessful at maintaining grade level status, and are more likely to engage in delinquent behavior (McCord, Widom, and Crowell, 2001). Moreover, when youth are held back a grade in school they are at greater risk of dropping out (Roderick, 1994). Poor school performance and retention rates are linked to learning disabilities. Youth in the juvenile justice system are three to five times more likely to have a learning disability than those in the general population (National Council on Disability, 2003). Brier (1989) found youth with a learning disability were more likely to engage in delinquency than youth without a disability. The National Council on Disability (2003) argued that schools and the juvenile justice system often target youth with learning disabilities because they exhibit impulsive and inattentive behavior, which may result in suspension or expulsion. McCord et al. (2001) reported that suspended students were significantly more likely to suffer from learning disabilities and perform poorly in school.

Family characteristics are an important factor tied to the development of delinquent behavior (Loeber and Stouthamer-Loeber, 1986; Sampson and Laub, 1993; Gottfredson and Hirschi, 1990; Warr, 1993). Negative parenting styles that include poor supervision, parental conflict, poor discipline, lack of involvement and support are frequently linked to delinquency (Wasserman and Seracini, 2001; Sampson and Laub, 1993; Loeber and Stouthamer-Loeber, 1986). Other factors related to delinquency include living in a single parent household, parental rejection, sibling delinquency, poverty, parental separation/divorce, and incarcerated parent(s) (Gottfredson and Hirschi, 1990; Farrington, 2003; Wasserman and Seracini, 2001). When a parent is incarcerated, a number of collateral consequences affect the youth, including emotional stress, loss of income, change in caregivers, and foster care involvement (Wasserman and Seracini, 2001). Parental criminality often contributes to family dysfunction, poor supervision and family conflict (McCord, 1991). Snyder (2004) reported that more than half of all committed juvenile offenders or delinquents have at least one parent who has served a jail or prison sentence. In addition, childhood abuse and neglect are also factors that contribute to delinquency. Widom (1992) found that child neglect because of stress or family disruption increases the likelihood of juvenile delinquency by more than 50 percent and adult criminality by approximately 40 percent.

Community and social influences — such as peers and the neighborhood — contribute to the development of delinquency. Social learning theory best illustrates the influence of negative peer relationships on delinquency (Sutherland, 1947), stating that a youth's association with antisocial peers reinforces their delinquent behavior. Association with delinquent peers (Lipsey and Derzon, 1998) and peer rejection (Coie and Miller-Johnson, 2001) are strong indicators of delinquency. Peer rejection in childhood can also lead to early aggression and increased delinquency later in adolescence (see also Patterson and Bank, 1989). Gang affiliation is also a risk factor for delinquency. The Rochester Youth Development Study (Battin-Pearson, Hawkins, Thornberry and Krohn, 1998), a longitudinal study following a group of 1,000 adolescents since 1988, found that youth who identified themselves as gang members had higher rates of delinquent offending than non-gang youth. Additionally, findings from the Seattle Social Development Project (Battin-Pearson et al., 1998) revealed that youth affiliated with gangs had higher rates of delinquent behavior and substance abuse than non-gang affiliated delinquent peers. Along with negative peer association, a range of neighborhood factors contributes to deviant behavior. Social disorganization theorists (Shaw and McKay, 1942) stated that inner city communities categorized as disorganized present youth with fewer conventional opportunities and expose them to crime, gangs, and disorder. Sampson and Groves (1989) found communities with limited peer networks; unsupervised youth, and low organizational participation had higher crime and delinquency. This is evident in educational establishments, which have suffered from high drop-out rates.

## *Other Factors Contributing the Focus on Mental Health among Delinquent Youth*

Grisso (2007) identified two other important factors that have contributed to the current focus on mental health issues among delinquent youth. First, there has been substantial growth in child advocacy between both the private and public sectors. A number of foundations, such as the McArthur Foundation and the Annie E. Casey Foundation, have devoted substantial resources to juvenile justice programs; particular those that provide community-based care (Grisso, 2007). The federal Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP), as well as a host of leadership organizations, such as the National Mental Health Association and the National Council of Juvenile and Family Court Judges, have also been very active in terms of funding and advocacy. Moreover, the National Center for Mental Health and Juvenile Justice and the National Commission on Correctional Health Care have both worked to develop guidelines for policy and practice with these youth. Second, Federal, state and local governments have made a substantial financial commitment to examining the prevalence and treatment of mental illness among detained youth (Grisso, 2007). The impetus for much of the financial commitment came from litigation and resulting consent agreements stemming from inadequate care and standards in juvenile detention facilities. "By 2000, it was not unusual to find states with juvenile justice agencies that suddenly had many millions of dollars added to their budgets annually, much of that for improving the mental health care of juveniles in their custody" (Grisso, 2007: 161).

## *Research on Program Effectiveness*

There is a fair amount of research on juvenile delinquency programs, though most of the studies have examined initiatives in the correctional setting. Lipsey (1992) conducted a meta-analysis of over 400 evaluations and found that programs were more likely to be effective if they used structured, focused treatment, based on behavioral, skill-oriented and multi-modal methods, as opposed to approaches that were less structured and focused. Other research has linked successful outcomes to proper program implementation, well-trained staff, longer treatment duration, and a focus on higher-risk offenders (Altschuler et al., 1999; Sherman et al., 1997; Gies, 2003; and Lipsey, 1992).

OJJDP has devoted substantial effort to identifying programs that effectively reducing juvenile crime, substance abuse and aggression. In July 2001, OJJDP named 11 model programs, or Blueprint Programs, that have received consistently positive evaluations. These programs vary in nature, emphasis, and timing over the life-course, ranging broadly from enhanced prenatal care to adolescent bullying prevention. Unfortunately, few of these programs deal with the CFI target population — youth with mental health problems who are returning from detention. One exception is Multisystemic Therapy (MST), which attempts to enhance pro-social behavior (Henggeler et al., 1986), improve family relations (Brunk et al., 1987; Borduin et al., 1995), and reduce risk factors.

However, most of the research in this area has suffered from methodological and implementation problems, has produced small effect sizes, and has not examined long-term outcomes. For example, OJJDP funded a five-year multi-site evaluation of its flagship Intensive Aftercare Program (IAP), which was carried out by the National Council on Crime and Delinquency. Results from the random assignment evaluation (Wiebush, Wagner, McNulty, Wang, & Le, 2005) indicate that every site struggled with implementation issues, including low program enrollment, treatment provision to control group youth, and staff turnover. There were no statistically significant differences in re-offending among IAP and control group youth, and the authors concluded that the "no-difference" findings should be considered in the context of implementation difficulties (Wiebush et al., 2005). Also, much of the research regarding Wraparound Service Planning Programs has suffered from implementation and methodological problems (e.g., Anderson et al., 2003) that have severely limited assessment of program effectiveness.

Moreover, little research has focused on community-based programs. As a result, there is now a solid body of research documenting the principles of effective correctional program in juvenile settings (Hubbard and Latessa, 2004; Landerberger and Lipsey, 2005; Wilson et al., 2005), but little is known about effective programming in the community.

## Next Steps for the Juvenile Justice Social Movement: Avoiding the Perils

Grisso (2007) stated that the latest phase in the juvenile justice social movement developed very rapidly, which did not allow for any long-term planning or discussion of sustainability. As a result, there are a number of "perils" that threaten the current movement. Chief among these threats is the tendency to "over-interpret the message" and assume that diagnosis equates with treatment. Both the severity of the disorder and a youth's ability to function normally affect treatment needs. "Thus, most experts recognize that it is not necessary and is probably unwise for the juvenile justice system to translate the published prevalence rates into a policy that seeks treatment for two-thirds of the youths in custody" (Grisso, 2007: 162).

The second peril — which Grisso (2007) calls "bandwagon incentives" — stems from pressure and urgency placed upon juvenile justice administrators to embrace reform. Under this pressure, administrators may have a tendency to act too quickly before carefully considering which options are most appropriate. Grisso (2007) points to documented misuse of the MAYSI-2 by juvenile justice administrators, as well as problems in program implementation. Lowenkamp and Latessa (2005) clearly demonstrated that program integrity is loosely linked to program effectiveness. Grisso (2007) suggests that, in the rush to embrace reform quickly, administrators have, in some cases, not "paid attention to the details." Grisso (2007: 164) suggests that the consequences of implementation and integrity problems can extend beyond equivocal research findings.

The third peril — called "iatrogenic injustice" — suggests that efforts to correct one problem or injustice can sometime create other kinds of injustices. The most serious concern with this peril is that the juvenile justice system will be transformed in the nation's mental health system. If there is tacit recognition that the juvenile justice system is the most viable link to mental health services that are otherwise difficult to obtain, there is an increasing likelihood that youth will be unnecessarily channeled into the justice system on delinquency charges merely to access those services (Grisso, 2007). In effect, there is the potential for a disturbing form of net-widening with little regard for the long-term consequences of juvenile justice system involvement. The solution to this peril is to improve community mental health services for children and reduce (or eliminate) the expectation that the juvenile justice system is the default option for mental health services. As part of this effort, there should be an increased emphasis on reentry transitioning and aftercare to facilitate the transition from detention back to the community.

## The Collaborative Family Initiative

The Collaborative Family Initiative was envisioned by the New York City Department of Juvenile Justice as a centerpiece program that would be grounded in the current state-of-the art research – particularly the recognition of multiple levels of risk factors – but that would also heed Grisso's (2007) concerns over threats to the sustainability of the current focus on mental health and juvenile justice. As such, CFI incorporates the principles of effective correctional programming, and the treatment protocol is tailored based on individual need determined through intensive intake and assessment procedures. The CFI partnership among researchers, the Department of Juvenile Justice, and mental health service providers has placed a premium on program implementation and integrity, evidenced by the real-time evaluation and emphasis on data collection. Finally, community-based care is the foundation of CFI. Although the Department of Juvenile Justice is centrally and intimately involved in the life of each CFI participant, the burden for mental health services has been shifted back to the community and is shouldered by the  stakeholder CFI service providers.

# BIBLIOGRAPHY

## References


Abrams, K. M., Teplin, L. A. and McClellend, G. M., Dulcan, M. K. (2003). Comorbid psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 60,* 1097-1108.

Abrams, L. S. (2006). From corrections to community: Youth offenders' perceptions of the challenges of transition. *Journal of Offender Rehabilitation, 44*(2/3), 31-53.

Altschuler, D. M., & Brash, R. (2004). Adolescent and teenage offenders confronting the challenges and opportunities of reentry. *Youth Violence and Juvenile Justice, 2*(1), 72-87.

Altschuler, D. M., Armstrong, T. L. and MacKenzie, D. L. (1999). *Reintegration, Supervised Release, and Intensive Aftercare.* Juvenile Justice Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Altschuler, D. M., & Armstrong, T. L. (1996). Aftercare not afterthought: Testing the IAP model. *Juvenile Justice, 3*(1), 15-22.

Anderson, J. A., Wright, E. R., Kooreman, H. E., Mohr, W. K. and Russell, L. A. (2003). The dawn project: A model for responding to the needs of children with emotional and behavioral challenges and their families. *Community Mental Health Journal, 39(1),* 63-75.

Barr, H (2003). Transinstitutionalization in the courts: Brad H. v. City of New York, and the fight for discharge planning for people with psychiatric disabilities leaving Rikers Island. *Crime & Delinquency, 49*(1), 97-123.

Barton, W. H. (2006). Incorporating the strengths perspective into intensive juvenile aftercare. *Western Criminology Review, 7*(2), 48-61.

Battin-Pearson, S. R., Thornberry, T. P., Hawkins, J. D. and Krohn, M. D. (1998). *Gang Membership, Delinquent Peers, and Delinquent Behavior.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Beck, A., Kline, S., and Greenfeld, L. (1988). *Survey of Youth in Custody*. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics.

Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M. And Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology, 63,* 569-578.

Borges, E. (2008). New York Office of Children and Family Services Accelerating Transformation of State Juvenile Justice Systems. Retrieved January 15, 2008 from: http://www.ocfs.state.ny.us/main/news/2008/2008_01_11_juvenilejusticetransformation.asp

Brier, N. (1989). The relationship between learning disabilities and delinquency: A reappraisal. *Journal of Learning Disabilities*, 22, 546-553.

Brunk, M., Henggeler, S. W. and Whelan, J. P. (1987). Comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Psychology, 55,* 171-178.

Bullis M., Yovanoff P., & Havel E. (2004). The importance of getting started right: Further examination of the community engagement of formerly incarcerated youth. *The Journal of Special Education*, *38*, 80–94.

Byrnes, M., Macallair, D., & Shorter, A. (2002). *Aftercare as Afterthought: Reentry and the California Youth Authority.* San Francisco: Center on Juvenile & Criminal Justice.

Chung, H. L., Schubert, C. A., & Mulvey, E. P. (2007). An empirical portrait of community reentry among serious juvenile offenders in two metropolitan cities. *Criminal Justice and Behavior, 34*(11), 1402-1426.

Cocozza, J. J., & Skowyra, K. R. (2000). Youth with mental health disorders: Issues and emerging responses. *Juvenile Justice, 7*(1), 3-13.

Coie, J. D. and Miller-Johnson, S. (2001). Peer factors and interventions. In *Child Delinquents: Development, Intervention and Service Needs*. Eds. Loeber, R. and Farrington, D. P. Thousand Oaks, CA: Sage Publications, Inc.

Conner, T. and Koeske, G. (2005). The impact of mental health treatment intensity on the emotional and behavioral problems of youth. Ed. Rapp-Paglicci, L. A. In *Juvenile Offenders and Mental Illness: I Know Why the Caged Bird Cries.* Binghamton, NY: The Haworth Social Work Practice Press.

Cromwell, P. F., Olson, J. N., & Wester Avary, D. A. (1991). *Breaking and Entering: An Ethnographic Analysis of Burglary*. Newbury Park: Sage.

Daum, J. M. (1981). Aftercare, the neglected phase of adolescent treatment. *Juvenile and Family Court Journal, 32*, 43-48.

Dembo, R. (1996). Problems among youths entering the juvenile justice system, their service needs and innovative approaches to address them. *Substance Use and Misuse, 31,* 81-94.

Desai, R. A., Goulet, J. L., Robbins, J., Chapman, J. F., Migdole, S. J., and

Hoge, M. A. (2006). Mental health care in juvenile detention facilities: A review. *The Journal of the American Academy of Psychiatry and the Law, 34,* 204-214.

Elliott, D. S., Huizinga, D. and Menard, S. (1989). *Multiple Problem Youth: Delinquency, Substance Use and Mental Health Problems*. New York, NY: Springer-Verlag.

Elliott, D. S. and Huizinga, D. 1989. The relationship between delinquent behavior and ADM problems. In *Juvenile Offenders with Serious Drug, Alcohol and Mental Health Problems,* Ed. Hampton, C. Washington, DC: U.S. Government Printing Office.

Farrington, D. P. (2003). Key results from the first forty years of the Cambridge Study in Delinquent Development. Eds. Thornberry, T. P. and Krohn, M. D. In, *Taking Stock of Delinquency: An Overview of Findings from Contemporary Longitudinal Studies*. New York, NY: Kluwer.

Feldman, P. (1993). *The Psychology of Crime: A Social Science Textbook*. Cambridge: Cambridge University Press.

Frederick, B. (1999). *Factors Contributing to Recidivism Among Youth Placed with the New York State Division for Youth: Technical Report*. Albany, NY: New York State Division of Criminal Justice Services.

Gies, S. V. (2003). *Aftercare Services.* Juvenile Justice Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Giordano, P. C., Cernkovich, S. A., & Rudolph, J. L. (2002). Gender, crime, and desistance: Toward a theory of cognitive transformation. *American Journal of Sociology, 107*(4), 990-1064.

Gottfredson, M. and Hirschi, T. (1990). *A General Theory of Crime.* Stanford, CA: Stanford University Press.

Grisso, T. (2007). Progress and perils in the juvenile justice and mental health movement. *The Journal of the American Academy of Psychiatry and the Law*, 35, 158-167.

Grisso, T. (2004). *Double Jeopardy: Adolescent offenders with mental disorders*. Chicago: University of Chicago Press.

Grisso, T. (1999). Juvenile offenders and mental illness. *Psychiatry, Psychology and Law, 6*(2), 143-151.

Halikas, J. A., Meller, J., Morse, C., and Lyttle, M. D. (1990). Predicting substance abuse in juvenile offenders: Attention deficit disorder versus aggressivity. *Child Psychiatry and Human Development*, *21,* 49-55.

Henggeler, S. W. (1997). *Treating serious antisocial behavior in youth: The MST approach*. Washington, D.C.: OJJDP.

Hirschi, T. (1969). *Causes of Delinquency*. Berkeley, CA: University of California Press.

Hochstetler, A. (2001). Opportunities and decisions: Interactional dynamics in robbery and burglary groups. *Criminology, 39*(3), 737-763.

Homel, R., & Clark, J. (1994). The prediction and prevention of violence in pubs and clubs. In R. V. Clarke (Ed.), *Crime prevention studies* (Vol. 3, pp. 1-46). Monsey, NY: Criminal Justice Press.

Horney, J., Osgood, D. W., & Marshall, I. H. (1995). Criminal careers in the short-term: Intra-individual variability in crime and its relation to local life circumstances. *American Sociological Review, 60*, 655-673.

Hubbard, D. J. and Latessa, E. J. (2004). Evaluation of Cognitive-Behavioral Programs for Offenders: A Look at Outcome and Responsivity in Five Treatment Programs. Ohio Office of Criminal Justice Services. Cincinnati: OH: University of Cincinnati.

Huizinga, D., Loeber, R., Thornberry, T. P., & Cothern, L. (2000). *Co-occurrence of Delinquency and Other Problem Behaviors*. Washington, D.C.: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Huizinga, D., Loeber, R., and Thornberry, T. P. (1993). Delinquency, drug use, sex, and pregnancy among urban youth. *Public Health Reports 108,* (supplement), 90-96.

In re Gault, 387 U.S. 541 (1966).

Indermaur, D. (1995). *Violent Property Crime*. St. Leichhardt, NSW: Federation Press.

Josi, D. A., & Sechrest, D. K. (1999). A pragmatic approach to parole aftercare: Evaluation of a community reintegration program for high-risk youthful offenders. *Justice Quarterly, 16*(1), 51-80.

Katz, J. (1988). *Seductions of Crime*. New York, NY: Basic Books.

Kumpfer, K.L. & Alvarado, R (1998). *Effective Family Strengthening Interventions*. U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention.

Kumpfer, K. L. (1994). *Family Strengthening in Preventing Delinquency: A Literature Review.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Kurlychek, M. & Kempinen, C. (2006). Beyond Boot Camp: The impact of aftercare on offender reentry. *Criminology & Public Policy, 5*(2), 363-388.

Landenberger, N. A. and Lipsey, M. W. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology*, *1(4):* 451-476.

Laub, J. H., & Sampson, R. J. (2003). *Shared Beginnings, Divergent Lives: Delinquents Boys to Age 70*. Cambridge, MA: Harvard University Press.

Lipsey, M. W., Wilson, D. B. and Cothern. (2000). *Effective Intervention for Serious Juvenile Offenders.* Juvenile Justice Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Lipsey, M. W. and Derzon, J. H. (1998). Predictors of violent or serious delinquency in adolescence and early adulthood: A synthesis of longitudinal research. In *Serious and Violent Offenders: Risk Factors and Successful Interventions*. Eds. Loeber, R. and Farrington, D. P. Thousand Oaks, CA: Sage Publications. Pages 86-105.

Lipsey, M. W. (1992). Juvenile delinquency treatment: A meta-analytic inquiry into the variability of effects. In *Meta-Analysis for Explanation.* Eds. Cook, T. D., Cooper, H., Cordray, D. S., Hartmann, H., Hedges, L.V., Light, R. J., Louis, T. A., and Mosteller, F. New York: NY: Russel Sage Foundation.

Loeber, R. and Stouthamer-Loeber, M. (1986). Family factors as correlates and predictors of juvenile conduct problems and delinquency. *Crime and Justice*, 7, 29-149.

Longshore, D., Chang, E., Hsieh, S.-c., & Messina, N. (2004). Self-control and social bonds: A combined control perspective on deviance. *Crime and Delinquency, 50*(4), 542-564.

Lowenkamp, C.T. & Latessa, E.J. (2005). Increasing the effectiveness of correctional programming through the risk principle: Identifying offenders residential placement. *Criminology and Public Policy, 4(2),* 263-290.

Maruna, S. (2001). *Making Good: How Ex-Convicts Reform and Rebuild their Lives*. Washington, DC: American Psychological Association.

McClelland, G. M., Teplin, L. A., & Abram, K. M. (2004). *Detection and prevalence of substance use among juvenile detainees*. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

McCord, J., Widom, C. S. and Crowell, N. A. (2001). *Juvenile Crime, Juvenile Justice: Panel on Juvenile Crime: Prevention, Treatment and Control.* Washington, DC: National Academy Press.

McCord, J. (1991). The cycle of crime and socialization practices. *Journal of Criminal Law and Criminology*, 83, 211-228.

McCord, J. (1979). Some child-rearing antecedents of criminal behavior in adult men. *Journal of Personality and Social Psychology*, 37(9), 1477-1486.

Mears, D. P. (2001). Critical challenges in addressing the mental health needs of juvenile offenders. *The Justice Policy Journal, 1*(1), 40-59.

Mears, D. P., & Travis, J. (2004). *The Dimensions, Pathways, and Consequences of Youth Reentry*. Washington, D.C.: The Urban Institute.

Migdole, S. and Robbins, J. P. (2007). Commentary: The role of mental health services in pre-adjudicated juvenile detention centers. *The Journal of the American Academy of Psychiatry & the Law* 35(2), 168-171.

National Council on Disability. (2003). *Addressing the Needs of Youth with Disabilities in the Juvenile Justice System: The Current Status of Evidence-Based Research.* Washington, DC: National Council on Delinquency.

Office of the Surgeon General. (2001). *Youth Violence: A Report of the Surgeon General.* Washington, DC: U.S. Department of Health and Human Services, Office of the Secretary, Office of Public Health and Science, Office of the Surgeon General.

Osher, T & Hunt, P (2002). *Involving Families of Youth who are in Contact with the Juvenile Justice System.* National Center for Mental Health and Juvenile Justice.

Parker, R. N., & Auerhahn, K. (1998). Alcohol, drugs, and violence. *Annual Review of Sociology, 24*, 291-311.

Patterson and Bank (1989). Some amplifying mechanisms for pathologic processes in families. Eds. Gunnar, M. and Thelen, E. *Symposia on Child Psychology*. Hillsdale, NJ: Lawrence Erlbaum.

Puzzanchera, C.M. (2002). *Juvenile Court Placement of Adjudicated Youth, 1989-1998.* Washington, DC: U.S. Department of Justice.

Raskin White, H., Tice, P. C., Loeber, R., & Stouthamer-Loeber, M. (2002). Illegal acts committed under the Influence of Alcohol and Drugs. *Journal of Research in Crime and Delinquency, 39*(2), 131-152.

Rhodes, W. M. (1989). The criminal career: Estimates of the duration and frequency of crime commission. *Journal of Quantitative Criminology, 5*(1), 3-32.

Roderick, M. (1994). Grade retention and school dropout: Investigating the association. *American Educational Research Journal*, 31, 729-759.

Rodriguez-Labarca, J., & O'Connell, J. P. (2004). *Delaware's Serious Juvenile Offender Program: An Evaluation of the First Two Years of Operation*. Dover: State of Delaware, Office of the Budget Statistical Analysis Center.

Rogers, K. M., Powell, E., & Strock, M. (1998). The characteristics of youth referred for mental health evaluation in the juvenile justice system. In *Child Welfare and Juvenile Justice* (329-334). Eds. Willis, J. Liberton, C., Kutash, K. and Friedman, R. Presented at the

10th Annual Research Conference, A System of Care for Children's Mental Health: Expanding the Research Base, Tampa: University of South Florida.

Rogers, K. M., Powell, E., & Strock, M. (1997). *The characteristics of youth referred for mental health evaluation in the juvenile justice system.* Paper presented at the A System of Care for Children's Mental Health: Expanding the Research Base, Tampa: University of South Florida.

Rutter, M., Giller, H., & Hagell, A. (1998). *Antisocial Behavior by Young People*. Cambridge: Cambridge University Press.

Sampson, R. J. and Laub, J. H. (1993) *Crime in the Making: Pathways and Turning Points Through Life.* Cambridge, MA: Harvard University Press.

Sampson, R. J. and Groves, B. (1989). Community structure and crime: testing social-disorganization theory. *The American Journal of Sociology,* 94, 4, 774-802.

Shaw, C. R. and McKay, H. D. (1942). *Juvenile Delinquency in Urban Areas.* Chicago, IL: University of Chicago Press.

Sherman, L. W., Gottfredson, D. C., MacKenzie, D. L, Kck, J., Reuter, P., and Bushway, S. (1997). *Preventing Crime: What Works, What Doesn't, What's Promising.* Report to the U.S. Congress. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

Shover, N. (1996). *Great Pretenders*. Boulder, CO: Westview.

Siegel, L.J. and Senna, J.J. (2007). *Essentials of Criminal Justice.* 5th ed. Belmont, CA: Thomson Wadsworth.

Snyder, H. N. (2004). An empirical portrait of the youth reentry population. *Youth Violence and Juvenile Justice, 2*(1), 39-55.

Soler, M. (2002). Health issues for adolescents in the justice system. *Journal of Adolescent Health*, 31: 321-333.

Steinburg, L., Chung, H., and Little, M. (2004). Reentry of young offenders from the justice system: A developmental perspective. *Youth Violence and Juvenile Justice,* 2(1), 21-38.

Sullivan, M. L. (2007). Youth perspectives on the experience of reentry. *Youth Violence and juvenile Justice, 2*(1), 56-71.

Sutherland, E. (1947). *Principles of Criminology*. 4th Ed. Chicago, Ill: Lippincott Co.

Teplin, L. A., Abram, K. M., McClelland, G. M., & Dulcan, M. K. M., Amy A. (2007). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 59*, 1133-1143.

Teplin, L. A., Abram, K. M., McClelland, G. M., Washburn, J. J., & Pikus, A. K. (2005). Detecting mental disorder in juvenile detainees: Who receives services? *American Journal of Public Health, 95*(10), 1773-1780.

Teplin, L. A., Abram, K. M., McClelland G. M., Dulcan, M. K. and Mericle, A. A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry,* 59, 1133-1143.

The President's New Freedom Commission on Mental Health (2003). Rockville, MD. Retrieved December 13, 2008, from: http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf

Timmons-Mitchell, J., Brown, C., Schulz, S. C., Webster, S. E., Underwood, L. A., & Semple, W. E. (1997). Comparing the mental health needs of female and male incarcerated juvenile delinquents. *Behavioral Sciences and the Law, 15*, 195-202.

Tolan, P.H., & Gorman-Smith, D. (1997). Families and the development of urban children. In *Children Youth: Interdisciplinary Perspectives* (pp. 67-91). Eds. Walberg, H. J., Reyes, O. & Weissberg, R. P. Thousand Oaks, CA: Sage Publications, Inc.

Vaughn, M.G., Wallace, J.M., Davis, L.E., Fernandez, G.T., Howard, M.O. (2007). Variations in mental health problems, substance use and delinquency between African American and Caucasian juvenile offenders; Implications for reentry services. *International Journal of Offender Therapy and Comparative Criminology*, *20(*10), 1-19.

Warr, M. (1993). Parents, peers, and delinquency. *Criminology*, 31, 17-40.

Wasserman, G. A. and Seracini, A. G. (2001). Family risk factors and interventions. In *Child Delinquents: Development, Intervention and Service Needs*. Eds. Loeber, R. and Farrington, D. P. Thousand Oaks, CA: Sage Publications, Inc.

Watson, D. W. (2004). Juvenile offender comprehensive reentry substance abuse treatment. *The Journal of Correctional Education, 55*(3), 211-224.

Widom, C.W. (1992). *The Cycle of Violence*. National Institute of Justice: Research in Brief. Washington, DC: Department of Justice.

Wiebush, R. G., McNulty, B., & Le, T. (2000). *Implementation of the Intensive Community-Based Aftercare Program*. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Wiebush, R. G., Wagner, D., McNulty, B., Wang, Y., & Le, T. (2005). *Implementation and Outcome Evaluation of the Intensive Aftercare Program*. Washington, D.C.: USDOJ, OJP, OJJDP.

Wilson, D. B., MacKenzie, D. L. and Mitchell, F. N. (2005). Effects of Correctional Boot Camps on Offending. A Campbell Collaboration systematic review, available at: http://www.aic.gov.au/campbellcj/reviews/titles.html

Wolfgang, M. E. (1958). *Patterns in Criminal Homicide*. Philadelphia, PA: J. Wiley.

Zimmermann, C. (2005). Always in custody? An agenda for juvenile reentry. *International Journal of Comparative and Applied Criminal Justice, 29*(1), 33-51.