

Recommendations for Ideal Community Based Residential Treatment

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Abstract:

Recommendations for Ideal Community Based Residential Treatment

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Under the Supervision of Susan Hilal.

Statement of the Problem:

Despite past trends which emphasized punishment and crime control, treatment remains the underlying philosophy of the juvenile justice system (Siegel, Welsh, & Senna, 2006). Interventions in the lives of at risk youth and juvenile delinquents, which address the areas of education, mental health, and alcohol and other drug abuse (AODA) issues are sought to help to reduce future criminality and recidivism. Although residential treatment has been found to be effective at reducing recidivism, which specific factors contribute to this needs more research (Lee & McMillen, 2007). These programs typically offer secure or semi-secure facilities where juveniles receive treatment for 30 days to several months, and due to this potentially lengthy placement many of these programs also address individualized educational needs as well. Furthermore, the lack of adequate evidenced based care of these youth could make an already vulnerable population even more vulnerable (Lee & McMillen, 2007). Recommendations are needed regarding which programming is most effective within residential treatment programs to ensure that funds are being wisely used, youth are being adequately rehabilitated, and the impact of delinquency on the community is minimized as much as possible.

Methods of approach:

The methodology for this study consists of secondary research and statistics gathered from available public data. Information reviewed about community based residential treatment including facilities available in Wisconsin, which address juveniles' mental health, educational and AODA needs is enriched by an empirical literature review and the integration of the differential reinforcement/learning theory. This information grounds recommendations for an ideal community-based treatment response for juveniles.

Findings:

Serious delinquents can desist in offending behavior and avoid incarceration or supervision when effective intervention programs are utilized (McGlynn, et al., 2012). Residential treatment centers have been shown to be highly effective as they provide individualized interventions in the lives of troubled youth and a variety of therapeutic programs aimed at reducing recidivism and problematic behaviors. The most effective of these programs provide rehabilitation through the use of several techniques used in combination (multimodal) and utilize programs which are comprehensive, build upon a juvenile's strengths, and have a socially grounded position (Bettmann, et al., 2011). Recommendations for an ideal community based residential treatment center beyond these crucial program components are to provide individualized care with integrity, accountability, and aftercare services.

TABLE OF CONTENTS

	Page
TITLE PAGE.....	i
ACKNOWLEDGMENT	ii
ABSTRACT	iii
TABLE OF CONTENTS.....	v
SECTIONS:	
I. INTRODUCTION.....	1
A. Statement of problem	
B. Purpose of the study	
C. Significance of the study	
D. Methodology	
E. Assumptions necessary to undertake the study & anticipated outcomes	
II. REVIEW OF LITERATURE	5
A. AODA, mental health and educational issues	
B. Residential treatment programs	
C. Evidenced based programs	
III. THEORETICAL FRAMEWORK	24
A. Differential reinforcement/learning theory	
B. Application of theory to residential treatment centers	
IV. FINDINGS & RECOMMENDATIONS	29
A. Individualized care	
B. Integrity	

C. Aftercare and accountability

V. SUMMARY AND CONCLUSIONS	38
VI. REFERENCES.....	41
VII. APPENDIX	45

Section I: INTRODUCTION

Statement of problem

Despite past trends that emphasized punishment and crime control, treatment remains the underlying philosophy of the juvenile justice system (Siegel, et al., 2006). The founding idea that the state should act as a parent in the best interest of the child (*parens patriae*) and that children ought to be treated differently than adults has evolved and continually changed in order to balance community protection with juvenile rights (Schmallegger, 2009). In the 21st century, there seems to have been a paradigm shift within the juvenile justice system towards “rehabilitation through individualized justice” (Snyder & Sickmund, 2006, p.94). As such, interventions in the lives of at risk youth and juvenile delinquents, which address the areas of education, mental health, and alcohol and other drug abuse (AODA) issues are sought to help to reduce future criminality and recidivism. However, how to address the individualized needs of juveniles entering the juvenile justice system most effectively while balancing public safety needs has been an ongoing topic of debate.

The mix of rehabilitative and retributive goals of the juvenile justice system is expressed especially well when looking at the non-institutional forms of corrections available which are used to avoid the unnecessary incarceration of youth (Siegel, et al., 2006). For example, approximately 29% of juvenile delinquents are placed in residential facilities where they have the opportunity to receive treatment instead of incarceration (Siegel, et al., 2006). Such residential community based treatment of juvenile delinquents has become increasingly more common (Siegel, et al., 2006). In 2011 there were 61,423 juveniles placed in various residential facilities (Sickmund, Sladky, Kang, & Puzanchera, 2013). These programs typically offer secure or semi-secure facilities where

juveniles receive mental health and AODA treatment programming for 30 days to several months and due to this potentially lengthy placement, many of these programs also address individualized educational needs as well. However, residential care has been compared to a “black box” (Lee & McMillen, 2007). Community based residential treatment programs offer hope-filled promises of rehabilitated youth, but the identification of which elements of such programs are crucial to success has yet to be determined.

Purpose of the study

The purpose of this study is to provide recommendations for ideal community based residential treatment programming for juveniles based upon criminological theory, existing literature, and available data. This paper provides an examination of community based residential treatment programs; highlighting those programming areas that have been shown to be most effective, especially for those with significant mental health, educational, and AODA issues. With limited resources and tight budgets in the juvenile and criminal justice systems, it is important to identify which program components lead to the best possible outcome for success towards the rehabilitation of juveniles through individualized justice. Community based residential treatment programs which address the individualized educational, AODA and mental health needs of juveniles are especially important considering that they provide alternatives to costly secure detention and confinement. They also balance the needs of the juvenile offender and the safety of the community, reduce overcrowding, cut the costs of juvenile detention centers, reduce the stigma of institutionalizing youths, reinforce positive relationships within communities and families, and limit youths exposure to more serious delinquent peers (Austin, Dedel, Johnson, & Weitzer, 2005).

Significance of the study

Despite reported drops in violent crime, a census of state and federal correctional facilities has shown an increase in the number of prisoners (McGlynn, Hahn, & Hagan, 2012). There are many theories as to why this is, including truth in sentencing, three strikes and mandatory minimum laws. It is estimated that approximately 3.25% of U.S. adults (about 7.3 million people) are involved in some capacity with the justice system (probation, jail or prison) (McGlynn et al., 2012). This burden on society translates to concerns about juvenile delinquency due to the documented connection between delinquent activities at an early age to increased crime and other difficulties in adulthood (McGlynn, et al., 2012). As such, effective intervention programs for serious juvenile offenders are especially important as they stand to increase public safety, reduce costs to society, and prevent future criminality (McGlynn, et al., 2012). This research aims to aid policy makers and funding authorities in making decisions regarding which juvenile community based residential treatment programs are of merit in addition to assisting such programs to make necessary changes in order to be successful in best serving the needs of this highly vulnerable population.

Methodology

The methodology for this study consists of secondary research and statistics gathered from available public data. Data collected about community based residential treatment, including facilities available in Wisconsin, which address juveniles' mental health, educational and AODA needs is enriched by an empirical literature review and the integration of the differential reinforcement/learning theory. This information grounds recommendations for an ideal community-based treatment response for juveniles.

Assumptions necessary to undertake the study and anticipated outcomes

Youthful offenders are in need of individualized treatment that balances their needs and struggles with the needs of the community for safety. It is anticipated that this study will determine that many at risk youth and juveniles involved within the criminal justice system would benefit from the rehabilitative efforts of community based residential treatment programs, especially those with significant mental health, educational, and AODA issues. Recommendations for ideal community based residential treatment programming for juveniles will be provided based upon the literature, best practices attained through available data and integration of the differential reinforcement/learning theory.

Section II: REVIEW OF LITERATURE

The following literature review is divided into four sections. The first section discusses the pathway from crime through the juvenile justice system and the scope of juveniles who are housed in residential facilities. The second section looks at statistics on the prevalence of AODA, mental health, and educational issues among those youth involved in the juvenile justice system. The third section reviews the history and types of programming offered in residential treatment program placement. The last section concludes with support for why community based residential treatment is effective and briefly provides some examples of programs which address the mental health, educational, and AODA needs of juveniles.

Pathway and scope of juvenile delinquency

Once a juvenile enters the juvenile justice system there are several paths that become available to that child which are designed to provide a balance of rehabilitative support, punishment, and safety for the community. The following overview by Schmalleger (2009) discusses the pathways available to youth involved with the juvenile justice system.

Juveniles enter the juvenile justice system by being arrested or via the filing of a juvenile petition by an aggrieved party such as community members, business owners, school administrators, or parents. The majority of juvenile cases originate with law enforcement. Upon entering the juvenile justice system the juvenile will go through an intake screening, at which point it will be determined by a professional, or a board or panel of professionals, whether the juvenile should be diverted to a community program, be released, be referred to the adult criminal justice system, or should proceed to a detention hearing. This screening procedure is unique in each state and is often largely dependent upon reigning philosophies, and economics. Community diversion programs could include residential placements, but most often they consist of community service

or outpatient education, training, or treatment programs. At this point it is also decided whether or not the juvenile presents a danger to themselves or to others; if so they will be placed into temporary residential custody such as a shelter, foster home, or juvenile detention center as determined by the intake worker while they await their hearing. If the juvenile proceeds through the juvenile justice system to a detention hearing, a judge or an appointed juvenile justice intake worker will decide whether or not the child should be waived into the adult criminal justice system, should be released, or should have a petition filed against them.

Once a petition is filed, the juvenile will go through a similar fact finding court process as an adult would called an adjudicatory hearing, however some procedural rules and nomenclature are altered to make it a more appropriate process for a child. If adjudicated or if the juvenile pleads guilty, the disposition phase for juveniles concludes with a consequence (sentence) that is nominal, custodial, or a conditional release. In the juvenile justice system the goal is rehabilitation, so the judge has great discretion to provide the least restrictive but most appropriate disposition to the juvenile.

A nominal disposition is simply a warning or reprimand. Conditional release dispositions entail community supervision (probation), fine, community service, restitution, or some combination thereof. Custodial dispositions occur when a juvenile is placed out of home in a placement such as a foster home, group home, residential facility, secure facility or detention. If a juvenile receives a custodial disposition, they may receive lower tier consequences such as a fine or probation as well. Also upon violation of a conditional release disposition, a juvenile could be revoked upon the decision of their probation officer, a juvenile intake worker, or judge and given a custodial consequence without a new adjudicatory hearing. Thus a juvenile can end up in a

residential facility via consequence due to adjudication, violation of conditional release or probation, or via private placement by their caregiver.

Scope of juvenile delinquency

The most recent statistics available from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) regarding the scope of the juvenile delinquency problem in the U.S. reveal that in 2011 a total of 1,236,186 juveniles were referred to juvenile court in the United States (Sickmund, Sladky, & Kang, 2014), of which 891,061 were males. Furthermore in 2011 there were 61,423 reported juveniles placed in various types of residential facilities nationwide, 21,090 of those juveniles were placed in detention centers, and 18,583 were placed in community placements such as group homes and another 16,662 were placed in long term secure facilities (Sickmund, Sladky, Kang, & Puzzanchera, 2013).

The OJJDP defines juvenile placements by level of restriction not by length of stay however, detention centers are deemed short term temporary care facilities which provide a physically restrictive environment (Sickmund, et al., 2013). Community placements including ranch/wilderness camps, group homes and boot camps are defined as long-term facilities for whom strict confinement is not necessary and contact with the community is deemed appropriate (Sickmund, et al., 2013). Lastly, long term secure facilities are specialized placements which provide strict confinement for juveniles, such as training schools and juvenile correctional facilities (Sickmund, et al., 2013).

Overall, throughout the United States residential placements were evenly distributed amongst state, local, and private facilities (Sickmund, et al., 2013). Wisconsin is a good statistical example of juvenile justice system residential placements as it ranked 23rd most placements

nationally in 2013 (Puzanchera, et al., 2014). However, in Wisconsin the juvenile arrest rate has declined at a slower rate of 50%, compared to the national average of 64%, at the same time that its per capita corrections spending has increased faster than the national rate, indicating diminishing returns on moneys spent on corrections (Boggs, Campbell, Martin, & Wolf, 2008). In 2010 of 1,256,600 juveniles in the state of Wisconsin through the upper age of jurisdiction (age 16), 24,599 juveniles were deferred to juvenile court (Hockenberry, Smith, & Kang, 2013). Nine hundred fifteen of those juveniles were placed in residential facilities for detainment (Sickmund, et al., 2013). Four hundred thirty eight of said Wisconsin juveniles were placed for crimes against people, such as robbery, simple assault, sexual assault, aggravated assault or criminal homicide; 252 were placed for property crimes and the remainder were placed for public order, or drug crimes, technical violations or status offenses (Sickmund, et al., 2013). In Wisconsin, most of the juveniles placed in residential facilities for detainment were ages 14-16 (Sickmund, et al., 2013). The most common type of residential treatment in Wisconsin is placement in public facilities, where 540 juveniles were placed in 2011 compared to the 375 placed in private facilities (Sickmund, et al., 2013). The most popular public facility in Wisconsin being Lincoln Hills School, which had an average daily population of 214.8 juveniles aged 14-16 in 2011 (Wisconsin DOJC Annual Report, 2013).

Nationally the majority of juvenile offenders were male, with only 8,344 of 64,423 juveniles placed in residential facilities being female (Sickmund, et al., 2013). The most prevalent crimes committed by category (other than technical violations) were property offences burglary, person offences robbery, and person offenses aggravated assault (Sickmund, et al., 2013). Approximately 20% of offenders placed in residential facilities were placed for 91 to 180 days, approximately 14% were placed for 181 to 365 days, approximately 8% were placed for

longer than one year and the remainder were placed for somewhere between 1 and 90 days (Sickmund, et al., 2013).

AODA, mental health and educational issues

Although crime rates in our nation have dropped since the 1990's and the politicalisation of crime has abated, how to solve the costly occurrence of juvenile delinquency in the most just way continues to be the focus of evidence-based programs, data driven policies, best practices, model programs, and principles of effective programming (Kim, Merlo, & Benekos, 2013). In part, this is because around half of the youth involved in the juvenile justice system will recidivate within the first few years after release (Thompson, Ringle, Way, Peterson, & Huefner, 2010). Programming techniques are continually being innovated in attempt to reach this population. Lengthy placements create a great opportunity for the time spent to be used constructively towards rehabilitation. As such there have been several studies whose aims have identified which areas are of greatest concern amongst juveniles, and therefore, warrant the focus of rehabilitative programming.

One such widely recognized longitudinal study conducted by Northwestern University Medical School examined the health issues and outcomes of youth in juvenile detention by interviewing 1,829 youths detained in a Cook County, Illinois juvenile facility between 1995 and 1998 and again between 2001 and 2003 (Robert Wood Johnson Foundation, 2005). In this study, alcohol, drug and mental health (ADM) disorders were studied and data were collected regarding the educational deficits, criminal history, history of physical and sexual abuse, and demographic variables of participants (Teplin, 2001). In the original data collection stage funded by federal agencies, private foundations, and the OJJDP, researchers examined ADM disorders, service use, and risky behaviors (Teplin, 2001). This preliminary data suggested that more than 670,000 youth

processed in the juvenile justice system nationwide would meet diagnostic criteria for one or more ADM disorders that would require substance abuse and/or mental health treatment (Teplin, 2001). Other key findings were as follows (as cited in Robert Wood Johnson Foundation, 2005): 46.8 percent of females and 50% of males had a substance use disorder, nearly three-quarters of females and nearly two-thirds of males met diagnostic criteria for one or more psychiatric disorders, 11 percent of males and nearly 14 percent of females had both a major psychiatric disorder and a substance use disorder. Yet of those requiring treatment few would receive it, thus increasing the burden on juvenile justice facilities (Teplin, 2001).

In the follow up portion of the study funded primarily by the Robert Wood Johnson Foundation (2005), interviews were collected from 2001 to 2003. Investigators used the same instruments as the first portion of the study, including urinalysis, to assess outcomes related to substance use, abuse and dependence, as well as comorbidity of substance use with psychiatric disorders. At the time of publication, the OJJDP estimated that over 104,000 youth were in custody in juvenile facilities, and public health professionals speculated that those youth were disproportionately the victims and perpetrators of violence. Some of the key findings from the Robert Wood Johnson study (2005) were as follows:

- 90.1% of youth interviewed reported substance abuse at some point in their lives, but when combined with urinalysis results, at least 94% were shown to have done so at some point in their lives.
- 77.3% of youth interviewed reported using a substance within the last 6 months, but when combined with urinalysis results, at least 85.4% were shown to have used an illicit substance within six months.
- Half (50.7 percent) of males and 46.8 percent of females had a substance use disorder.

- 66.3 percent of females and 73.8 percent of males met criteria for two or more psychiatric disorders, including major depressive, manic, psychotic, attention-deficit/hyperactivity, alcohol use disorder, and others.
- When conduct disorder which is common among detained youth was excluded, 59.7 percent of males and 68.2 percent of females met diagnostic criteria and had a functional impairment related to the diagnosis for at least one psychiatric disorder.
- Almost 14 percent of females and 11 percent of males had both a substance use disorder and a major psychiatric disorder such as psychosis, manic episode or major depressive disorder.
- Youth with a major psychiatric disorder when compared with youth having no major psychiatric disorders, had significantly greater odds (1.8 to 4.1) of having substance use disorders.

These findings are consistent with other meta-analysis which state that youth in the juvenile justice system typically experience significantly higher rates of mental health disorders than youth in the general population (Cocozza & Skowrya, 2000). Youth in the juvenile justice system consistently experience mental disorders at twice that of youth in the general population, which are estimated to experience serious emotional disturbance at a rate of 9 to 13 percent (Cocozza & Skowrya, 2000). This means that approximately one in five youth in the juvenile justice system has a serious mental health problem (Cocozza & Skowrya, 2000). Serious mental health disorders refer to a specific diagnostic category which includes schizophrenia, major depression, and bipolar disorder (Cocozza & Skowrya, 2000). Whereas the majority of youth in the juvenile justice system qualify for a less serious mental health disorder diagnosis (Cocozza & Skowrya, 2000). For

instance, it is not unusual for 80 percent of the population in the juvenile justice system to be diagnosed with conduct disorder (Cocozza & Skowrya, 2000).

As noted in the longitudinal study conducted by Northwestern University Medical School, the presence of such significant mental health issues in our youth is highly problematic due to the high level of co-occurring substance abuse disorders (Cocozza & Skowrya, 2000). Left untreated in youth, as many as 73 percent of adult jail detainees with serious mental health disorders were found to have a dual diagnosis of substance abuse disorder (Cocozza & Skowrya, 2000).

Educational difficulties are also found significantly more often with juveniles who are involved with the juvenile justice system, such as lower IQ test results (Butler, 2011). When tested, juveniles in secure facilities average an 85 IQ, compared to the average score of 100 in the general population (Butler, 2011). Educational difficulty differences between delinquent and non-delinquent youth, which can be seen by educational subject and age group, get progressively worse as youth get older (Katsiyannis et al., 2008). Delinquent students between kindergarten and second grade had a 31% greater difficulty in reading, 30% greater difficulty in spelling, 21% greater difficulty in math, and a 22% greater difficulty in handwriting (Katsiyannis et al., 2008). Whereas delinquent middle school students had a 54% greater difficulty in reading, 51% greater difficulty in spelling, 34% greater difficulty in math, and a 32% greater difficulty in handwriting (Katsiyannis et al., 2008). In 2000, of 33,831 detained juveniles 33.4% were found to have a disability and to be receiving special education services of some type within the juvenile justice system as compared to the 8.8% of students who received services in 2001 through the U.S. Department of Education (in mainstream schools) under the Individuals with Disabilities Education Act (Quinn, et al., 2005).

According to research published by the OJJDP, effective community based alternatives should be used whenever possible (Cocozza & Skowrya, 2000). Considering the prevalence of significantly greater needs within the population of adjudicated juveniles combined with research which identifies correctional placement of juveniles as ineffective at reducing recidivism, it is no wonder why officials within the juvenile justice system have increasingly sought out the more risk appropriate, individualized, and cost efficient treatment alternative found in community based programming such as residential treatment (Austin, et al., 2005).

Residential treatment programs

History

Early on in the history of juvenile justice, reform schools were created to allow for the more humane treatment of adjudicated and at risk youth (Siegel, et al., 2006). The first was the House of Refuge which was established in 1825 (Siegel, et al., 2006), followed by the Lyman School for Boys which opened in 1848 in Massachusetts (Cole & Smith, 2005). The latter half of the nineteenth century, cottage systems were used where 20 to 40 children were placed in “group home” type houses with a set of parents, the first was established in Massachusetts in 1855 (Siegel, et al., 2006).

Following World War I, juvenile camps began to be run in a more militaristic fashion like those run by the Civilian Conservation Corps in the 1930’s (Siegel, et al., 2006). Such camps kept jails from filling up and provided low wage labor (Siegel, et al., 2006). The congregate care for the poor and parentless in orphanages and work camps shifted near the end of the 19th century towards the more current model of the residential treatment center (Brown, et al., 2013). In the 1980’s through the 1990’s however, as correctional institutions continued to crowd past capacity,

funds were shifted towards public facility growth and alternative treatments such as residential care began to be provided more frequently by smaller private sector centers which could specialize placements to fit specific mission statements such as treatment of females with mental health needs, or treatment of males with conduct disorders (Siegel, et al., 2006). Each states dependence on private facilities varies, however nationwide approximately 30% of juveniles involved within the juvenile justice system were in private facilities (Siegel, et al., 2006). In 2011 there were 18,839 juveniles throughout the United States placed in privately operated facilities according to the OJJDP Census (Sickmund, et al., 2013).

Definition and types of treatment programming

Community based residential treatment centers typically provide 24 hour supervision of juvenile offenders and at risk youth, most of whom are often non-violent (Austin, et al., 2005). According to Lee (2008) the term “residential treatment center” can be used to refer to many types of programming whose range includes wilderness camps, group homes, sex offender inpatient programs, mental health facilities similar to psychiatric units, therapeutic boarding schools, residential treatment facilities, all of which are run by a combination of multidisciplinary staff (as referenced in Bettmann, et al., 2011). Five components which have been identified to define residential treatment include: a therapeutic milieu, deliberate client supervision, multidisciplinary core team, intensive staff supervision and training, and consistent administration and clinical oversight (Bettmann, et al., 2011). Such juvenile offender treatment programs have been found to be the most effective at rehabilitation when several techniques are used in combination and the programs are comprehensive, build upon a juvenile’s strengths, and have a socially grounded position (Bettmann, et al., 2011).

According to a study conducted by Borge, et al. in 2013, within the context of therapeutic residential treatment a therapeutic milieu consists of the inpatient care of residents with dual diagnosis (more than one presenting problem) by a team of purposefully collaborated interdisciplinary professionals. These multidisciplinary core teams within a residential treatment facility are comprised of the following critical team members: psychiatrists, psychologists, social workers, nurses, occupational therapists, educators, and multidisciplinary direct care staff. Such collaboration and cooperation is important in order for psychotherapeutic work to take place in the three domains of learning in psychotherapy; alliance building and maintenance, technical interventions, and relearning. Therefore, when residents engage in a therapeutic milieu, they are able to increase personal growth, acquire knowledge, learn new habits and obtain more functional behavior. The therapeutic milieu achieves this by allowing residents to be met on equal terms in a predictable environment with a structured framework, which encourages motivation, recognition, cooperation and a sense of personal value (Borge, et al., 2013).

A community based residential treatment center goes about deliberately supervising clients via 24 hour direct care staff whose interdisciplinary teamwork engenders recognition, utilization, and the integration of the diverse perspectives and expertise of the staff (Borge, et al., 2013). These residential staff members act as caregivers and function as a surrogate family system throughout the residential treatment process (Brown et al., 2013). This sort of cooperation is achieved through shared goals, common language, intensive staff supervision and training, and consistent administration and clinical oversight (Borge, et al., 2013). Some rehabilitative programs which are comprehensively effective at treating juveniles who struggle with a combination of AODA, mental health, educational and/or delinquency issues which are often used in combination include: Cognitive Milieu Therapy (CMT), Cognitive Behavioral Therapy (CBT), Trauma Systems

Therapy (TST), and Dialectical Behavioral Therapy (DBT). Most importantly given the current social culture towards juvenile care and rehabilitation, treatment programs like those previously listed are considered most desirable because they are strength based. This means that the driving philosophies behind all of the programming within a given treatment center is meant to build upon and encourage a juvenile's strengths in order to foster a sense of responsibility and the self-confidence necessary to address their mental health challenges, chemical dependency issues or other presenting problems (Gulf Coast Trades Center, 2014).

Although some juvenile offenders may require confinement, or intensive supervision in order to become rehabilitated and to protect public safety, research published by the OJJDP has found that many can be rehabilitated effectively through community-based supervision and interventions (Austin, et al., 2005). Youth in residential settings may present an array of behaviors, but the degree to which they defy social norms and create risk to themselves and others unifies their common need for treatment (Brown, et al., 2013). Quality programs of this type must be accessible in order to ensure the "judicious use" of more expensive detention and confinement programs (Austin, et al., 2005, p.2). Community based alternatives to secure detention and confinement were created not only for the purpose of balancing the needs of the juvenile offender and the safety of the community but also to reduce overcrowding, cut the costs of juvenile detention centers, reduce the stigma of institutionalizing youths, reinforce positive relationships within communities and families, and limit youths exposure to more serious delinquent peers (Austin, et al., 2005). According to the Child Welfare League of America (2005), residential care services fulfil an essential role in providing for educational, mental health and medical services, and are a fundamental component of the service continuum for children (as cited in Bettmann, et al., 2011). Such programming has been found to be both responsive to the risks and needs of

delinquents and to have “powerful effects in reducing subsequent involvement in delinquency (Austin, et al., 2005, p. 3).”

Evidenced based therapeutic programs

Residential treatment programs work because of the sum of their components. According to Lipsey and Howell’s 2012 meta-analysis which took a sample of 548 programs, those which took a therapeutic approach by improving skills, relationships, insight, restoration (restitution, etc.), skill building (cognitive, social, academic, vocational, etc.), and offered counseling, and multimodal or multiservice interventions designed to meet the tailored needs of individual offenders (or offender groups) were the most notably effective at reducing recidivism. It has also been shown that programs which stress the collaboration of parents, social service agencies, schools and the juvenile justice system which have clear goals, have the greatest likelihood of success (Benekos & Merlo, 2004). The following are some examples of programs that fit the residential treatment model.

The Gulf Coast Trades Center (GCTC) located in New Waverly, Texas, is a residential treatment program which focuses on fostering skill building in troubled youth (Austin, et al., 2005). This program serves youth ages 16-19 who are referred by a probation officer or the Texas Youth Commission and provides education, job training, life skills planning, and aftercare (Austin, et al., 2005). According to the GCTC website (2014), they are particularly successful because of their passion driven philosophies and multifaceted individualized treatment of juvenile delinquents and at risk youth. The open enrollment Raven School on campus provides GED, vocational, and driver education training. Educational programs are provided for students based on an assessment of their grade level and beyond that, vocational classes are also offered based on student interest

in culinary arts, building maintenance, bricklaying masonry, and business information management. Support services at the GCTC include anger management, substance abuse, medical care, nutrition, self-challenge course, individual case management, individual and group counseling, after care, and job development which includes one on one coaching prior to and throughout the aftercare process. Residents in the GCTC residential treatment program live together in one of eight small groups where they experience the Positive Peer Culture treatment modality and are given privileges and responsibilities based on an incremental step system. The GCTC employs a strength based philosophy which empowers residents to utilize and develop their strengths and provides positive, predictable and nurturing environments and relationships. Residents at the GCTC enjoy a variety of recreation activities on the 57 acre campus located within the Sam Huston National Forest through the physical education program which boasts an Olympic swimming pool, a gymnasium, football field, sand volleyball court, baseball field, an outdoor covered basketball pavilion, and an indoor weight room. Through the Texas Association of Charter Schools, the youth may choose to participate in leagues and tournaments for flag football, volleyball, baseball and basketball. Juveniles placed at the GCTC also enjoy a collaboration with the Montgomery County United Way and Healing Hands Ranch through which they are taught horticulture and aquaponics. Youth leaving this program had a 16% re-arrest rate compared to 54% of youth released from the Texas Youth Commission (Austin, et al., 2005).

Another successful residential treatment center is Northwest Passages Inc., whose philosophy is to blend mental health treatment alongside teaching troubled adolescents personal responsibility (Northwest Passage, Ltd., 2014). According to the Northwest Passage website (2014), they provide a detailed clinical analysis and individually designed programming for each client. They provide practical interventions and individualized goals throughout the treatment

process and assist clients with their transition to the community through aftercare follow up services. Located in northwestern Wisconsin, there are three Northwest Passage sites which in sum provide four 8 bed houses for teen boys, a 16 bed facility for teen girls and a residential assessment center for children ages 6-18. Teachers and multidisciplinary direct care staff provide 24 hour supervision of youths housed in each facility where there are on site psychiatrists, medical professionals, therapists, and case managers. Clients at Northwest Passage receive a multifaceted treatment approach from an interdisciplinary team; this includes a psychiatric evaluation, ongoing psychiatric services, individual therapy, a variety of group therapies such as art and equine therapy, family therapy, and milieu therapy. If needed, they receive psychotropic medications and medication management with a psychiatrist throughout their placement. Northwest Passage also provides an accredited educational program tailor fit to each student and enrichment programming such as their expressive arts photography programming which includes off grounds nature ventures. Northwest Passage clients are given multiple opportunities each day to work in groups so that they may learn how to engage in healthy relationships and develop appropriate social skills within a milieu. These groups include independent living, cultural diversity, creative arts, healthy living, character development, nutrition, physical exercise, yoga, relationship and sex education, Dialectical Behavioral Therapy (DBT), Sexual Issues Group (SIG) and AODA therapy. They are also given several opportunities to complete restitution and community service projects. Residents at Northwest Passage also enjoy a strength based philosophy and incremental privileges based on a phase program like the GCTC which empowers them to utilize and develop their strengths and provides positive, predictable and nurturing environments and relationships. In 2013, Northwest Passage had the most optimal placements of any residential placement site in the state of Wisconsin (Wisconsin OHC Dashboard, 2014).

Within Wisconsin there are twenty seven residential (treatment) care centers for out of home placement of at risk or delinquent youth not including group homes, listed in the Appendix (Wisconsin OHC Dashboard, 2014). These placements generally offer many of the same standard programs available in Wisconsin's correctional facilities for juveniles as well as some additional academic, vocational, and enrichment programming (Wisconsin OHC Dashboard, 2014). Such programs include (Boggs, et al., 2008):

- Individualized case planning
- AODA treatment
- Serious sex offender programs
- Juvenile cognitive interventions
- Culturally specific services
- Individual, group and family counseling
- Anger management
- Intensive mental health services
- Alcoholics anonymous
- Recreational activities
- Parenting groups
- Victim impact programming
- Independent living services
- Trauma groups
- Spiritual/pastoral counseling
- Mentoring programming
- Restorative justice
- Adventure-based programming
- Mental health treatment
- Academic programs for a range of grades
- High school diploma programs
- Special education services
- Library services
- Computer classes
- Life works education program
- Human sexuality and health education
- Physical education and WIAA sports
- Vocational programs
- Restitution

- Community Service

Nationally 80% of juvenile facilities were designed to house only 40 or fewer residents (Schmallegger, 2009). Therefore while twenty seven available placements (not including group homes) that offer a multitude of therapeutic programming may seem like a lot of options, if each serves between 20-50 children at a time, that means that only 540-1,350 youth out of the 24,599 juveniles were deferred to juvenile court in 2010 (Hockenberry, Smith, & Kang, 2013) could have been placed into a residential treatment facility at once in the state of Wisconsin. Annually approximately 69% of youth admitted to residential care have been placed through the child welfare or juvenile justice systems (Brown, et al., 2013). So, this becomes especially problematic when one considers that these are primarily private companies providing a service to the state who at their discretion, may also take private pay (insurance or out of pocket payment) youth whose parents are exasperated with their children's conduct and want to intervene before their children's behavior or issues lead to involvement with the juvenile justice system (Bettmann, et al., 2011). Other considerations include the specific missions of each placement, or programming available at each facility; many of which are gender specific and/or only take particular types of clients (violent, non-violent, learning disabled, autistic, sex offenders, etc.) (Wisconsin OHC Dashboard, 2014). Without guidelines for an ideal community based residential treatment model, these scarce programs may not be operating as efficiently or assisting at risk and juvenile delinquent youths as effectively as possible.

Conclusion

There are several pathways from crime through the juvenile justice system and a variety of outcomes for those within it. A majority of cases referred to the juvenile court originate with law

enforcement (Schmallegger, 2009). The screening or assessment procedure which follows a juvenile's intake is a critical part of the process which could be standardized and improved upon, as discussed later in the findings portion of this paper. Of the 1,236,186 juveniles whom were referred to the juvenile court in 2011 (Sickmund, Sladky, & Kang, 2014), 61,423 were reported to have been placed in residential facilities (Sickmund, Sladky, Kang, & Puzzanchera, 2013).

More research is needed to discover if these statistics are accurate as some states distinguish delinquency and welfare cases regarding calculation of residential placements. Furthermore additional research is needed to calculate how many juveniles could have been referred to a residential facility were there a placement available for them, in order to accurately measure the demand for residential placements. This is especially important considering the significant prevalence of AODA, mental health, and educational issues among those youth involved in the juvenile justice system.

More than 670,000 youth processed in the juvenile justice system nationwide would meet diagnostic criteria for one or more alcohol, drug, or mental health disorders that would require substance abuse and/or mental health treatment (Teplin, 2001). Youth in the juvenile justice system consistently experience mental disorders at twice that of youth in the general population, which are estimated to experience serious emotional disturbances at a rate of 9 to 13 percent (Cocozza & Skowrya, 2000). This means that approximately one in five youth in the juvenile justice system have a serious mental health problem (Cocozza & Skowrya, 2000). Educational difficulties are also found significantly more often with youth who are involved with the juvenile justice system, such as lower IQ test results (Butler, 2011). Residential placements have been a response to the need to address these issues as youth in residential settings may present an array of behaviors, but the degree to which they defy social norms and create risk to themselves and

others unifies their common need for treatment (Brown, et al., 2013). As such, from their outset as reform schools, residential placements have been established for the purpose of rehabilitating youth.

The term residential treatment center can be used to refer to many types programming whose range includes wilderness camps, group homes, sex offender inpatient programs, mental health facilities similar to psychiatric units, therapeutic boarding schools, residential treatment facilities, all of which are run by a combination of multidisciplinary staff (as referenced in Bettmann, et al., 2011). Five components which have been identified to define residential treatment include: a therapeutic milieu, deliberate client supervision, multidisciplinary core team, intensive staff supervision and training, and consistent administration and clinical oversight (Bettmann, et al., 2011). Such juvenile offender treatment programs have been found to be the most effective at rehabilitation when several techniques are used in combination and the programs are comprehensive, build upon a juvenile's strengths, and have a socially grounded position (Bettmann, et al., 2011). However, community based alternatives to secure detention and confinement were created not only for the purpose of balancing the needs of the juvenile offender and the safety of the community but also to reduce overcrowding, cut the costs of juvenile detention centers, reduce the stigma of institutionalizing youths, reinforce positive relationships within communities and families, and limit youths exposure to more serious delinquent peers (Austin, et al., 2005). The placements discussed and the programming opportunities outlined show support for why community based residential treatment is effective due to the sum of its components.

Section III: THEORETICAL FRAMEWORK

The following section provides a theoretical framework supporting the use of community based residential treatment centers based upon differential reinforcement/learning theory, as created by Burgess and Akers (1966), and referenced from Tibbetts and Hemmens text (2010). This section is composed of two parts. The first discusses the definition and origin of differential reinforcement/learning theory and the second provides an application of the theory to community based residential treatment centers.

Differential reinforcement/learning theory

Differential reinforcement theory, sometimes referred to as learning theory, is largely regarded as “one of the most valid theories of human behavior, especially in regard to crime (Tibbetts & Hemmens, 2010).” Expounding upon Sutherland’s criminological theory of differential association, Burgess and Akers theory of differential reinforcement or learning theory takes all three learning processes into one theoretical model. While including classical conditioning as did Sutherland in the basis for differential association, Burgess and Akers also incorporated operant conditioning, and imitation/modeling learning theories within their differential reinforcement theory to explain how individuals learn criminal behavior through the same processes that they learn all behavior.

Classical conditioning is a type of learning which was first developed and understood by Pavlov, who used dogs to show how it works. Essentially this type of learning assumes that people and some organisms and animals are capable of unwittingly being conditioned through associations between stimuli and responses. In Pavlov’s original experiment, dogs were

conditioned to salivate at the sound of a bell (negative stimulus) after being conditioned to associate it with food (positive stimulus). This can be seen when people recall positive memories by the smell of a particular food, experience PTSD when hearing a negative sound (gunshot), etc. Applied to juvenile delinquency, one could reasonably believe that the more frequently an offender associates a positive reward with any behavior, even illegal activities, the more likely they are to engage in that type of behavior in the future. Sutherland and Burgess and Akers theories believe that as positive associations with criminal activities outweigh negative associations, criminals become conditioned towards law breaking behaviors.

Operant conditioning is a type of learning which was first developed and understood by B.F. Skinner, who experimented with mice, pigeons and other animals to show how it works (Tibbetts & Hemmens, 2010). This type of learning goes beyond classical conditioning's passive stance of the subject to show that humans and some other organisms and animals are capable of proactively seeking out rewards (positive reinforcement) and avoiding punishments (negative reinforcement). This could be seen in the original experiment when animals pressed certain levers or buttons to receive treats and avoided others which caused electric shocks. When applied to human behavior, an easy example is potty training, where parents praise and reward children who perform as desired (positive reinforcement). When children don't perform as desired, they are uncomfortable, possibly ashamed, and don't receive praise (positive punishment). When applied to criminal behavior this portion of learning theory is critical because it assumes that the criminal is not a passive actor predestined by his genetics, associations, past, or conditionings, but instead is a discerning and active participant, who considers opportunities to seek potential rewards or avoid potential punishments. This part of Burgess and Akers differential reinforcement theory considers both past and future behavior and postulates that criminal behavior is likely to occur

when its potential rewards are perceived greater than potential punishments (Tibbetts & Hemmens, 2010).

Imitation/modeling is a type of learning which was first developed and understood by Gabriel Tarde and Albert Bandura, who were able to show through a series of experiments that learning can take place without any conditioning. Bandura showed that even when unrewarded or unpunished, people and some animals are capable of learning behavior simply by observing it. Examples of such behavior can be seen when people follow fashion trends, emulate celebrities, or imitate other behaviors that they've observed people in their family or friend groups engaging in. With regards to criminal behavior this is an important theoretical perspective for differential reinforcement theory because it speaks to media, cultural, familial and peer influences that impact youths and contribute towards potential delinquency. Criminologically this theory asserts that individuals are both influenced by and choose influences whom uphold their values (Burgess & Akers, 1966).

As a positivistic theory, differential reinforcement theory assumes that individuals are born with a blank slate and as such must be taught how to behave appropriately through various forms of learning and conditioning such as operant, classical, and imitation/modeling (Burgess & Akers, 1966). This theory further posits that individuals choose and learn negative behaviors in the same ways that they choose and learn positive behaviors, which has significant implications for treatment or correction of undesirable or maladaptive behaviors in at risk and adjudicated juveniles (Tibbetts & Hemmens, 2010).

Application of theory to residential treatment centers

Each of differential reinforcement theory's learning processes can be seen within the programming of residential treatment centers, despite the fact that the term residential treatment

center can be used to refer to many types of programs ranging from wilderness camps to group homes, to sex offender inpatient programs, to mental health facilities similar to psychiatric units, to therapeutic boarding schools, to residential facilities run by a combination of multidisciplinary staff (Bettmann, et al., 2011). This is because several of the core five components which have been identified to define residential treatment including: a therapeutic milieu, deliberate client supervision, multidisciplinary core team, intensive staff supervision and training, and consistent administration and clinical oversight (Bettmann, et al., 2011) provide a parallel purpose within the context of differential reinforcement theory.

When a child is assigned to a residential treatment center, they are removed from the typical influences that they'd become accustomed to which were supporting their deviant lifestyle, furthermore they are not put in a more negatively influential environment such as juvenile detention. Residential treatment centers provide classical conditioning by offering a therapeutic milieu. Association with others who model and support pro-social and law abiding norms is one way that individuals learn positive behaviors (Burgess & Akers, 1966). The associations that one keeps are just one variable which can operate to motivate or control delinquent and criminal behavior however, promoting conformity can be very impactful (Burgess & Akers, 1966).

Residential treatment centers provide operant conditioning by offering a structure of rewards and punishments alongside skill building. The repetition of acts provide reinforcement that affects the probability that the acts will be repeated later (Burgess & Akers, 1966). In this way the juvenile sees their immediate impact through voluntary choices on reinforcers or punishments and is able to shape a response differentiation; they are then able to discriminate and generalize between stimuli (choices), make stimulus-response constellations, and eventually learn to conform their behavior accordingly (Burgess & Akers, 1966). By using operant conditioning,

residential treatment centers provide an opportunity for youthful offenders to get into a pattern of thinking before they act through use cognitive-behavioral conditioning.

Lastly, residential treatment centers provide an opportunity for imitation/modeling through the use of skilled multidisciplinary staff. These staff teach the juveniles in their care skills such as effective interpersonal communication, self-control, humility, patience, confidence and an abundance of other pro-social skills the youth may not have been exposed in their prior home lives simply by behaving that way in front of them day in and day out for the several months that the juveniles are placed there and are building relationships with them. The same imitation/modeling is possible with peers, as the youth in residential treatment centers are also able to emulate their peer's positive behaviors that they are exposed to over time.

Eventually the outcomes of residential treatment using cognitive behavioral modification counter the process through which Akers describes delinquents endorsing criminal thought and behavioral patterns. This is done by reversing these four components of criminal behavior: differentially associating with others who commit, support, and model violations of legal and societal norms, differential reinforcement of that behavior (as it's seen to yield more reward) over conformity to the norm, exposure to and observation of more deviant than conforming models and eventually, learned definitions favorable to committing deviant acts (Tibbetts & Hemmens, 2010). This is possible for residential treatment centers to achieve because social learning accounts for an individual becoming prone to criminality or deviant behavior and for the change in that propensity (Tibbetts & Hemmens, 2010).

Section IV: FINDINGS & RECOMMENDATIONS

Serious delinquents can desist in offending behavior and avoid incarceration or supervision when effective intervention programs are utilized (McGlynn, et al., 2012). Residential treatment centers have been shown to be highly effective as they provide individualized interventions in the lives of troubled youth and a variety of therapeutic programs aimed at reducing recidivism and problematic behaviors. The following section provides a discussion of which elements of community based residential treatment are effective and recommendations and obstacles regarding the implementation of each.

Individualized Care

Individualized care means tailoring treatment to fit a specific child and their needs, strengths, deficits, disorders, supports and risks. Individualized care for youth participating in residential care is necessary given that their needs, especially mental health needs, significantly deviate from the general population averages (Lee & McMillen, 2007). Thus a bureaucratic, norm-seeking approach towards the best care for at risk and delinquent juveniles would be ineffective (Lee & McMillen, 2007). There is not a “one size fits all” program for all at risk and delinquent youth. However this is not to say that standards cannot be developed or that programs should not be held accountable to the specific populations they seek to serve, rather individual needs simply call for individualized care. Recommended core components of such individualized care include individualized case management, risk assessment, and risk based program admission.

Individualized case management

Individualized case management promotes the principle that the child's worker acts as their advocate by striving to find resources for and encourage the rehabilitation of each child by focusing on their needs versus punishing offenses or structuring care based on system limitations. Individualized case management which focuses on improving future behavior in order to achieve public safety goals rather than punishing past behaviors, is more sustainable and produces larger system wide payoffs (Lipsey & Howell, 2012). Real barriers to implementing individualized case management are oversized case loads, budgetary problems providing ideal services, and in some areas, high turn around rates of juvenile offenders and at risk youth coming through the system. These obstacles create hurdles necessary to overcome in building the relationships which establish trust and uncover each area in need of repair within a child's life.

Risk Assessment

Risk assessments are tools which help to aid case managers and care providers when determining the specific areas in which a child would benefit from services. Risk management models should determine program placement and supervision levels on the basis of objective risk and needs assessments (Lipsey & Howell, 2012). Components to consider when implementing a risk assessment procedure are cost, training appropriate staff to administer tests, collaboration of the professionals required, (such as neuropsychologists, child psychiatrists, and teachers) and developing one assessment tool that is consistently helpful and used throughout the region or state. For instance, in Wisconsin the Child and Adolescent Needs and Strengths (CANS) tool is used. From adequate assessments, individualized treatment plans can be created and youth can be placed into programs which most appropriately accommodate their needs and risk (Lipsey & Howell, 2012). This in turn allows the juvenile to have a better chance at receiving services matched to their needs and thus be more likely to become rehabilitated.

Risk appropriate programming

Placements should provide services to children with similar risk levels for the most successful milieu experiences. Many researchers have identified juvenile treatment program success to be reliant upon interventions being relevantly clinically matched to the needs and risks of clients (Jones & Wyant, 2007). Palmer's risk assessment model argues that when the case manager has access to risk and needs information about a juvenile, the potential success of their treatment is maximized because the juvenile client can then be matched to specific services provided by juvenile programs (Jones & Wyant, 2007). Andrews (2001) furthered the concept of risk-need-responsivity via stating that programs should prioritize treatment to medium/high risk juveniles so that specific criminogenic needs are most targeted. Lipsey and Howell found that positive intervention effects such as reductions in recidivism were found across differences in mean age, gender or ethnic mix of juveniles in residential treatment (2012), especially when grouped by risk. By focusing on providing risk appropriate services to juveniles, community based residential treatment services provide the most cost effective care possible. On average, interventions applied to high risk delinquents produced larger recidivism reductions (Lipsey & Howell, 2012). This reinforces the claim that research evidence most supports interventions whose primary aim is the treatment of the higher risk juveniles (Lipsey & Howell, 2012). Obstacles to this initiative are primarily found in staffing and funding programs aimed to help more high risk children who are often the most difficult to supervise and require longer placements and more extensive services.

Integrity

Another important component of successful community based residential treatment is integrity. As discussed earlier, there are several types of programming used frequently in

community based residential treatment centers; for this reason, it is important that each are accurately describing the services they are using (preferably using the same nomenclature) and are conducting them correctly. Without integrity, community based residential treatment centers are likely to be improperly categorized, evaluated, and poorly matched to the youth they serve. Recommendations to foster integrity in programming within residential treatment centers are to utilize multifaceted cognitive behavioral treatment, future focused, and skill building programming that is facilitated by well trained staff who provide an environment of meaningful modeling within an appropriate time for that specific type of placement.

Quality Programming

According to a meta-analysis which took a sample of 548 programs, those which took a therapeutic approach by improving skills, relationships, insight, restoration (restitution, etc.), skill building (cognitive, social, academic, vocational, etc.), and offered counseling and multimodal or multiservice interventions designed to meet the tailored needs of individual offenders or groups of offenders, were notably more effective at reducing recidivism (Lipsey & Howell, 2012). This included every generic program nested within the broader categories which fit these requirements. However, specifically cognitive behavioral interventions have shown the most promise for reducing recidivism in the juvenile population (Thompson, et al., 2010). One of the primary obstacles necessary to overcome when implementing this type of programming is the shift from punitive/punishment focused care to future focused and skill developing treatment. Cognitive behavioral treatment models are able to encourage a child to accept responsibility for behavioral problems and change them by helping youth to uncover their individual skills and develop them alongside consistent structure, positive reinforcement and effective counseling.

Fidelity

Well trained, impassioned, staff working as a multifaceted team are crucial to the process of effectively carrying out rehabilitative youth programming. Lipsey and Howell found through their meta-analysis that positive effects such as reductions in recidivism could be found for average program types which met their definition for a treatment program (2012). This means that programs operating as such can be assumed to be effective but only if implemented with fidelity to the protocols which match the characteristics of corresponding programs with average or above average effects (Lipsey, & Howell, 2012). This can only be ensured if providers are well trained, use defined protocol, and their adherence to that protocol is monitored (Lipsey, & Howel, 2012). When this occurs, staff can provide truly meaningful modeling for youth which reinforces the programming structure and purpose within community based residential treatment.

Time Management

In order to match the researched evidence of effectiveness to any generic residential treatment program, the program must show average positive effects within the average amount of time given for supporting program types (Lipsey, & Howell, 2012). When Lipsey summarized over 500 studies on juvenile offender programs, he found that those with the lowest recidivism rates were staffed by treatment staff versus law enforcement personnel, lasted for at least 6 months, used a well-articulated treatment model implemented with fidelity and had been in operation for at least 2 years (Thompson, et al., 2010). This supports the notion that treatment is most effective for juveniles when they spend the appropriate amount of time in the correct placement. Increasing opportunities for autonomy and freedom within a placement or lowering tiers of restriction via transfer to a new placement help youth transition back into the community more successfully, as they are able to test using their treatment skills with the support network of treatment staff still involved in their care. As such, residential treatment centers need to determine what an optimal

length of stay is given their programming and case mix so that it isn't defined by bureaucratic funders and regulators looking to confine costs (Lee, & McMillen, 2007).

Aftercare and Accountability

Promising programs incorporate aftercare, emphasize teaching positive interactions with peers and adults, provide consistent and fair discipline, use consequences for positive and negative behavior, monitor and supervise youth activities, ensure a lack of opportunity for youth to associate with peers who continue to engage in antisocial behavior, promote positive behavior and academic achievement, and develop formal and informal support in the youths family environment (Thompson et al., 2010). Aftercare and accountability are core elements of effective community based residential treatment. Research has shown that the longer an adolescent is in treatment and/or participates in aftercare programs, the less likely they are to relapse (Jones & Wyant, 2007). Components of effective aftercare and accountability in community based residential treatment include connecting services to the community and family, fair evaluation protocol, providing opportunities for feedback, and maximizing efficiency and impact. The following section discusses recommendations and obstacles regarding the implementation of each.

Making connections

After a juvenile has been placed out of the home for a significant period of time, aftercare is the transition step between that placement and being back at home full time. Ideally the same case manager who has monitored the out of home placement of the child will continue to facilitate their aftercare supervision by helping to reconnect them with their family and community, as well

as the resources available to them there. The most effective aftercare interventions that have been supported by research conducted by the OJJDP, have reduced recidivism through impacting the factors that influence delinquency (McGlynn et al., 2012). Such programs support the use of aftercare as the youth are in care and transitioning back home into their communities (Thompson, et al., 2010). The three components found most important in effectively preparing youth for successful reentry into the community are 1) discharge planning throughout the duration of out of home placement, 2) involvement of aftercare staff throughout the out of home placement and transition process, and 3) the use of re-integrative services which guarantee effective service provisions and appropriate social control levels (Thompson, et al., 2010). The most common issues with providing effective aftercare are large case loads, budgets which don't promote frequent home visits and a lack of resources in communities.

Evaluation protocol

Effective evaluation protocols must be established which take into account a risk-adjustment that do not penalize residential treatment centers that take on higher risk or more challenging case mixes in comparison to other facilities (Lee & McMillen, 2007). Ideally, standardized report cards which rate care across providers would be developed to outline residential treatment facilities expected outcomes and actual outcomes (Lee & McMillen, 2007). This is a far more productive approach than comparing all facilities to each other. Accurate evaluation translates to better care for a vulnerable population, more easily replicated results, and a platform for further advancement and refinement of treatment for at risk and delinquent youth (Lee & McMillen, 2007).

Gaining feedback

In order for completely genuine program evaluations to occur, ongoing and accurate evaluations of residential programs outcomes compared to their expected outcomes need to be collected, and appropriate risk assessment tools which define the case mix of each facility are needed (Lee & McMillen, 2007). Were this feedback sought out, collected and published, facilities could greatly improve services, enhance consistency across placements offering similar services, and better foster involvement with the youth placed in their programs and their families. Quality indicators and standards for residential care could then be established which could heighten fiscal accountability among programs (Lee & McMillen, 2007). The opportunity for feedback to be provided to residential treatment facilities is an area in need of development.

Maximizing efficiency and impact

Evaluation protocol must also take into account the benefits gained from programs weighed against the costs in order for the evaluation to be relevant and useful in policy decisions (MacKenzie, 2000). Thus far, community based residential treatment has been shown to be both effective and efficient at reducing recidivism. Furthermore, for each dollar spent on programming, the public receives between \$1.13 and \$7.14 in returned savings (McGlynn, et al., 2012). On top of reductions in recidivism and lowered costs of programming, other benefits received from reducing juvenile delinquency are reduced costs to victims, increased employment earning, and savings to public welfare and health care (McGlynn, et al., 2012). There are lots of costs associated with juvenile delinquency such as over-reliance on social services, loss of productive workers, increased crime, increased incarceration rates, and the physical and mental health care of those in the states care (Thompson, et al., 2010). It is estimated that saving a high risk adolescent from a life of crime will save an average of 2.6 to 5.3 million (Thompson, et al., 2010).

Section V: SUMMARY & CONCLUSIONS

This seminar paper provided a review of literature concerning which needs are most critical for residential placements to address in delinquent and at risk youth, as well as a discussion of which components of community based residential treatment are necessary to promote success. Support for an ideal community based residential treatment model was provided through a discussion of key programming recommendations and by highlighting model programs that appear to address such issues. Effective community based residential treatment facilities aim their programming at serving high risk youth with significant mental health, educational, and AODA issues. By balancing the needs of the juvenile offender and the safety of the community, they reduce overcrowding, cut the costs of juvenile detention centers, reduce the stigma of institutionalizing youths, reinforce positive relationships within communities and families, and limit youth's exposure to more serious delinquent peers (Austin, Dedel, Johnson, & Weitzer, 2005).

In 2011 a total of 1,236,186 juveniles were referred to juvenile court in the United States (Sickmund, Sladky, & Kang, 2014). Of those juveniles, 61,423 were placed in various types of residential facilities nationwide (Puzzanchera, Sladky, & Kang, 2014). Juveniles can end up in a residential facility via consequence due to adjudication, violation of conditional release or probation, or via private placement by their caregiver. This research has shown that youth in this population experience significantly elevated reported incidences of alcohol and other substance abuse/dependence problems, as well as severe mental health disorders and disturbances. Furthermore, they experience a higher rate of dual diagnosis as youth (in residential treatment) with a major psychiatric disorder when compared with youth having no major psychiatric

disorders, had significantly greater odds (1.8 to 4.1) of having substance use disorders (Robert Wood Johnson Foundation, 2005). Another compounding issue for this population are educational difficulties which are highly elevated amongst juveniles in residential treatment; this stands to only further complicate their successful treatment and rehabilitation.

Considering the increased rate of unique needs among these youth, individualized treatment has become the established treatment ideal. This treatment modality has been made possible by the privatization of residential treatment facilities which can provide community based, specialized therapeutic options. Although there are many labels and different types of therapeutic interventions associated with community based residential treatment, the five components which have been identified to define residential treatment include: a therapeutic milieu, deliberate client supervision, multidisciplinary core team, intensive staff supervision and training, and consistent administration and clinical oversight (Bettmann, et al., 2011). The most effective of these programs provide rehabilitation through the use of several techniques used in combination (multimodal) and the programs are comprehensive, build upon a juvenile's strengths, and have a socially grounded position (Bettmann, et al., 2011).

As discussed in the findings section, recommendations for ideal community based residential treatment beyond the previously listed program components are to provide individualized care with integrity, accountability, and aftercare services. In order for this to be possible, government funding should be directed to programs which focus on the highest risk youth and more research is necessary especially in the development of assessment tools for these youth and the programs that serve them. Within residential treatment facilities, it will also be necessary for leadership to espouse a philosophy and mission of providing creative individualized

programming which empowers youth with complicated treatment needs to make meaningful changes in their lives.

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Section VII: APPENDIX

List of Residential Care Centers/Residential Treatment Centers available in Wisconsin

(Wisconsin OHC Dashboard, 2014):

- Benet Lake Child and Adolescent Treatment Center
- Carmelite Home Inc.
- Casey House
- Chileda Institute Inc.
- Eau Claire Academy
- Family Services
- Family and Children's Center
- Genesee Lake School
- Homme Youth & Family Programs
- Lad Lake
- Lakeview Specialty Hospital and Rehabilitation
- Milwaukee Academy
- Mother Kathryn Daniels Conference Center
- Norris Adolescent Center
- Northwest Passage Child and Adolescents Center
- Northwest Passage I
- Northwest Passage II
- Northwest Passage III
- ODTC – Cheryl House
- Rawhide Inc.

- Saint A. Inc.
- Sawyer House
- St. Charles Inc. – F. Bldg.
- St. Rose Youth & Family Center Inc.
- Tomorrows Children Inc.
- Washington Co. Youth Treatment Center
- Willowglen Academy – Main Bldg.