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Examining the impact of a juvenile justice diversion program for youth with behavioral health concerns on early adulthood recidivism

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ABSTRACT

The majority of juvenile justice-involved youth report significant behavioral health and trauma concerns. The complexity of the needs of these youth have led many jurisdictions to develop diversion programming as an alternative to detention. While evidence exists that these programs can produce positive outcomes, particularly as they relate to juvenile recidivism, much less is known about their impact on adult offending. To explore this, we examined data from Ohio's Behavioral Health Juvenile Justice (BHJJ) Initiative, a diversion program for juvenile justice-involved youth with behavioral health issues. Three groups were examined, youth appropriate for BHJJ but who did not participate, youth who participated but did not complete treatment, and youth who successfully completed treatment. Results indicated youth who successfully completed BHJJ had lower odds of offending as young adults and fewer young adult offenses compared to youth who completed unsuccessfully or who did not participate. Implications for juvenile diversion programming are discussed.

1. Introduction

The majority of youth involved with the juvenile justice system report significant mental health and/or substance abuse issues (i.e. behavioral health issues). Many researchers report that between 65 and 75% of juvenile justice-involved youth have at least one mental health or substance abuse disorder and 20% to 30% report suffering from a serious behavioral disorder (Cocozza & Skowyra, 2000; Shufelt & Cocozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). Rates of similar behavioral disorders among the general adolescent population are far lower (Collins et al., 2010; Cuellar, McReynolds, & Wasserman, 2006; Friedman, Katz-Levy, Manderscheid, & Sondheimer, 1996; Merikangas, et al., 2010; Otto, Greenstein, Johnson, & Friedman, 1992; U.S. Department of Health and Human Services, 1999). Common diagnoses include Disruptive Behavior Disorders (e.g. Conduct Disorder), Mood Disorders (e.g. Depression), and Anxiety Disorders (e.g. PTSD) (Arroyo, 2001; Beringer, 2007; Cuellar et al., 2006; Teplin et al., 2002). Teplin et al. (2002) found that even when the commonly diagnosed Conduct Disorder was excluded from their sample, nearly 60% of males and over two-thirds of females continued to meet diagnostic criteria for at least one additional disorder.

Juvenile justice-involved youth also experience disproportionate levels of trauma and violence exposure compared to youth in general (Arroyo, 2001; Butcher, Galanek, Kretschmar, & Flannery, 2015; Cauffman, Feldman, Watherman, & Steiner, 1998; Ford, Chapman, Hawke, & Albert, 2007; Hennessey, Ford, Mahoney, Ko, & Siegfried, 2004; McLaughlin et al., 2013; Steiner, Garcia, & Matthews, 1997; Wasserman & McReynolds, 2011). One study found over 60% of juvenile detainees reported a history of psychological trauma (Ford, Hartman, Hawke, & Chapman, 2008) while another study found that over 90% of juvenile detainees reported experiencing one or more traumas, with an average of over 14 separate incidents (Abram et al., 2004). Juvenile justice-involved youth are more likely to experience multiple forms of victimizations, known as poly-victimization, than youth from the general community (Ford, Elhai, Connor, & Frueh, 2010; Ford, Grasso, Hawke, & Chapman, 2013). Furthermore, studies have found between 11% and 50% of juvenile justice-involved youth met criteria for Posttraumatic Stress Disorder (PTSD) (Abram et al., 2004; Arroyo, 2001; Garland et al., 2001; Ko et al., 2008; Teplin et al., 2002; Wasserman et al., 2002).

1.1. Juvenile justice/behavioral health diversion programs

The prevalence of juvenile justice-involved youth with behavioral health issues has led to increased attention on the most effective ways to care for these youth. In many cases, the first time a youth is screened for behavioral health problems is at intake to the juvenile justice

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system. While these services are important, the justice system is often ill-prepared to properly assess and treat these youth (Cocozza & Skowyra, 2000; Skowyra and Cocozza, 2006; Teplin et al., 2002; U.S. Department of Justice, 2005). As a result of the increasing number of youth entering the juvenile justice system with behavioral health issues and the lack of sufficient care in these facilities, many communities have begun to rethink their approach to juvenile justice. Many jurisdictions have developed diversion programs or specialized dockets, including mental health and drug courts, as an alternative to detention placements or traditional juvenile court processing. These programs allow for in-depth assessment and more comprehensive and evidence-based treatment and supervision services than are available in most juvenile justice facilities. Allowing youth to remain in the community also allows them to participate in treatment modalities best delivered in community settings, such as family-based treatment.

There are few published evaluations of juvenile justice diversion programs that target youth with behavioral health issues. The studies that are published generally support the effectiveness of these programs, particularly around reductions in future juvenile delinquency and out of home placements compared to previous rates or comparison groups who received more traditional court processing (Colwell, Villarreal, & Espinosa, 2012; Cueller, McReynolds, & Wasserman, 2006; Kretschmar, Butcher, Flannery, & Singer, 2016; Lyons, Griffin, Quintenz, Jenuwine, & Shasha, 2003; Schwalbe, Gearing, Mackenzie, Brewer, & Ibrahim, 2012; Sullivan, Veysey, Hamilton, & Grillo, 2007). While recidivism and other juvenile justice-related outcomes are often the focus of many evaluations of these programs, those that collect behavioral health outcome data report improvements in areas such as mental health functioning, problem severity, drug and alcohol use, and trauma symptomatology (Colwell et al., 2012; Kretschmar et al., 2016; Kretschmar, Butcher, Kanary, & Devens, 2015; Lyons et al., 2003).

While some evidence suggests that these diversion programs can produce positive outcomes, particularly as they relate to future juvenile delinquency, much less is known about the impact that juvenile diversion programs have on adult outcomes. Juvenile diversion programs have been found to reduce future juvenile delinquency, but do those effects extend to adult offending? Very little research has been conducted on adults who took part in diversion programming as youth or on the longitudinal impacts of the treatment models that are typically used in these programs. And while a few studies have found treatment modalities designed for juvenile justice-involved youth can have positive, long-term benefits for participants, much more research is needed to understand how these models and programs impact the participant into adulthood (Gordon, Graves, & Arbuthnot, 1995; Sawyer & Borduin, 2011; Schaeffer & Borduin, 2005; Timmons-Mitchell, Bender, Kishna, & Mitchell, 2006).

1.2. Current study

A principal intent, whether explicitly stated or implied, of juvenile justice-related diversion programs is to reduce future offending. Ideally, this reduction in offending would extend into adulthood, and in particular, early adulthood. The types of interventions employed by diversion programs, particularly those that address behavioral health issues, should strive to produce effects that last well beyond the actual time in treatment. However, as noted, there exists very little evidence of the impact of such programming into early adulthood. The current study addresses a gap in the literature by examining the impact of juvenile justice diversion programming for youth with behavioral health issues on early adult offending. Specifically, we examined early adult offending between ages 18 and 19 years.

The research questions are: 1. What are the odds of being charged with an adult offense given treatment group membership? 2. What are the odds of increasing frequency of adult offense charges given group membership? 3. How do times to first adult charge vary according to group membership? 4. How is group membership, in consideration of other covariates, associated with the rate of being charged with an adult offense the first time? 5. How is group membership, in consideration of other covariates, associated with the rate of being charged with an adult offense multiple times over the course of a year?

We identified six study hypotheses: 1. Youth who are identified for but do not participate in diversion programming will have the highest odds of being charged with an adult offense, followed by youth who participate but do not complete diversion programming (non-completers), compared to youth who participate in and successfully complete diversion programming (completers); 2. Youth who are identified for but do not participate in diversion programming will have significantly more adult offense charges than non-completers and completers, and non-completers will have significantly more adult offense charges than completers; 3. Those eligible but who did not participate in diversion will have a first adult charge sooner than those who participated but did not complete and those who participated and completed; 4. Compared to those who participated and either did or did not complete, not participating in diversion increases the risk of being charged with an offense as an adult; 5. Those who participated but did not complete diversion will have higher odds of committing a first adult offense compared to those who participated and completed; and 6. Compared to those who participated and did or did not complete, those who were eligible but did not participate in diversion will have higher odds of committing multiple adult offenses over the course of a year.

2. Methods

2.1. Study population

Participants in this study are youth who were identified as appropriate for a juvenile justice diversion program for youth with serious behavioral health issues in Montgomery County, Ohio called the Behavioral Health Juvenile Justice Initiative (BHJJ) (Kretschmar et al., 2016; Kretschmar, Butcher, & Flannery, 2013). The intent of the BHJJ project is to transform the local systems' ability to identify, assess, evaluate, and treat multi-need, multi-system youth and their families and to identify effective programs, practices, and policies. The initiative was designed to divert juvenile justice-involved youth with mental health or substance use issues from either local detention centers or state-run juvenile prison and into community and evidence-based behavioral health treatment.

Montgomery County, Ohio has operated the BHJJ program since 2005. From 2005 to 2007, the project served only female juvenile offenders. Currently, the program serves females and males between the ages of 10 and 18 who are involved with Montgomery County Juvenile Court and who have at least one DSM diagnosis. The local juvenile court serves as the entry point into the program. Youth who come into contact with the court are screened for behavioral health issues. First-time offenders are eligible to participate, although the project targets youth who have a history of offending. If a youth screens positive, a fuller assessment is conducted to determine if the youth meets criteria for BHJJ. The assessment is conducted by a local behavioral health agency through a contract with the court. If the youth meets criteria and a judge or magistrate agrees to allow the youth to be referred to the program, the family is given the option to participate in BHJJ. All youth and families participating in the BHJJ program are referred into Functional Family Therapy (FFT) (Alexander & Parsons, 1982; Alexander, Waldron, Robbins, & Neeb, 2013).

2.2. Functional family therapy

Functional Family Therapy (FFT) is a family and strength-based treatment model appropriate for youth between 11 and 18 who have been referred for behavioral or emotional problems by various child-serving systems, including: juvenile justice, mental health, child welfare, and schools (Alexander et al., 2013; Alexander & Parsons, 1982).