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ALTERNATIVES FOR YOUTH: A MENTAL HEALTH PERSPECTIVE

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Abstract of the Dissertation

ALTERNATIVES FOR YOUTH: A MENTAL HEALTH PERSPECTIVE

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Since the 1980's, the common practice in handling juvenile justice involved youth in the United States has been with punitive sanctions and institutional placement. The general agreement among policy makers, politicians and juvenile justice professionals is that there is a better way to help these young men and women than with institutional placement or detention. It has been shown that most youth involved in the juvenile justice system can be better served by community based supports grounded in evidence based principles and practices.

The purpose of this study was to discover the factors associated with successful outcomes and failures for youth involved in a juvenile justice diversion program in Suffolk County, New York. The subjects in this research project were all participants in the Suffolk County Alternatives For Youth Program during their first year of operation, from October 2005 until October 2006 (573 youth). AFY uses a "wraparound" approach involving the collaboration and coordination of juvenile justice, child welfare, mental health and other youth service providers to provide short term intensive assessment and intervention services. The objective of this program is to provide at risk youth and families referrals to services and supports needed to prevent involvement in the juvenile justice system.

Through examining the juvenile justice outcomes of the AFY participants, 85% (n=486) did not require any additional court involvement or placement up to five years post AFY intake. Of the remaining 87 participants, 71 (12.4%) were deemed a juvenile delinquent and 16 (2.8%) were adjudicated a "PINS" (status offender) by Suffolk County Family Court. The outcome data also showed that only 1.9% or 11 youth (of 573 AFY participants) were placed in a residential facility, and only 4.9% (28) of the AFY youth received probation or juvenile drug treatment court.

DEDICATION

This dissertation is dedicated to my family. First, to my children, Emily and Jacob, who hopefully one day will understand how much they provided my motivation and determination to complete this process. To my husband David, who provided not just love and support, but without you, the three most important accomplishments in my life would never have happened.

To my mother, Estelle, who had been my editor of papers since I learned to write. Your wisdom, compassion and strength will always be an inspiration. You have supported and inspired me throughout my life and for that I am eternally grateful. Finally, to my sisters (and sister in- laws), brothers (and brother in- laws), family and great friends whose support and encouragement never waivered.

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CHAPTER I
INTRODUCTION

Since the 1980's, the common practice in handling juvenile delinquent behavior in the United States has been with punitive sanctions and institutional placement. Over the years billions of dollars have been spent, an average of $210,000 per youth, per year, and consensus is that this approach has failed (Vera Institute, 2009). As a result, there is agreement among politicians, juvenile justice and child welfare professionals that the placement of youthful offenders in residential facilities is a costly and ineffective approach to dealing with the problem of juvenile offenders. Overwhelming research has shown that juvenile delinquents and status offenders have an abundance of mental health, educational, and substance abuse problems that are not adequately addressed in the juvenile justice system (Vera Institute, 2009, Annie Casey Foundation, 2008). As a result, many leave the juvenile justice system and return to the adult criminal justice system just a short time later. The most recent recidivism data indicate that of all youth released from New York State custody between 1991 and 1995, 75% were re-arrested, 62% re-convicted, and 45% were re-incarcerated within three years (Federick, 1999). Clearly, something needed to change.

The institutionalization of youth is a nationwide problem and in most states the largest portion of the juvenile justice budget is spent on confining youth, either in correctional facilities or detention centers pending trial or placement (Annie Casey Foundation, 2008). On any day, it is estimated that 100,000 young people nationwide are "in placement" in juvenile institutions, residential treatment centers, or group homes by order of juvenile court (Sickmund et al, 2005). The reliance on institutional placement is an upsetting solution for many since the majority of the youth placed in facilities were not a risk to public safety. The alternative solution of community

based “treatment” or alternatives to placement of delinquent youth have been viewed by some as being “too soft” on crime and a risk to the community.

The effective management of juvenile delinquent behavior has always been a challenge in the United States. To understand the difficulty that policy makers and juvenile justice professionals struggle with in how best to intervene with troubled and delinquent youth, it is important to review the history of the juvenile justice system in the United States.

The History of the Juvenile Justice System

The first juvenile delinquency court was established in the United States in 1899. Prior to that, America followed the British traditions and categorized young people into either “infant” or “adult”. A child under seven years old was presumed incapable of criminal intent and exempt from prosecution. Children ages seven through 14 could try the “infancy defense” to convince the court of their incapacity for criminal intent. If the prosecutors were “successful” the child could face criminal penalties including imprisonment or death. Children over 14 were always prosecuted and punished as if they were adult criminals (Grossman & Portly, 2005).

In the 1800’s, members of the Society for the Prevention of Cruelty to Animals started a movement for prevention of cruelty to children (believing that animals were treated better than children). This movement helped establish separate courts for juveniles and adults. The first juvenile court in the United States began in Cook County, Illinois in 1899. The court established a comprehensive set of policies to regulate the treatment of dependent, neglected and delinquent children. The court was charged with promoting the welfare of children in trouble to avoid the stigma of being a criminal and “ as far as practical, treat children not as criminals but as children in need of aid, encouragement and guidance” (Trattner, 1989).

By 1925, all but two states had established juvenile courts based on the British doctrine of *parens patriae* (the state as parent). This doctrine allowed states to intervene in the lives of children without the consent of parents. This approach included the concept of individualized justice, where each child receives individualized treatment based upon their situation and circumstance. Distinguishing it from the adult criminal justice system, the concept of individualized justice remained the hallmark of the juvenile justice system (Grossman & Portly, 2005).

In the 1960's and 1970's there were three U.S. Supreme Court decisions which caused the pendulum to shift from the *parens patriae* doctrine to "punishment" oriented outcomes. These three Supreme Court decisions were: *Kent v. United States* (1966), *In re Gault* (1967), and *In re Winship (*1970). The outcomes of these decisions provided youth more rights including the right to an attorney, due process, and the burden of proof to beyond a reasonable doubt. Although the intent of these decisions were to provide youth with more rights, during this period, juvenile delinquency courts began to use the words "punishment" and "accountability". The juvenile courts started focusing on the criminal nature of delinquent acts and adopted the essential due process rights afforded to adult criminal defendants. This shift also caused increased concern for the youth who had committed acts that would not be considered criminal if committed by adults- referred to as status offenders. The Juvenile Justice and Delinquency Prevention Act of 1974 was passed to limit the placement of status offenders in secure detention or correctional facilities (Grossman & Portly, 2005).

The category of "status offender" was a way to separate juveniles who had committed crimes, from truants, runaways, underage drinkers, and others who had broken rules applying only to children. In 1961, California was the first state to create a special category for status

offenders. In 1962, New York State passed the Family Court Act distinguishing their status offenders, referred to as Person's In Need of Supervision (PINS), from juvenile delinquents. New York State defined a PINS as a "male less than 16 years of age and a female less than 18 years of age who does not attend school in accord with… the education law or who is incorrigible, ungovernable or habitually disobedient and beyond the lawful control of parent or other lawful authority or who violates the provisions section 221.05 of the penal law [unlawful possession of marijuana]" (New York Family Court Act Section 712). The courts later declared the difference in the cutoff ages for males and females unconstitutional and until 2001, the New York PINS jurisdiction was limited to youth under the age of 16 (Souweine, 2001).

The next major shift in the juvenile justice system began in the 1980's in response to the rapid escalation in the volume and seriousness of youth crime. There was a growing public perception that delinquency courts were "soft" on crime and many state legislatures significantly modified their juvenile justice systems to address this concern. Since then, the focus of handling juvenile delinquent behavior in the United States has been with punitive sanctions and institutional placement.

With the simple slogan, "adult time for adult crime" there was a momentum to prosecute youth in adult courts and punish them in the adult corrections system (Annie Casey Foundation, 2008). Paradoxically, the new momentum for punishing youthful offenders as adults gained popularity as new empirical evidence demonstrated that punishing youth as adults was based on false foundations and had negative results (Annie Casey Foundation, 2008). Many scientific studies defended the belief that children are not just "mini adults". New technologies in neuropsychology have shown that the brain functioning associated with impulse control, planning and thinking ahead, are still developing during adolescence and continues beyond the

age of 18. Research confirmed that many adolescents lack the ability to assess risks and consequences, control impulses, manage stress and resist peer pressure (MacArthur Foundation Research, 2008; American Medical Association, 2005). Lastly, one study had revealed that the most important difference between adolescent and adult offenders is that most youthful offenders will outgrow lawbreaking as part of the normal maturation process (Elliott, D.S., 1994).

Contrary to the timing of these findings, virtually every state amended law in the 1990's to increase the number of youth transferred to criminal court and tried as adults. The justification for charging youth as adults was that it would reduce crime. (Annie Casey Foundation, 2008). Youth tried and punished as adults are more likely to recidivate and laws prosecuting youth as adult offenders do not decrease juvenile crime rates (Annie Casey Foundation, 2008). New York is one of only three states that statutorily define age 15 as the cut off point for juvenile jurisdiction. Any child, who allegedly commits a crime at age 16 or older, regardless of the offense, is processed in the adult criminal justice system. In New York State, youth who are arrested may fall into two categories:

> Juvenile Delinquent (JD): A youth who was found by family court to have committed an act while between the ages of 7 and 15 that would constitute a crime if committed by an adult.
>
> Juvenile Offender (JO): A youth who committed a crime while under the age of 16 and was tried and convicted in the criminal (adult) court rather than family court, due to the severity of the offense (Vera Institute of Justice, 2009)

New York State has also been reforming responses to Person's In Need of Supervision (PINS). PINS youth are status offenders (under 18 years of age) who enter the juvenile justice system for non-criminal behavior such as truancy, incorrigibility, or running away. In New York State, 2001 PINS reform legislation increased the age for filing a PINS petition from (under) 16

to (under)18 years of age. A few years later, New York State's Family Court Act was amended (2005) to enhance diversion requirements for PINS cases and discourage the filing of PINS court petition (to narrow the circumstances which PINS youth may be detained) (Salsich et al., 2008). According to New York State statute, Juvenile Delinquents (JD's) can be admitted into both secure and non-secure facilities, while PINS youth may only be detained to non –secure facilities (Salsich et al., 2008).

Placement or Treatment?

The general agreement among policy makers, politicians and juvenile justice professionals is currently that there is a better way to help these young men and women than with institutional placement or detention. States across the country have been developing and implementing new programs to address the great needs of juvenile justice youth. The nation's approach to juvenile justice had previously been costly, discriminatory and ineffective (Annie Casey Foundation, 2008). Luckily new policies, practices and programs have recently emerged gaining support and attention for being effective alternative solutions to the institutionalization of our high risk youth.

It has been shown that most youth involved in the juvenile justice system can be better served by community based supports grounded in evidence based principles and practices. Since it has been documented that up to 70% of youth in the juvenile justice system suffer from mental health disorders (Skowkra & Cocozza, 2001), a model of effective strategies, policies and services aimed at improving services for youth involved in the juvenile justice system received national recognition (Skowkra & Cocozza, 2001). Research indicates that community- based alternatives to placement often produce lower recidivism rates than placement (Drake et al, 2009; Holman & Zeidenberg, 2006; Skowkra & Cocozza, 2001). The shift is to keep youth at

home where they can access community based services (Drake et al, 2009). The New York Task Force on transforming juvenile justice has a number of strategies in hopes to improve alternative to placement programs. One of the strategies states that New York needs to broaden the evidence based field by supporting and conducting evaluations of new, innovative programs that apply the principles of best practice (Vera Institute, 2009).

Alternatives For Youth

This study is a descriptive evaluation of one of the new innovative programs in Suffolk County, New York which is an alternative to residential placement and a diversion program designed to prevent any court involvement for the youth and their families. Alternatives For Youth (AFY) uses the "wraparound approach" to the treatment of juvenile youth. AFY assesses the needs of the high risk youth and their families in an attempt to address the issues underlying problem of the problematic behavior of the youth. The symptoms usually include incorrigible behavior, truancy, substance abuse, educational difficulties and for most of them, severe and multiple mental health needs. The purpose of this study is to explore the sociodemographic variables, behaviors and clinical diagnoses of the AFY participants and gather information on how the AFY program may divert youth from institutionalization and court involvement.

Young people bring an excess of problems to the courts. However, because mental health needs are often at the core of many of these issues and often overlooked or untreated, the mental health needs of the young offenders will be the focus of this descriptive study.

CHAPTER II

REVIEW OF THE LITERATURE

Juvenile Justice and Mental Health

One of the most pressing problems facing the juvenile justice system is the inability to address the serious mental health issues of youth it serves. Experts support the claim that youth with mental disorders are a significant portion of the youth who appear in juvenile courts (Teplin et al., 2003; Otto et al., 1992). Recent statistics cite approximately 70% of youth in the juvenile justice system suffers from a mental health disorder and 25% of these youth are suffering from a severe mental health disorder (Cocozza & Skowyra, 2007). The incidence of mental disorders among youth in the juvenile justice system has been reported at two to three times higher than the general population (Ruffalo et al., 2004). Numerous studies also indicate that up to 80% of foster children have a developmental or mental illness and they are over-represented in the juvenile justice system (AACAP, 2001). Despite their disproportionate mental health needs, the lack of mental health services and resources continues to be a problem for both the child welfare and juvenile justice systems (Ruffalo, et al., 2004).

Contact with the juvenile justice system is frequently the first and only opportunity that some youth have to receive help (Cocozza & Skowyra, 2007). Unfortunately, this opportunity to intervene early is often wasted by the juvenile systems and youth do not get the services they need (Cocozza & Skowyra, 2007). In addition, many youth are detained in the juvenile justice system for minor, nonviolent offenses simply due to a lack of community based treatment options available to them (Cocozza & Skowyra, 2007). In an article entitled “Mentally Ill Offenders Strain Juvenile System,” a Texas psychiatrist at the Texas Youth Commission states: “We’re seeing more and more mentally ill kids who couldn’t find community programs that were

intensive enough to treat them. Jails and juvenile justice facilities are the new asylums" (Moore, 2009, p.2).

Historically, juvenile justice facilities have been ill-equipped to effectively manage the mental health (and substance abuse) needs of youth. Agencies identify the following factors as barriers to meeting those needs: insufficient resources; inadequate administrative capacity; lack of appropriate staffing; and lack of training for staff (Federal Advisory Committee on Juvenile Justice, 2006). Since youth are often subjected to neglect and violence in the juvenile facilities, studies have shown that mental illnesses can become worse while placed in detention (Moore, 2009). Additionally, it has been estimated that 80% of these children who enter the juvenile justice system return or go to prison within three years of their release (Office of Children and Family Services, 2008).

Two–thirds of juvenile detention facilities report having children as young as seven years old awaiting mental health placement. In 2004, Congress documented that approximately seven percent of youth held in detention were locked up simply pending an appropriate treatment placement (U.S. Congress, Committee on Government Reform, 2004). Many youth enter the juvenile justice system with mental health, substance use, and other mental/emotional disabilities inadequately addressed by other social service agencies, including child welfare, schools, and mental health systems (Spangenberg Group, 2001).

Clinical disorders, likely to be found with the juvenile justice and child welfare population are: Mood Disorders (Major Depressive Disorder, Bipolar Disorder, Dysthmia); Anxiety Disorders (Generalized Anxiety Disorder, Obsessive Compulsive Disorder, Panic, Posttraumatic Stress, Separation Anxiety, Social Phobia); and Disruptive Disorders (ADHD, Conduct, Oppositional Defiant Disorder) (Garland, et al., 2001). Reports show that in the general

population, youth with Disruptive Disorders are more likely to obtain mental health services than those with Mood Disorders (AACAP, 2008; Stiffman et al., 1997).

In a frequently cited study (Teplin et al., 2003) researchers examined psychiatric disorders in a randomly selected, stratified sample of 1,829 youth who had been recently detained in a juvenile detention center in Cook County, Illinois. They presented six-month prevalence estimates by demographic subgroups (sex, race, and ethnicity) for the following disorders: Affective (Mood) Disorders; Anxiety Disorders: Psychosis; Disruptive Behavior Disorders; and Substance Use Disorder (alcohol and other drugs). They found nearly two- thirds of the males and three-quarters of the females met diagnostic criteria for one or more psychiatric disorders. Excluding conduct disorder (common among detained youth) nearly 60% of males and more than two- thirds of females met diagnostic criteria and had diagnosis specific impairment for one or more psychiatric disorders. Significantly more females (56.5%) than males (45.9%) met the criteria for two or more disorders in the diagnostic categories of: Mood, Behavior, Anxiety, Psychotic and Substance Abuse: 17.3% of females and 20.4% of males had only one disorder (Teplin et al., 2003).

A comprehensive study conducted by the National Center for Mental Health and Juvenile Justice included a collection of mental health data in three states for 12 months (from 2003 until 2004). The results confirmed that regardless of level of care or geographic region, the majority of the male and female youth in the juvenile justice system met the criteria for at least one mental health diagnosis. Overall 70.4 percent of youth were diagnosed with at least one mental health disorder. Among males the Disruptive Disorders were the most prevalent (44.9%) followed by Substance Use Disorders (43.2%). Among females, Anxiety Disorders (56%) followed by Substance Use Disorders (55.1%). The mental health status was complicated by the presence of

more than one disorder, 79.1% of youth met the criteria for more than one disorder (Cocozza & Skowyra, 2007).

The Office of Juvenile Justice and Delinquency Prevention (ODJJP) Survey of Youth in Residential Placement (SYRP) is the first comprehensive survey conducted to collect information about the needs of youth in custody by surveying the detained offenders (Sedlak & McPherson, 2010). Researchers found that youth in residential placement self reported numerous mental and/or emotional issues. The survey questions were not diagnostic of specific mental disorders, but were indicative of symptomatic behaviors in a number of domains. Symptoms of attention problems, hallucinations, anger, anxiety, isolation/depression, trauma, and suicide related thoughts were reported (Sedlak & McPherson, 2010). Problems with anger were especially prevalent (more than 60 percent); depression and anxiety (51 percent) and most notably, the majority of youth (70 percent) reported some type of traumatic event. One- fifth of the youth in placement admitted to having two or more recent suicidal feelings classifying "caution" or "warning" on the Massachusetts Youth Screening Instrument (MAYSI). The MAYSI is commonly used for assessing the mental health needs of youth in the juvenile justice system (Grisso & Barnum, 2006). The prevalence of past suicide attempts (22 percent) is more than twice the highest rate for peers in the general youth population. Additionally, an overwhelming majority of youth responding to the survey (70 percent) responded "yes" to the question "Have you ever had something very bad or terrifying happen to you?" Sixty seven percent responded "yes" to the question "Have you ever seen someone severely injured or killed (in person- not in the movies or on TV)?" (Sedlak & McPherson, 2010, p.2).

Although mental health services in the form of evaluation, therapy or counseling are universally available in the facilities, many youth do not receive counseling from qualified

mental health providers. Although there are mental health professionals in 77 percent of the facilities, 88 percent of youth reside in settings where some or all of the counselors are not mental health professionals (Sedlak & McPherson, 2010). A mental health professional is defined by the National Mental Health Association as any Medical Doctor, Psychologist, Social Worker, Licensed Professional Counselor, Mental Health Counselor, Certified Alcohol and Drug Counselor, Nurse Psychotherapist, Marital and Family Therapist or Pastoral Counselor. These professionals hold medical, doctoral, master's degrees, or certification/ licensure with specific clinical training. There could be serious implications for youth in detention facilities with serious mental health needs if they are not being treated by mental health professionals. More than one fourth (27 percent) of staff conducting suicide assessments are untrained, and other mental health assessments are not being administered by qualified staff (Sedlak & McPherson, 2010). Appropriate assessment of mental health issues is an essential aspect of treatment and requires appropriate training and skills.

In a service needs assessment of New York State operated juvenile facilities, approximately 48 percent of the 891 youth (429) admitted needing mental health services (Vera Institute, 2009). Furthermore, the Department of Justice found that some state operated facilities failed to provide adequate programs to address the mental health needs of these youth needs (Vera Institute, 2009).

The Civil Rights Division of the US Department of Justice (2005) conducted a series of investigations and found consistent inadequacies of the mental health care and services in juvenile facilities in a number of states (US Department of Justice, 2005). This recognition of the problem of the mental health needs of youth has influenced the trend towards examining the reliance on the juvenile justice system to care for youth with mental illness. Juvenile justice

officials regard servicing the serious mental health problems (and the multiple and complex issues surrounding the treatment) of the youth in their system as one of their greatest challenges (Cocozza & Skowyra, 2000). Juvenile justice experts agree "that whenever possible, youth with serious mental health disorders should be diverted from the juvenile justice system" (Cocozza & Skowyra, 2000 p.8).

Substance Use and Juvenile Justice

The relationship between substance abuse and delinquent behavior has been well documented in the literature. The Survey of Youth in Residential Placement (SYRP) indicates that nearly three fourths (74 percent) of youth in custody have tried alcohol and 84 percent admitted to using marijuana. More than half the youth (59 percent) replied that they were drunk or high several times a week or more during the months before they were taken into custody. Two thirds (68 percent) reported problems related to the substance use such as getting into trouble under the influence, not meeting their responsibilities or having a blackout experience (Sedlak & McPherson, 2010). In 2002, a study done by the office of Substance Use and Mental Health Services Administration (SAMHSA) found the substance use disorder rate among youth (ages 12-17) who had ever been in detention or jail was 23.8 percent (triple to the 8 percent rate of youth who had never been jailed or detained) (SAMHSA, 2002).

Recent studies have documented the prevalence of substance use among juvenile offenders (Caldwell et al., 2010; Chassin, 2008) along with specific factors and problems this presents for this population. Juvenile offenders who continue to use drugs are more likely to continue with criminal or delinquent behavior. Substance use among juvenile offenders is linked with other health risk behaviors such as more sexual risk behaviors, violence and accidents

(Teplin et al., 2005). Among all adolescents (not just juvenile offenders) youth using substances tend to have negative educational, occupational and psychological outcomes (Chassin, 2008). Substance use disorders among juvenile offenders are also complicated given the frequently co-occurring mental health disorders, learning disabilities and academic failures (Teplin et al., 2005). Youth with co-occurring mental health disorders tend to have more severe substance abuse disorders, greater family dysfunction, and poorer treatment outcomes (Rowe et al., 2004).

The American Academy of Child and Adolescent Psychiatry (2006) emphasizes the need for the identification and treatment of mental illnesses that often are present in youth who use drugs and/or alcohol. "Many children and adolescents with ADHD or depression have co-occurring substance abuse disorder," says Dr. Anders, M.D. (President of AACAP). "We cannot treat one problem and ignore the other" (AACAP, 2006, p.91).

Experts in the juvenile justice system acknowledge the frequency of mental health and substance abuse co-morbid disorders associated among juvenile offenders (Caldwell et al., 2010; Chassin, 2008; Rowe et al., 2004). SYRP documented extensive substance abuse and mental health problems of youth in the custody of juvenile justice systems but also found that existing intervention and treatment programs were not serving the large sectors of youth who need them. Only about half of the youth surveyed reported receiving substance abuse counseling in their facility. Recommendations for effective approaches and policy will be explored later in the discussion chapter.

Institutionalization of Juveniles

Each year, it is estimated that approximately 500,000 youth are brought to juvenile detention centers. On any given day more than 26,000 youth are detained (Sickmund ,et al., 2005).

Institutionalization, placement or detentions are terms frequently used interchangeably in the literature. There are different levels of residential placement in juvenile justice. In New York State there are three types of placement: non-secure, limited secure and secure residential facilities:

> *Non-Secure Residential Centers (NSD):* provide a non-secure level of placement that consist of a variety of urban and residential centers. Admissions to these facilities consist of adjudicated juvenile delinquents. Youth in NSD's require removal from community but do not require more restrictive settings. These facilities allow agencies to lower costs and provide smaller, flexible rehabilitation settings for youth.
>
> *Limited Secure Residential Settings*: provide more restrictive service setting for the juvenile delinquent population. First admission to these facilities is comprised of adjudicated juvenile delinquents. Limited secure facilities are also used for youth previously placed in secure facilities as a first step transition back to the community. Most limited secure facilities are located in rural areas, and virtually all services are provided on grounds. Services provided include education, employment training, recreation, counseling medical and mental health services.
>
> *Secure Residential Centers*: provide the most controlled and restrictive of the residential programs. Secure facilities are located in non-urban areas with virtually all program services provided on-grounds. Access to and from secure facilities is strictly controlled. The facility is either a single building or a small cluster of buildings surrounded by security fencing and individual resident rooms are locked at night. Youth in secure centers have an extensive history of delinquent behavior and involvement with the juvenile justice system that includes out- of –home placements.
>
> (Office of Children and Family Services, Division of Juvenile Justice and Opportunities for Youth, www.ocfs.state.ny.us.main/rehab.).

Unless otherwise noted, the terms "placement," and "institutionalization" denote any form of residential center defined above. There are 591 secure "detention" centers nationwide housing hundreds of thousands of youth every year. Detention centers are intended to temporarily house youth posing a high risk of reoffending before their trial or deemed unlikely to appear for their trial, these facilities are often filled with youth who do not meet these criteria. Approximately 70% of the youth in secure residential centers are detained for non- violent

offenses (Sickmund, et al., 2005). Typically, PINS youth or status offenders are placed in non-secure facilities while JD's can be placed in any of the above depending on their criminal background and nature of the crime.

The increased and unnecessary use of secure facilities exposes youth to an environment often resembling adult prisons and jails rather than community and family-based intervention programs that have proven to be most effective (Holman & Ziedenberg, 2006). Similar to adult crime, the act of placing youth in residential facilities, increased the crime rate by aggravating the recidivism of those youth who are detained (Holman & Ziedenberg, 2006). It has been shown that many youth naturally age out of "delinquent" behavior and placement can slow or interrupt that process (Holman & Ziedenberg, 2006).

A study done on 2006 found that "pretrial jailing" of youth not yet determined to be delinquent and placing youth in secure facilities does not deter juveniles from future criminal or delinquent behavior (Holman & Zeidenberg, 2006). The incarceration of youth in residential facilities or prisons can seriously damage a youth's chance of future success. The placement of young people in state's custody undermines the youth's opportunities to acquire life skills such as the educational, vocational, and social skills required for success and self sufficiency (Annie Casey Foundation, 2008).

Another disturbing problem with the reliance of institutional placement in the United States is the inequities and disproportionality of the juvenile justice system when it comes to minority youth, specifically African American youth. Whereas African American youth comprise 16% of the total juvenile population, 38% of youth in juvenile correctional facilities and 58% of youth sentenced to prison are African American (National Council on Crime and Delinquency, 2007). It is estimated that African American youth commit about the same amount

of crime as White youth, yet they are arrested at dramatically higher rates and once arrested they are more likely to be: "detained; formally charged in juvenile court; placed in a locked correctional facility; waived to adult court; incarcerated in an adult prison once waived to adult court" (National Council on Crime and Delinquency, 2007, p.3). This problem is evident in New York State as it has an obvious overrepresentation of minority youth in the residential facilities. African Americans represent only 19% of New York's total youth population ages 10-17, yet they accounted for more than 60% of all youth in residential placements in 2006 (Salich et al, 2008). It has been studied but not much has been done to correct it.

Finally, the juvenile justice system has often been characterized as the "dumping ground" for other public systems that do not have the resources or ability to manage these high risk youth. Youth with mental health problems, learning disabilities, or those in foster care have historically been steered into the juvenile facilities (Annie Casey Foundation, 2008). These young people are more at risk for delinquency related to their disability or disadvantage of a lack of resources. An example of this is the prevalence of mental health issues for court involved youth compared to the overall youth population. Some estimates find that youth in the juvenile justice system are two to three times more likely to suffer from a mental health disorder compared to the adolescent population at large (Skowyra & Cocozza, 2006). Grisso (2004) stated that: "During the 1990's, state after state experienced collapse of public mental health services for children and adolescents…the juvenile justice system soon became the primary referral for youth with mental health disorders" (p10.) Although some youth with complex mental health treatment needs may require out of home care for their problems, many more can be appropriately served in the community where youth behavior can be addressed in its social and familial context (National Mental Health Association, 2004).

The residential placement of youth is expensive and ineffective. Alternatives to institutionalization and diversion programs is an essential aspect of juvenile justice that needs to be explored and established as an effective way of dealing with high risk youth.

Diversion Programs

The Mentally Ill Offender Treatment and Crime Reduction Act of 2003 passed by Congress (S.1194/H.R. 2387) maintains that collaborative service programs between mental health treatment and justice systems can reduce the number of individuals in corrections facilities while also improving public safety. The growing trend toward diversion programs in the juvenile justice system is based on the evidence that most juveniles commit minor offenses, outgrow their delinquencies, and do not require formal intervention to live out crime free lives (Cuellar et al., 2006).

The support for diversion programs and specifically mental health treatment in lieu of court involvement is expressed in a report by the New Freedom Commission on Mental Health which finds that people are frequently misdiagnosed or not diagnosed with mental disorders. Many mental health professionals recognize that it is important to keep adults and youth with serious mental illnesses who are not criminals out of the criminal justice system. The experts also believe that many nonviolent offenders with mental illnesses could be diverted to more appropriate and typically less expensive supervised community care (Cuellar et al, 2006; New Freedom Commission on Mental Health, 2003). The Commission also supports the understanding that if people with mental illness received the services they need, they would not end up as part of the court system (Council of State Governments, 2002). In addition, media attention and reports documenting the growing problem of mental health issues in the juvenile justice systems of New Jersey, Arizona, California, Michigan, and Pennsylvania have also drawn

national attention to an issue that historically, has not received coverage (Cocozza & Skowyra, 2007).

This recognition of the problem of the mental health needs of youth has influenced the trend towards examining the reliance on the juvenile justice system to care for youth with mental illness (Cocozza & Skowyra, 2000). Juvenile justice officials regard servicing the serious mental health problems (and the multiple and complex issues surrounding the treatment) of the youth in the system as one of their greatest challenges (Cocozza & Skowyra, 2000).

Recently in New York State, the inadequacies of juvenile facilities to adequately address the needs of at-risk youth have taken center stage. In 2010, the Commissioner of the Office of Children and Family Services (OCFS) committed to the transformation of the failing juvenile justice system including closing down a number of juvenile residential facilities. Commissioner Gladys Carrion announced in an address to the New York juvenile justice professionals that these young people need intervention and support. She specifically emphasized the need for education, job training, and mental health and substance abuse services to support their rehabilitation and return to the community (OCFS, 2008). Instead of continuing to pour money into the broken system of juvenile justice, confining children while moving them hundreds of miles from their home, OCFS began aggressively moving toward community based alternatives to incarceration where the children could maintain and strengthen connections with their families and to significant adults in their lives (OCFS, 2008). Community based programs have proven to prevent youth crime and drop recidivism rates to as low as 30 percent (OCFS, 2008).

Diversion and Alternatives to Placement Programs

Diversion programs and alternatives to placement (or incarceration) programs are two types of interventions which attempt to redirect juvenile offenders out of residential placement to community based treatment programs. Diversion programs attempt to provide necessary services to identified youth (commonly status offenders or Person's In Need of Supervision) and prevent any court involvement and placement. Alternatives to placement are programs geared towards the youth who have been arrested or petitioned to court as a way to keep them out of secure (limited or non secure) residential programs. These programs were a way to reserve institutional placement for youth who pose "a significant risk to public safety, and to ensure that no youth is placed in a facility because of social service needs" (Vera Institute of Justice, 2009, p.926).

In New York State, there are two system points where youth might be sentenced to community based alternatives to placement: in court at the time of disposition (sentencing) or; when they are placed in custody of the Office of Children and Family Services (OCFS). When parents wish to obtain a PINS petition for their youth, diversion programs are typically the first step that parents must attempt before the filing of the petition and court involvement.

The Efficacy of Diversion Programs

The initial goal of diversion programs was to steer juvenile offenders from juvenile court in order to avoid stigmatizing youth (Feld, 2000). The earlier diversion programs focused on requiring youth to provide community service, follow educational directives, and/or receive services from youth agencies (Cueller et al., 2006). The more recent trend is to divert youth to mental health treatment: "Mental health diversion programs, along with other specialized programs such as mental health courts, are one response to a policy problem" (Cueller et al.,

2006, p.198). Under such programs, justice and social service agencies collaborate to divert youth offenders with mental health problems to treatment in lieu of court processing: “It is hoped that, if mental health treatment is effective, diversion programs can help to reduce recidivism and the severity of the crimes committed by the offenders with mental disorders, thereby reducing the societal cost of crime” (Cueller et al., 2006, p.198).

Utilizing diversion programs is one way to minimize court intervention and justice costs, and supervise youth offenders with minimal response (Cueller et al., 2006). Through the provision of community services, the digression from the court’s involvement is also intended to be more responsive to a youth’s individual, family and social needs (Feld, 2000). Behavioral interventions, such as interpersonal skills training and psychotherapy are more effective than vocational or wilderness programs (Lipsey, 1999). Diversion programs intervene in a manner consistent with the youth’s developmental and treatment needs (Cueller et al., 2006). Mental health diversion programs are adapted to address the specific type of disorder and problems of the youth based upon the mounting evidence that mental disorders are prevalent among juvenile offenders and contribute to youth crime. Although studies have found a correlation between mental disorders and crime, this does not imply a causal relationship. Empirical evidence also suggests that mental health treatment can reduce crime. In a study done examining this point, researchers found that mental health treatment reduces subsequent detention rates of youth in foster care (Cuellar et al., 2004).

Current research supports the effectiveness and cost savings associated with the appropriate diversion of youth with mental health and substance abuse needs to home and community based programs (Greenwood, 2008; US Department of Justice, n.d.). Most experts in the field of juvenile justice recognize the unmet mental health and substance abuse needs of

youth in the juvenile justice population and call for increased action, better data on the prevalence and manifestation of the disorders, and greater availability of screening, assessment and treatment approaches. Former Presidents Clinton and Bush recommended that juvenile justice agencies partner with other child serving agencies to transform mental health care for children and youth, focusing on early identification and referral to home and community-connected services (New Freedom Commission on Mental Health, 2003).

Juvenile Justice/Child Welfare in New York State

In 1998, New York State developed an agency system designed to integrate two systems of care, child welfare and juvenile justice. The New York State Office of Children and Family Services (OCFS) was formed on January 8, 1998 by merging the Division For Youth (DFY) (formerly the agency responsible for juvenile offenders within the Probation Department) with the family and children's' programs administered by the former Department of Social Services(DSS) (Johnson, 2004). OCFS is responsible for the oversight and monitoring of all elements of the child welfare (foster care, adoption, child protective services etc.) and the juvenile justice system referred to as the Division of Juvenile Justice and Opportunities for Youth (DJJOY). OCFS has the responsibility to certify and license the state's DJJOY juvenile justice programs. OCFS is responsible for the transformation of the juvenile justice system, the overall administering and managing of their residential facilities, community-based group homes, day-placement centers, and all other programs for juvenile delinquents and juvenile offenders placed in the custody of the OCFS Commissioner.

The Division of Juvenile Justice and Opportunities for Youth (DJJOY) provides the operation of the residential and community treatment of court-placed youth, including intake,

management of over 2,000 beds throughout the State in facilities ranging from secure centers to community residences, as well as day placement programs and aftercare services. DJJOY manages the different types of residential placement centers and intake functions for youth re-placed in voluntary agencies.

The division of OCFS/DJJOY custody is a confusing issue in New York State since they do overlap and vary from county to county. For example, PINS youth who are in private voluntary agencies in residential care are usually in the custody of the local county Department of Social Services (DSS). JD's can be placed with the local county DSS, or placed in the state custody of OCFS in a private voluntary agency for residential care (considered the foster care or child welfare system). JD's can also be in OCFS custody in a residential placement in state operated DJJOY facility.

This overlap between foster care/child welfare and juvenile justice youth was the subject of a study of done of children in a private voluntary residential treatment facility in New York State (Dale et al., 2007). Due to the changes and overlap of the systems, researchers found a significant increase in the proportion of youth with mental health and juvenile justice backgrounds compared to 10 years earlier in facilities originally designated for child welfare youth (Dale et al., 2007). Compared to 1991, there were significantly more children and youth entering residential treatment centers (RTCs) in 2001 with characteristics usually associated with serious mental health problems (history of psychiatric hospitalization and psychotropic drug use) and serious behavior problems(history of juvenile delinquency and substance abuse) (Dale et al., 2007).

The study also found three distinct groups of children entering RTC's: youth who have come in contact with juvenile justice systems; youth involved with mental health system; and youth traditionally served by child welfare system (Dale et al., 2007). The researchers of the study note that based on the limitations of their data collection methodology (missing or incorrect data in case record review) they believe it is probable that the percentage of children with mental health and behavioral problems is greater than reported (Dale et al., 2007).

The data showed that more than half of the youth being served in RTC's have a range of characteristics more common to children traditionally served by either mental health or juvenile justice facilities. Over the past 10 years this has increased substantially and has coincided with the decrease in options for child/adolescent psychiatric facilities and a shift in the approach of the juvenile justice system towards a child welfare perspective (for all but the worst offenders). Researchers found that this shift out of psychiatric hospitals and the more confining correctional facilities could have been a positive shift for the children of New York State if it was well planned and if appropriate resources were allocated to meet the needs of this challenging population (Dale et al., 2007). Unfortunately, the resources were not allocated differently and the systems were in need of a change of practice and policy.

Mental health, child welfare and juvenile justice are not interchangeable systems. As they each provide out of home care, they were each designed and shaped by a different philosophy and perspective. Mental health espouses a medical model, intended to stabilize the "patient" and improve the illness and the behavior. The juvenile justice system has used a correctional model to punish and correct socially unacceptable behavior (and protect the community) (Dale et al., 2007). Both the mental health and juvenile justice systems operate secure and locked facilities and have high staff to client ratios in order to support their missions. In contrast, the child

welfare system's RTC program operates from a social service perspective, with permanency planning as the driving force. The goal of an RTC is to discharge children to a permanent living situation. RTC's are non- secure facilities, have comparatively low staff to child ratios and no defined period for treatment (Dale et al., 2007).

Experts in the field of juvenile justice, child welfare and mental health recommend effective and innovative programming to divert these young people away from residential facilities (Greenwood, 2008; US Department of Justice, n.d.; Chui & Mogulescu, 2004). Child welfare and juvenile justice professionals support the claim that placing troubled youth into residential facilities is seldom the answer to getting youth the help and services they need (OCFS, 2008; Dale et al., 2007; Howell, 2004; Lerman, 2002).

Persons In Need of Supervision (PINS)

In New York State, a common pathway for parents to receive support for their emotionally and/or behaviorally troubled adolescent is by reporting them as PINS (Person In Need of Supervision). "Person's In Need of Supervision" is a program within the juvenile justice system that helps families intervene with children who are habitually truant, disobedient, incorrigible, or exhibit ungovernable behavior. Nationally, the term PINS is referred to as "status offenders" because the laws they break apply only to minors.

In New York, PINS petitions are filed through the Probation Department and ultimately may be adjudicated by a family court judge. At any point through the process, depending on the youth's behavior, the youth may be remanded into state custody (Office of Children and Family Services) and placed in foster care. At that time, they may be placed in a secure, limited, or non-secure facility or a community-based residential treatment center (RTC) for adjudicated youth (Johnson, 2004).

In November 2001, New York State raised the age limit from (less than) 16 to (less than)18 years old at which a youth can be adjudicated a PINS. Prior to this, a PINS petition might be filed in family court for a child "less than sixteen years of age." Parents in New York State fought to change this legislation in order to have support of the state as they attempted to deal with their troubled older children. Parents wanted services for their children, as well as official support for their parental authority (Souweine & Kashu, 2001).

The governor and the legislature responded to the parents by increasing the age limit; however, the increase threatened to undermine the goal of the PINS program by burdening an already overloaded system (Souweine & Kashu, 2001). Additionally, the PINS population is one of the least studied or understood groups that appear before the family court and, currently, no court model exists for effectively handling these cases (Lippman, 2001).

The estimated percentage increase in PINS cases translated between 6,500 and 10,000 more cases being referred to New York State Family Court (Lippman, 2001). It was anticipated that the elevated age limit would intensify the mental illness, substance abuse, and educational problems that the young people struggle with (Lippman, 2001).

Out-of-home placements are the most expensive components of the PINS system. The length of stay usually is guided by the court calendar so the youth may well spend weeks or months in residential placements pending a hearing or a judge's final decision (Chui & Mogulescu, 2004). Research indicates that an out-of-home placement often exacerbate the problems that cause family conflict (Chui & Mogulescu, 2004). It also may lead young people to have diminished school performance and to adopt criminal behaviors as a result of increasing their exposure to negative peer groups (Chui & Mogulescu, 2004).

Most PINS petitions are submitted by the parents of the children, although school administrators and police departments also may file. The data suggests that the same underlying issues exist for a PINS petition (mental health, substance abuse, educational issues and abuse) regardless of the petitioner (Souweine & Khashu, 2001).

In 2005, the New York State's Family Court Act was amended one again, this time to enhance diversion requirements for PINS cases and discourage the filing of PINS court petitions (Salsich et al., 2008). The provisions of this law promised to address the need for early, effective intervention, and required each county in New York to enhance PINS diversion services. The diversion programs were also compelled to respond to the families, and provide appropriate alternatives to placement (Johnson, 2005).

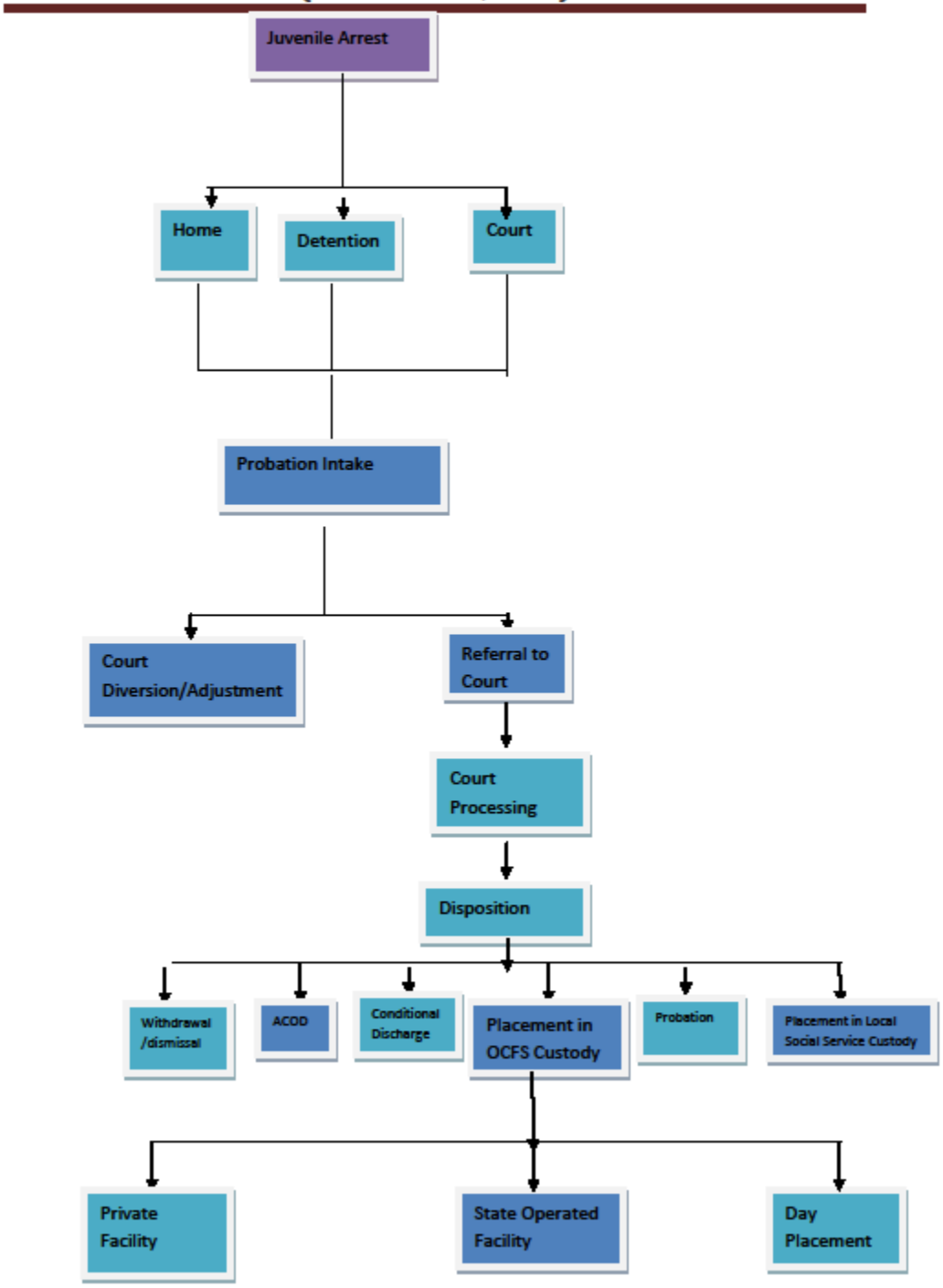
The diversion programs as well as the application process for a PINS petition vary from county to county in New York State. This variation has historically complicated the data collection and program analysis of PINS and diversion programs. As a result, there is limited research on both the PINS population and the programs that provide services to this challenging population.

Statistics of JD/PINS Youth in Care (NY)

In New York State, the juvenile system is fragmented across a number of agencies (law enforcement, probation, placement, family court, and social services). Each agency is required to collect and report particular data elements. Until recently however, the data had never been compiled or distributed in a way that could offer a comprehensive overview of the juvenile justice system. In 2005, the New York State Office of Children and Family Services established a task force on Juvenile Justice Indicators to address this issue. *Widening the Lens: A Panoramic*

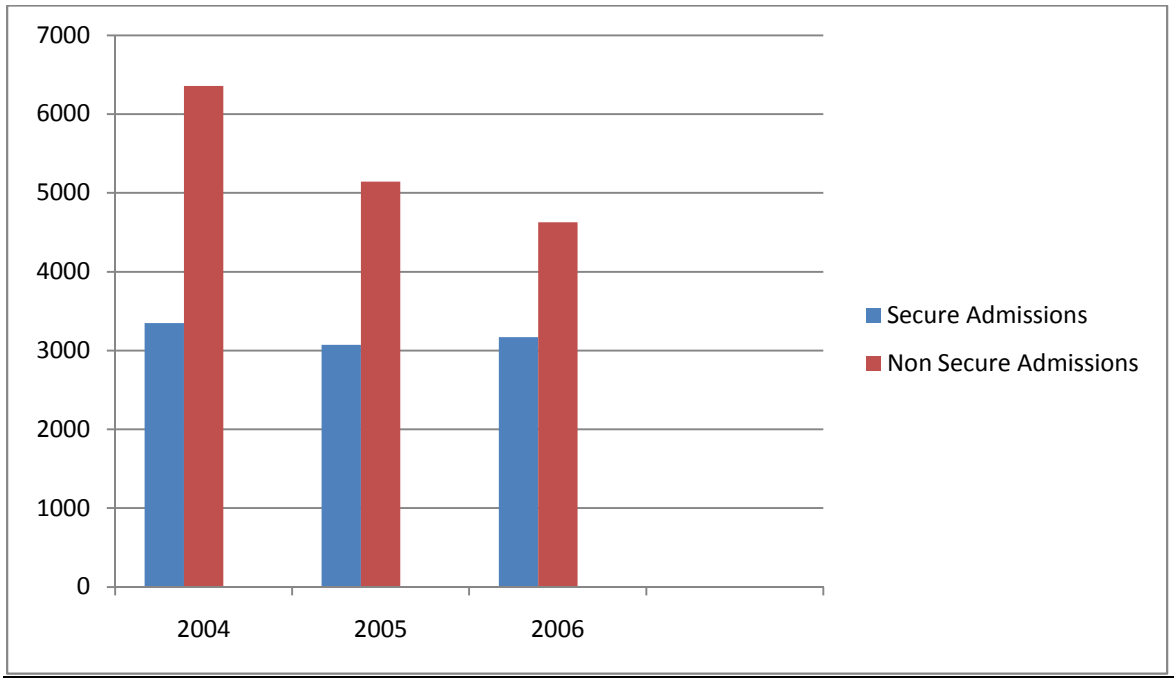
View of Juvenile Justice in New York State, published in 2008, draws on three years of data, from 2004 to 2006. The report summarizes five key areas of the juvenile justice system which includes arrest, referral to court, detention, court processing and disposition. (Salsich et al, 2008). A Flowchart of the Juvenile Justice System in New York State is represented in Figure 1.

Figure 1: Flowchart of NYS Juvenile Delinquency System (Vera Institute, 2008)



In 2004, there was a total of 9,705 (6,355 non-secure, and 3,350 secure) admissions to secure and non-secure facilities across New York State. In 2006, there was a 20 percent decrease to a total of 7,797 (4,627 non-secure, and 3,170 secure) (Salsich et al., 2008). This decrease in statewide admissions to secure and non-secure facilities is represented in Figure 2, and mostly seen in non-secure. Since PINS youth are detained in non-secure facilities, it can be surmised that this decrease during the 2004-2006 (represented in Tables 2 & 3) was influenced by the change in PINS legislation in 2005.

Figure 2: NYS Juvenile Detention Admissions (excluding NYC) 2004-2006

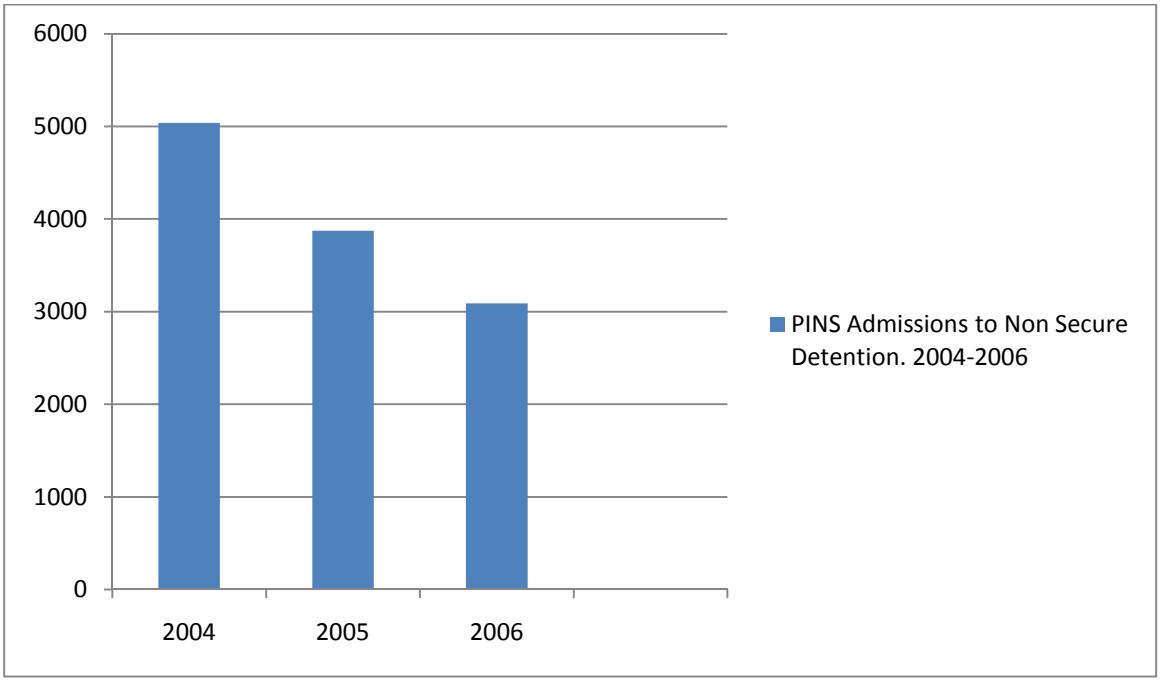


Source: Salsich, A; Paragini, A., Estep, B. (2009).Addendum to Widening the Lens 2008. New York: Vera Institute of Justice. www.vera.org

PINS court petitions have decreased across the state by 41 percent since 2004, from a total of 12,429 in 2004 to 7,349 in 2006. Consequently, admissions of youth to non-secure

facilities have also significantly decreased by 39 percent across the state. In 2004 there were 5,038 PINS admissions to non- secure detention, and in 2006, there were 3,090 (Salsich et al., 2008). The decrease in the number of PINS petitions is represented in Figure 3. Suffolk County was one NY county which demonstrated a significant decrease in PINS non-secure detention rates and PINS petitions (court involvement) (Salsich et al., 2008).

Figure 3: NYS PINS Admissions to Non-Secure Detention, 2004-2006



Source: Salsich,A, Paragini,A, Estep, B. (2008).Widening the Lens: A Panoramic View of Juvenile Justice in New York State. New York: Vera Institute of Justice. www.vera.org

Despite the significant decreases, PINS admissions to non-secure detention facilities across the state (excluding NYC) continue to account for nearly half (47 percent) of the state's total detention facility usage (JD secure detention admissions account for 31 percent, and JD

non-secure admissions account for 22 percent) (Salsich et al., 2008). The PINS population in New York remained a significant problem to the juvenile justice system. During the time period of 2004-2006, policy makers and researchers were exploring ways to resolve some of the core issues of the PINS youth and families.

In 2001, changes to the New York State PINS law increased the age limit for filing a PINS petition from (less than) 16 to (less than) 18 years of age. The initial concern and assumption was that this would overload the court system (Lippman, 2001). As a result of this concern, a number of PINS diversion programs were put into place to address the increased number of youth eligible for PINS and help alleviate some of the problems of the youth and their families.

Two specific programs that were developed to reduce court involvement and out-of-home placement in New York State were the Family Keys Program in Orange County, NY, and the Family Assessment Program (FAP) in New York City. The goals of the FAP program are: to connect children and families to appropriate services more quickly; to reduce the city's reliance on family court in PINS cases; and, consequently, to reduce the number of out-of home placements for PINS youth (Chui & Mogulescu, 2004). These programs were the basis for a program initiative in Suffolk County, called Alternatives for Youth (AFY).

Alternatives For Youth

In October, 2005, the Suffolk County Departments of Social Services, Health, Probation, and Youth Bureau developed a new program called Alternatives for Youth (AFY). Modeled on the Family Keys Program and Family Assessment Program, AFY attempts to intervene and prevent cases from reaching family court and thus reducing the number of out-of home

placements for PINS youth. By preventing court involvement and placement, it was expected that AFY would be a cost effective manner to help PINS youth in Suffolk County, NY.

Between 2000 and 2002 the average number of PINS youth in residential settings from Suffolk County, NY increased from 96 placements to 157 (64%). In 2005, Suffolk County spent $21 million dollars for institutional foster care and $17.25 million for Juvenile Delinquents/ PINS residential placements. In 2006, Suffolk spent an estimated $25.9 million for foster care placements and $17.25 million for JD/PINS placements (Suffolk County DSS Budget, 2005). The average annual cost for a child in placement in New York State is $210,000 (OCFS, 2008). This is a significant percentage of the Departments budget and many child welfare and juvenile justice administrators were hoping to find a solution.

The growing concerns for PINS petitions include the: relative cost for placement, use of out–of-state facilities, and the inability to work with families given the distance and location of placement. The increasing numbers, escalating cost, the ineffectiveness of residential placement present a compelling argument for an alternative to the PINS referral process. Since the PINS process in Suffolk County begins at the Department of Probation, it initiated an exploration of the background and problems of the PINS youth.

The Suffolk County Department of Probation reviewed the case histories of a number of children and youth who had been placed in institutional care in order to develop a profile of youth problems. The department found that 70% of the youth had a history of mental illness, alcohol and substance abuse, and learning disabilities (AFY, 2005). They also had other emotional or behavioral problems including: aggressive behavior, suicidal symptoms, runaway behavior, and sexual acting out (AFY, 2005).

During 2003, close to 1600 youth were seen for a PINS intake by Suffolk County Probation, of which 1200 were referred to the Designated Assessment Service Teams (DAS). DAS teams attempted to divert the youth and families from family court. DAS units assessed the needs of families and youth, referred them to services, and developed a service plan. Referrals were made for mental health services, substance abuse treatment, family counseling, education, and other support services. The work of the DAS team then, was to formulate an assessment, motivate the family and youth to engage in treatment, and avoid placement into foster care (Armstrong, 1998).

AFY was designed as a short-term (3-4 weeks) crisis intervention, case management program linking families to long term services. One difference between AFY and the aforementioned DAS is the elimination of the involvement of probation and the reduction of the need for filing a PINS petition. Another difference is the anticipated collaboration and integration of county departments and services, referred to as a "wraparound" approach. Participating county departments have enhanced and expanded the diagnostic, preventive, mental health, alcohol and substance abuse, education, and mentoring services and have augmented what was available to youth and their families. Additionally, the Education and Assistance Corporation (EAC) of Suffolk County is the contract agency responsible for the provision of the case management services for the AFY program. EAC is a not-for-profit agency which provides vocational, educational, counseling, mediation and intervention services across New York State.

To be eligible for the Suffolk County AFY program, a parent contacts the PINS program at Suffolk County Probation. The AFY probation workers complete a phone intake to determine if the youth's presenting problems and background are appropriate for the program; that is, youth should not be in imminent danger to self or others, and parents should be willing to be involved.

If the AFY worker determines the youth and family to be appropriate, the family is accepted into the program. The AFY worker will contact the family to schedule an assessment interview within a day or two if possible so that intensive case planning and management could begin immediately. If however, the youth's behavior is deemed inappropriate for the AFY program, the parent will file a PINS petition with the Suffolk County Department of Probation.

Suffolk County has an "AFY Oversight Committee" to manage the necessary interagency collaboration. The Committee meets regularly to discuss problems, conflicts, and challenges involved in program implementation.

THEORETICAL FRAMEWORK

Integrating Political Organizations

The development of the AFY Oversight Committee is an effort to improve collaboration and integration among the numerous political departments and organizations involved in AFY. To understand the complexity of integration among these agencies, the issue will be examined within the framework of a "political organization model." The political organization model views organizations as political arenas that accommodate complex webs of individual and group interest. It is based on the propositions that: (1) organizations are coalitions of diverse groups and individuals; (2) enduring differences exist among coalition members; (3) the most important decisions involve the allocation of scarce resources; (4) the enduring differences and scare resources create conflicts that are central to the organization; (5) power is the most important asset; and (6) goals and decisions emerge and bargaining, negotiating, and jockeying takes place among competing stakeholders (Bolman & Deal, 2003).

Interorganizational theory is based on the study of the interaction that occurs between two organizations. This interaction is affected "in part at least, by the nature of the organizational pattern or network within which they find themselves" (Warren, 1971). Benson (1975) reports that interorganizational theory has two deficiencies: 1) a problem of confusion and overlap; and 2) being insufficiently concerned with issues of macrostructure. These deficiencies, especially with the processes of conflict and cooperation, may be incorporated into the same model of organizational interdependence (Aiken & Hage, 1967).

The relevance of the systemic political model to this research rests on the great difficulties that youth service systems have in the provision and coordination of services. Both consistency and communication among service providers are necessary components in the treatment of young people who have been diagnosed with mental illness. Unfortunately, this collaboration among service providers is a rare occurrence (Jenson & Potter, 2003; AACAP, 2002). Planned and coordinated transitions between the service providers of the services and the youth and their families are integral to effective treatment (AACAP, 2002).

AFY and The Homebuilders Model

Before discussing the theoretical base for this study, it is important to discuss the original theory for which AFY was developed. EAC/Alternatives For Youth initially designed the theoretical foundation of its program on the Homebuilders Model. The Homebuilders Model began in 1974 based on Family Preservation Services (FPS). Family Preservation Services is a child welfare model designed to give caseworkers and families an option of intensive, in-home support as an alternative to removing children from their families and placing them in foster care (Kinney et al., 2009). A 1999 Surgeon General's report noted that:

> In a [third] study, records were analyzed from a large sample of youth (nearly 700) presenting to the Home Based Crisis Intervention (HBCI) program in New York over a 4-year period. Youth received short-term, intensive, in-home emergency services. After an average service period of 36 days, 95% of the youth were referred to, or enrolled in other services…(Satcher, 1999).

The Homebuilders Model was designed from FPS not only to prevent the out- of- home placement of children, but specifically for children at risk for foster care. Homebuilders programs seek "to prevent the unnecessary out-of-home placement of children who could remain at home safely with the provision of services" (Wells, 1994).

Features of intensive home-based services include immediate contact with families, assessments and service plans developed by family members and workers, and the linking of families to resources. The Homebuilders program is "one of the most well-established, family centered, family preservation service programs in the nation" (Fraser et al, 1999, p.2). Homebuilders works with families with a multitude of problems, teaching them new skills and suggesting a range of other services to help them stay together (Fraser et al, 1999). It is important to emphasize that Homebuilders Model and FPS wereoriginally designed for the child welfare system, and keeping children and youth out of foster care for abuse, neglect and other parent issues. Although there have been studies done on the efficacy of FPS and the Homebuilders model with juvenile justice populations, they have been single group or quasi-experimental designs (Haapala & Kinney, 1988; Pecora et al., 1991). While the studies suggested some promise, other experimental evaluations of FPS have not supported favorable long term outcomes with juvenile justice populations (Henggeler et al., 1993).

The Homebuilders Model was the theoretical basis chosen for the EAC/AFY program. Nevertheless, the 'wraparound' approach is the guiding theory and theoretical approach used in this descriptive and exploratory study. Wraparound theory is designed to preserve families and

prevent placement of youth in placement. It is a collaborative model which identifies the family as the primary decision maker, using inherent strengths and "wrapping" a series of supports around the individual and family to improve their situation. It focuses on utilizing community resources as a source of empowerment and change. The Wraparound model has been used with high risk youth and specifically those with mental health needs. Wraparound philosophy is a relevant theoretical framework for the AFY program.

Guiding Theory

Wraparound Theory

The wraparound philosophy began in Canada in the early 1980's and was adapted in the United States soon after. It is a philosophy of care that uses flexible, integrated services to meet the needs of troubled youth and their families (Burns and Goldman, 1998). There are many components of the wraparound philosophy, but the following factors are at the core: strengths based approach to youth and families; family involvement in the treatment process; needs-based service planning and delivery; individualized service plans; outcome-focused approach (Burns et al, 2000). Wraparound theory has "coalesced around a broadly stated strengths-based, family focused, ecological process emphasizing individualized services in the least restrictive setting appropriate for a child's need" (Malysiak, 1997). Wraparound philosophy has been a shift from a categorical, (professional) deficit assessment intervention, to a more integrated, individualized service, and a strengths-based engagement of families as the decision making participants (Malysiak, 1997).

Ecological systems theory is one which is most closely associated with wraparound. Environmental ecological theory assumes that a child functions at their best when the larger

system surrounding him/her coordinates efficiently with the micro system of his/her family and home (Burns et al, 2000). Supportive relationships among family, school, and community facilitate the improvement of behavior for a child or youth. The theory stresses the importance of understanding the relationship between the child and various environmental systems but also the relationship and communication among the systems themselves. Effective intervention begins with understanding each child's unique interactions in their own social, cultural, and interpersonal systems environment. The intervention also requires that representatives of the different systems in a child's environment work together in a collaborative and coordinated approach to rearrange the environment in ways that promote adaptive functioning (Walker & Schutte, 2004)

The ecological perspective draws upon concepts from ego psychology specifically emphasizing coping and adaptation; the rational , cognitive, problem solving capacities of people; the need for personal competence; and the importance of creating better fits between an individual's developmental phase specific needs and environmental resources. Ecological theory gives a key role to restructuring the environment as well as improving individual capacities (Goldstein, 1995).

Wraparound is an individualized approach to applying comprehensive services within a system of care for youth who have a multitude of complex problems (Burns & Goldman, 1998). It is a system level intervention that "wraps" existing services around youth and their family in an attempt to address their problems based on ecological theory. Wraparound also refers to the collaboration of services, involving all agencies involved in a coordinated way. Wraparound is intended for youth involved in the juvenile justice, child welfare, mental health, education

systems. Wraparound philosophy assumes that direct intervention in the service system will lead to positive change within the child and family (Stambaugh et al., 2007).

Although the wraparound approach has been around for almost 30 years, it has only recently come into more widespread implementation. Reviews of evidence based studies describe the approach as promising since there have been positive outcomes from randomized trials and multiple quasi-experimental studies (Burns et al 2000). Wraparound studies with youth in juvenile justice have found improvements in school performance and decreased instances of running away (Carney & Buttell, 2003; Pullman et al, 2006).

Wraparound theory is sometimes compared and confused with case management programs. The reason for this is because of one of the most significant features of the wraparound approach is individual case management, although wraparound services are not traditional case management programs. Case management programs merely provide youth with an individual case manager (or probation officer) who guide the youth through existing social services or juvenile justice systems. Case management programs do not operate in the same highly structured, integrated services environment that characterizes true wraparound initiatives (US Department of Justice, n.d).

Numerous public agencies and research organizations, including the National Mental Health Association (NMHA), the US Surgeon General's Office, the National Wraparound Initiative, and the Substance Abuse and Mental Health Services Administration (SAMSHA), have offered their own definition of what constitutes a wraparound program. A "true" wraparound program feature several basic elements; a collaborative, community-based interagency team; a formal interagency agreement; care coordinators; child and family teams; a unified plan of care; systematic, outcomes- based services (US Department of Justice, n.d).

Literature on the wraparound approach also emphasizes the importance of recruiting committed and persistent staff and creating programs that are culturally competent and strengths based (Bruns et al, 2004; Franz, 2003). It has been estimated that as many as 200,000 youth and their families may be enrolled in wraparound efforts nationwide (Burns & Goldman, 1999).

One of the most successful and most frequently cited wraparound program is Wraparound Milwaukee. This program is a unique merger of wraparound services and managed care financing. Participants in the program pay a set capitation fee (usually covered by Medicaid) and then become eligible for individualized case management and extensive treatment services. Repeated evaluations show that participants demonstrate marked improvements in their behavior and socialization, and are less likely to recidivate than graduates of conventional treatment programs. The average monthly cost of treatment in Wraparound Milwaukee is also less than half the cost of traditional residential programming (Milwaukee County Behavioral Health Division, 2003).

Wraparound initiatives can be used to reach many types of at risk youth. To date most of the nation's wraparound initiatives focus on youth with mental health needs. Alternatives For Youth (AFY) utilizes a wraparound approach to servicing a challenging population of the juvenile justice system. For a number of reasons, including variations within counties and states, there is lack of research on the PINS population. This high risk population of youth has numerous behavioral and emotional needs, and for those who work with the population, PINS youth are a complicated and complex group to service.

Policy Implications

Juvenile justice and mental health professionals expect that the adolescent mental health crisis will continue to increase over the years but resources will continue to decrease (GAO, 2003). Therefore, the method by which the juvenile justice system attempts to effectively address the adolescent mental health problem can set a significant standard and measure of practice with this difficult population. Any program which is successful in integrating and providing the myriad of service needs while preventing youth from court involvement or placement may have important policy implications nationwide.

Additionally, there is a growing trend away from the use of residential placement for youth with emotional and behavioral issues as numerous studies demonstrate it is costly and ineffective (Howell, 2004; Lerman, 2002). Researchers need to offer policy makers programs that have been proven empirically effective. A program that prevents placement will save agency administrators and parents the expense and distress of removing a child or adolescent from home. Nationwide there is huge momentum towards community based options for at- risk youth and reallocating funds from residential programs to community based services. Community treatment is more appropriate for addressing the young person's behavior in relation to family school and peers. It has been demonstrated that young people who are served within their own communities have been shown to be more likely to succeed in their treatment (Vera Institute of Justice, 2009).

Understanding the needs of status offenders is an important aspect of prevention and intervention in the juvenile justice system. In New York State specifically, the PINS population has been a complex and complicated population of the juvenile justice system. They present the

courts with a multitude of problems and service needs and juvenile justice professionals have little information on the most effective interventions for status offenders.

The purpose of this study is to describe an innovative diversion program which provides services and treatment to youth at risk for court intervention, adjudication, and placement in to the juvenile justice system. If the majority of outcomes indicate success, child welfare and juvenile justice agencies will have initial evidence of how to effectively address and attempt to resolve the adolescent's behavioral and emotional challenges. It may influence standards of practice with this difficult population locally and nationally.

The literature reflects the abundant agreement that current policy and practice necessitate the need for youth service systems to work together with new and creative programming (Howell et al., 2004; Johnson, 2004; Brown, 2003; Souweine & Kashu, 2001; Armstrong, 1998). This study attempts to determine if Alternatives For Youth is such a program. AFY's effort to coordinate and integrate services for youth in the juvenile justice systems, may well serve as a model for other county agencies.

Statement of the Problem

It has been well-documented in the literature that youth in the juvenile justice system have an abundance of mental health issues (Otto et al., 1992; Teplin et al., 2003; Cocozza & Skowyra, 2007). Traditionally, juvenile justice systems nationwide had been trying to solve the problem of juvenile offenders with residential placement (Sedlak A & McPherson, K, 2010; Annie Casey Foundation, 2008). Recently, however, there has been vast recognition of the ineffectiveness of this approach and a shift in the approach to best practice with juvenile offenders is gaining momentum (OCFS, 2008; Skowykra & Cocozza, 2007). The utilization of

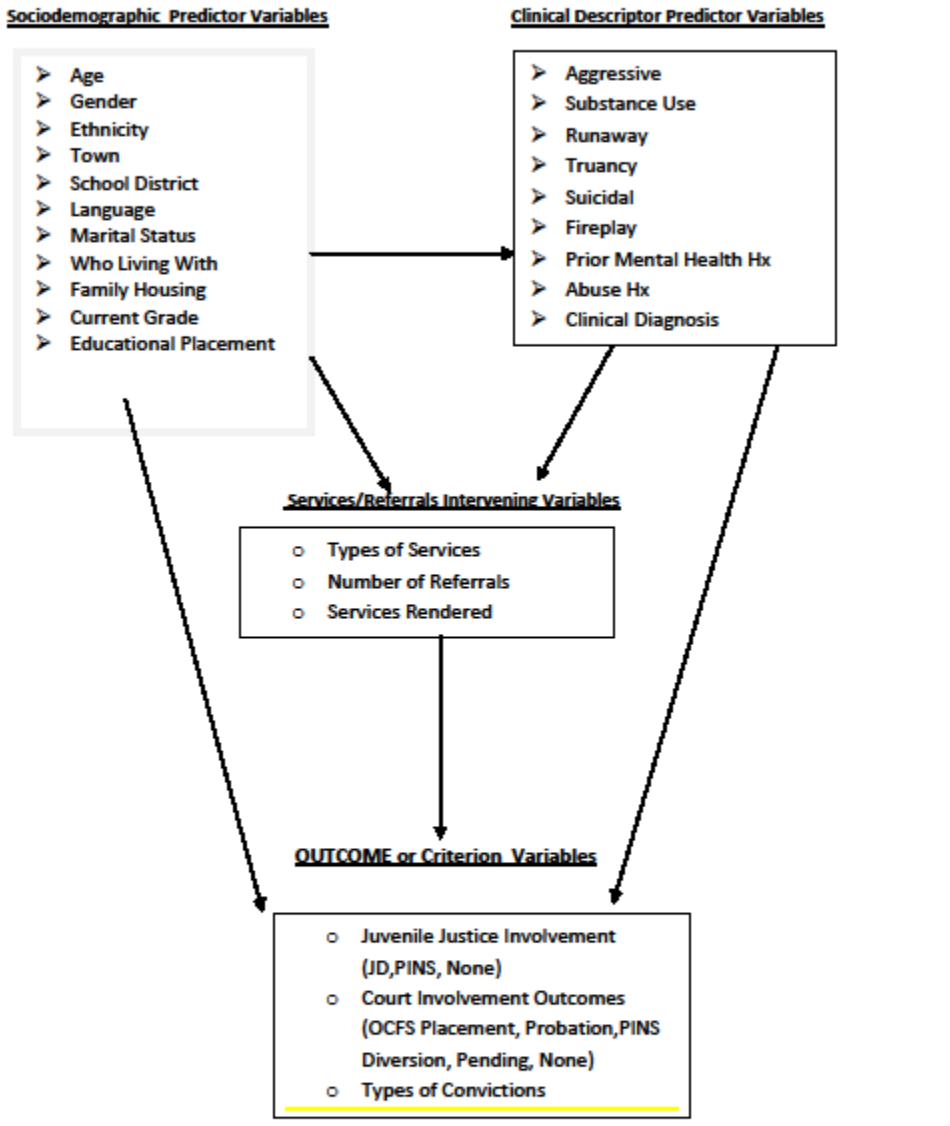
creative diversion and alternative to placement programs has gained attention and policy makers are examining closely effective programs documented through research.

This exploratory and descriptive study specifically looks at the PINS population in Suffolk County, New York. It examines the outcomes of the youth enrolled in the Alternatives For Youth Program from October, 2005 until October 2006. Outcomes were considered any time after the case was "closed" in AFY, from 4 weeks to 3 months following the initial intake date. This study focuses on the mental health issues that the AFY participants disclosed during the initial intake interview and the impact these issues had on the outcome.

Conceptual Model

Figure 4 represents the conceptual model explored in this study. The "Sociodemographic Predictor Variables" and the "Clinical Descriptor Variables" are delineated and described. Predictor variables were chosen to explore relationships believed to be associated in the research of juvenile offenders and delinquency. Since this is a descriptive and exploratory study, the terms "predictor", "criterion" or "outcome" variable are used. The "Services/Referrals Intervening Variables" are the specific referrals and services provided by the AFY program and would be expected to moderate the relationship between predictors and outcomes. The "Outcome" or Criterion Variables were the variables obtained through the Department of Probation case record database, and the case record extraction to discover some information about those youth who "failed" the AFY program (or entered the system after AFY) and their outcomes included placement, arrest or court involvement. These outcomes were measured at any time after the families 4-6 week involvement with the AFY program.

Figure 4: Conceptual Model



Specific Research Questions:

- What are the socio-demographic and clinical intake characteristics of youth referred to the AFY program?
- What services are provided for AFY participants? What are the overall outcomes for AFY participants?
- What is the relationship between the demographic characteristics of the youth and all other variables in the conceptual model?
- What is the relationship between all intake characteristics and outcomes?
- What services are provided by the AFY program for youth with and without mental health diagnosis at intake?

Final Research Question:

What is the relationship between a mental health history and outcome of PINS diversion, juvenile justice, and/or residential placement up to 5 years following the AFY intake date, when all other pre-existing conditions and AFY interventions are also considered?

CHAPTER III
METHODOLOGY

This exploratory and descriptive study was conducted in partial fulfillment of a doctoral dissertation for the Stony Brook University School of Social Welfare. Its purpose was to discover the factors associated with successful outcomes and failures for youth involved in a probation diversion program in Suffolk County, New York. The quantitative study used pre-experimental, one shot case study design with previously collected de-identified data of youth enrolled in the Suffolk County Alternatives For Youth (AFY) Program (Kreuger & Neuman, 2006).

AFY is an innovative program administered through the Education and Assistance Corporation (EAC) and contracted through Suffolk County Department of Probation and Suffolk County Department of Social Services. It uses a "wraparound" approach involving the collaboration and coordination of juvenile justice, child welfare, mental health and other youth service providers to provide short term intensive assessment and intervention services.

The subjects in this research project were all participants in the Suffolk County Alternatives For Youth Program during their first year of operation, from October 2005 until October 2006 (573 youth). EAC/AFY provided the researcher with previously collected data acquired through the agency's usual course of business and kept in computerized case records. The data included demographic information, educational history, family history, substance abuse and mental health history, types of services to which the participants were referred, court involvement and emotional/behavioral changes. For each case, data collection for AFY started at the date of intake, and continued through the close of the case, anywhere from four weeks to three months following intake and service referrals. For some cases, the date of case closure was not always recorded due to follow-up problems in contacting AFY participants.

Because of inconsistent outcome information in the AFY databases, it was necessary to obtain subject outcomes from an alternate source. Outcomes were defined based on the number of residential placements and court involvement (including arrests and PINS petitions) after participation in AFY. This data was obtained through case record review of probation records, and included outcomes up to five years after initial AFY intake.

DESIGN

The pre-experimental, one shot case study design was chosen as the most appropriate plan for this study. The one shot case study design is also called the one group, posttest-only design with one group, a treatment, and a post test (Kreuger & Neuman, 2006). In this study, all AFY participants enrolled in the program are the "one group." The "treatment" is referring to the services and referrals the AFY program provides the youth and families. The "posttest-only" is the outcome variable, juvenile justice involvement.

The major limitation of a design with only one group and no control or comparison group, is that it cannot be claimed for certain that the treatment affected the dependent/criterion variable. Since the subjects are the same before and after the treatment, the researcher would not be able to determine if any changes are the result of the treatment (Kreuger & Neuman, 2006).

Overview of AFY Program

New York State requires all parents seeking a PINS petition to first enter into a diversion program. In Suffolk County, N.Y., parents seeking to obtain a PINS petition must first contact the Suffolk County Department of Probation. The Probation Department will then refer the family to AFY for services. Within 24 hours the family is contacted by an AFY caseworker to schedule an intake appointment at the youth's home within 48 hours.

The AFY caseworker meets with the family to identify the services needed by the youth and family to ameliorate the problems they are facing and then develops a plan for obtaining needed services. Services can include mental health treatment, educational assistance, substance abuse treatment, mediation services, social service, all of which will help families build personal and community supports. On average, the caseworkers work with the families to stay with the AFY program for four to six weeks by which time other supports should be in place.

All visits by the AFY caseworker occur in the youth's home and workers maintain phone contact with the family while the case is open. AFY is a voluntary program in that the family can withdraw at any time. If the family withdraws from AFY services without complying with recommended services and then attempts to file a PINS petition again, probation will refer them back to AFY for another attempt.

AFY Intake Process/Data Collection

Staffing for the AFY program during the data collection process averaged nine to ten caseworkers (both full time and part time workers), a full time Program Director and part time Deputy Director. From October 2005 through October 2006, there were a total of 17 caseworkers assigned to a maximum of 10-12 cases each. Cases were assigned by the program director based

upon the geographic location of the family and/or strengths of the AFY caseworkers along with needs of the family and youth (workers with particular experience i.e., mental health, gangs, substance abuse are matched with those cases). Once the case was designated to a worker, the worker contacted the family to schedule an intake interview. The intake ideally was completed within 48 hours and all information was obtained through the parents and youth at the time of the intake in the client's home. If an intake was not completed within the 48 hours it was usually due to the parent's/guardian's late night work hours and difficulty scheduling a time for the caseworker to come to the house.

The AFY caseworker administered the CANS (Child and Adolescent Needs and Strengths) assessment tool during their intake process. CANS is a standardized tool used nationally to measure behavioral changes and mental health issues of children and adolescents. CANS may be a reliable and valid instrument to measure behavior if the assessment is measured at three different points in time. Due to the nature of the program (often used as a crisis intervention program) the CANS assessment was not always completed at the intake stage and rarely at the follow up (three and six months). As a result, the CANS assessment was not used in this study.

The information collected by AFY workers at intake and at follow up was entered into the AFY database by the worker (See Appendix A). The database program designed for AFY was limited in the number of fields and entries for some questions, which led to inconsistent and missing entries. Some of the categorical variables did not have the option of "other" and if the answer did not fit the category it was left blank. In other cases it was unclear whether a blank response indicated absence of a problem, refusal to answer the question or question not being asked.

The original study plan was to use the outcome of the referrals to different services and the improvement of behavior as the "outcome measures". This was to be gathered by AFY case managers when contacting the family by phone or by a mailed survey. These two approaches often failed leaving very little information to measure the effectiveness of their intervention.

Due to the limited data available, other sources were needed to measure outcomes. Data from existing case records of youth involved with the Suffolk County Department of Probation were obtained after receiving approval from the Stony Brook University Institutional Review Board (IRB).

AFY provided the Suffolk County Department of Probation (DOP) the names of the AFY participants, which were then entered into the DOP database. The study coordinator then extracted the relevant outcome data from the existing DOP case records (kept in the course of usual business) using a data extraction form developed specifically for this study (See Appendix B). The information provided in the probation records were often typed Presentencing Investigations (PSIs). Not all information was completed on all the youth, and for the youth who were deemed "PINS" there was very little information documenting the details. In addition, many of the youth were still "pending" outcomes in the records. These limitations will be addressed in the discussion section, along with future research recommendations. After the data was extracted, the Department of Probation combined the two data files into one complete data file with no identifying information included. No variables that could be used to identify the participants in any way were recorded, analyzed or used for this study.

IRB Compliance

The database used for analysis is compliant with all IRB and HIPAA rules. The application for "exempt" status was completed and submitted to Stony Brook University Committee on Research Involving Human Subjects (CORIHS) on the IRB Net site. The HIPAA Waiver Form (verifying the use of a de-identified data set), the memo detailing the amendments to the study and the data extraction form were also submitted and reviewed.

The initial research proposal was approved by the Stony Brook University Committee on Research Involving Human Subjects (CORIHS) on July 25, 2007. The addendum and modifications to the original application was approved on March 9, 2010 (Project ID: 20076794).

Data Cleaning

The AFY database had a total of 250 variables. However, due to missing data and the inability of the database to differentiate between a true "no" answer and a default "no" answer, numerous variables were excluded in the analysis. Some variables needed to be included in the analyses despite their high numbers of missing data. As a result, the missing number of cases will be reported in the results section.

Due to the low numbers of subjects with some intake characteristics or outcomes, many key predictor and outcome variables needed to be recoded. This will be described at length below. Additionally, suggestions on how to improve the data collection process will be included in the discussion chapter.

Department of Probation records also varied considerably in the amount of information available. Some records had extensive information, including psychosocial reports, and others

were limited in the amount of information. Consequently, there were missing data in the case record extraction as well.

Subjects

All participants in the Suffolk County Alternatives For Youth Program who enrolled in the AFY program from October 1, 2005 until October 31, 2006 were included in the study. There was a total of 603 intakes, however, 29 of these youth were repeat clients (and one had three intakes) for a total of 573 youth. When a youth had repeat intakes, it was decided that the initial intake would be the one that would be used since that intake was the most complete. An outcome variable of "AFY repeat" was then added to indicate repeat services.

AFY participants were primarily male (56%), White (58%), had a mean age of 14.8 years, and were living with a single parent (55%). Detailed intake characteristics of the AFY participants will be reported in the results section.

MEASURES

Biopsychosocial Predictor Variables

The following **socio-demographic predictor variables** obtained through the AFY database were used in the analyses: ***age, gender, race/ethnicity, town, school district, primary language of parents and youth), marital status of parent/legal guardian, who youth lived with, family housing, current grade and educational placement***. The AFY program serviced almost all of Suffolk County including 87 towns and 44 school districts. The complete table of all towns and districts is provided in Appendix C. Educational variables included ***current grade, educational placement and school district***. ***Educational placement*** was a string variable and

had a number of responses including: *alternative, day treatment, special education, regular education and parochial school.* For bivariate analyses ***educational placement*** was recoded to *regular education, special education, not in school* and *missing*. Since alternative and day treatment programs are considered special education services in many school districts, *alternative* and *day treatment* responses were recoded into *special education*, and *parochial* was recoded with *regular education*. There was only one response for *not in school* and 53 intakes had missing information on their ***educational placement.***

The clinical/mental health characteristics of the youth were the focal point of this study. The different variables that measured mental health were all considered and recoded in the analysis. **Clinical descriptor (CD)** predictor variables were coded as "*positive"* if they were acknowledged as either a current behavior issue or a prior problem. These descriptors included ***aggressive behavior, substance use, runaway, truancy, suicidal, fire play, sexual abuse victim, physical abuse victim or sexually abusive.*** CD's were distinguished from ***clinical diagnosis*** in the study since they were simply behavioral descriptors, self- reported by either parent and/or youth at the intake process.

Clinical diagnosis variable described any official mental health disorder attributed to the youth. Although these were also self-reported by the youth and family, names of service and specific details of the treatment were often included and supported the disclosures. For the bivariate and multivariate analyses***, clinical diagnosis*** was recoded into four main categories; *Behavior Disorders* (including ADHD, Conduct, and Oppositional Defiant Disorder); *Mood Disorders/Bipolar Disorder* (including Major Depressive Disorder, Depressive Disorder NOS, and Bipolar); *Other* (including Anxiety Disorders and Psychotic Disorders) and N*o Diagnosis.* Many of the youth had co-morbid diagnoses with one diagnosis often including a behavioral

disorder. Given the population of JD‘s and PINS youth, this was anticipated as Behavior Disorders are typically diagnosed in this population. As a result, the ***clinical diagnosis*** variable was coded as a diagnosis other than a Behavior Disorder if more than one disorder was disclosed. In addition, there were a number of youth who had mental health treatment or intervention (counseling or therapy) that may not have had an official diagnosis.

A number of variables were created to describe different types of previous mental health treatment experienced by the AFY youth, including ***outpatient services, psychotropic medication treatment, prior psychiatric hospitalizations*** **or** ***visits to a psychiatric emergency room***. In addition, the variable ***mental health history*** was created to represent the youth who had never received any type of counseling or mental health services in any manner prior to participating in AFY.

It is important to note that many of the youth who entered AFY with behavior problems and emotional issues did not have had prior treatment or a clinical diagnosis. AFY was the first phase of their mental health treatment and these youth were not coded positively in the variables of diagnosis or prior mental health history.

Intervening Variables

The original AFY database had the specific names of agencies to which participants were referred. The ***types of services*** **and** ***number of referrals*** could be important when exploring the relationships between intake characteristics and outcomes for AFY youth. Most of the youth had more than one referral with a range of “wraparound services” provided. The ***types of services and referrals*** variable were recoded into service areas with “yes” or “no” responses including ***mental health, substance abuse, education, aftercare and parenting problems. Mental health***

included psychiatric evaluations, individual and family counseling, MST (Multi Systemic Therapy) and anger management***. Substance abuse*** was any substance abuse referral and education was any educational referral. ***Mediation*** was a common type of service and was recoded into the ***parenting*** category. The number of referrals was coded into the ***number of referrals*** and then to ***categorical number of referrals.*** An important variable that was often missing and incomplete in the AFY case records were the outcomes of the linkages to these referrals. This issue will be discussed at length in the discussion section.

Outcome/ Criterion Variables

The three outcome measures that were used for this study were: ***juvenile justice involvement; court involvement outcomes;*** and ***types of conviction.*** The ***juvenile justice involvement*** variable was determined after the Department of Probation ran the AFY participants into their database. The data was then extracted from the existing case records of those youth who appeared in the probation data base. After a youth's name was entered, if their name did not appear in the database, the outcome was entered as *none*; if a JD charge or arrest appeared it was *JD*; and finally any family court *parent or school PINS* was the third outcome (parent PINS and school PINS were combined for data analysis).

Court involvement outcomes were determined through the case record review and data extraction. ***Court involvement outcomes*** included *OCFS placement* (into a Department of Juvenile Justice or Child Welfare Residential Treatment Facility) *or incarceration* (adult institution*); probation* or j*uvenile drug treatment court; felony* or *misdemeanor charge pending; dismissed* or *fined; court mandating further PINS diversion;* or *none of the above.*

The charges that JD's were convicted of were coded into the variable ***types of convictions.*** The coding included categorizing the charges and offenses by the guidelines used by Suffolk County/New York State Department of Justice. The categories include: *violent; drug; sex offenses; DWI/alcohol; property; and assaults.* Definitions of the categories and specific charges are provided in Appendix D. The youth who were deemed PINS with no other conviction were placed in a category of *PINS.*

Original Research Question:

The research question at the onset of the study was: 'What are the intake factors and successful outcomes associated with the youth who were referred and linked to mental health treatment through AFY?"

This exploration could not be pursued because of the large amount of missing data in the secondary data sets. This was due primarily to the inability of caseworkers to obtain necessary data during the intake process and the failure of AFY parents/ youth to follow up with the AFY workers to report the outcome of their referrals. Due to the crisis oriented nature of the intake interview, the AFY workers' primary goal at intake was to assess the crisis, ameliorate the troubled relationship of the parents (caregivers) and youth, and provide immediate referrals and resources. Consequently, the specific details of the intake interviews were often not completed. After the youth and family connected with the agency and/or services were recommended by the AFY worker, the outcomes were often obtained.

Upon completion of "phase 1" of AFY, participants may have been referred to "phase 2" which included aftercare services by other contract agencies (Family Service League, Suffolk County Department of Social Services, and Suffolk County Department of Mental Health).

Although referrals to the "phase 2" aftercare programs were documented, the number enrolled in any aftercare program was not recorded.

The CANS assessment instrument was another measure of behavior change intended to be used at the onset of the study. The CANS assessment was not completed at intake or at follow- up dates and thus was not used as an outcome measure. AFY workers stated that parents/families would not respond to the workers attempts to obtain the follow up data necessary for CANS.

The CANS assessment was designated as the assessment tool before AFY began. The CANS instrument was designed to measure behavior improvements over a period of time and follow up measures are required for validity and reliability. This was not an appropriate choice of behavior assessment given the nature of the program (crisis, short term), and recommendations will be made in the discussion section about recommended alternative assessment tools.

Statistical Analysis Plan

The Statistical Package for Social Sciences (SPSS) 18.0 for Windows was used to analyze the data. Univariate descriptive analyses were used to identify data entry errors, describe the frequencies of data items, facilitate recoding, and eliminate the variables with numerous missing responses.

Due to the majority of categorical variables, crosstabs and chi-square were the primary bivariate analyses done for the research study. Chi- square analysis was used to test the association between two predictor variables; between predictor and intervening variables; and between predictor and outcome variables. Chi-square examines whether the observed frequencies obtained from a sample are similar to the frequencies expected under the null

hypothesis that there is no relationship between the two variables (Abu-Bader, 2010). T-tests and Analyses of Variance (ANOVA) were used to test the statistical significance of the relationships between age (the only ratio level predictor variable) and all other predictor and outcome study variables. T-tests were used to test whether there were differences in mean age between groups of youth when the grouping variable had only two levels. Simple one-way analysis of variance (ANOVA) was performed to examine the relationship between age and other predictor and outcome variables when the latter variable had more than two categories of response. The purpose of the one-way ANOVA is to examine the difference between groups with one continuous variable (Abu-Bader, 2010). The alpha level was set at $p \leq .05$ to determine the statistical significance for all bivariate relationships.

Binary logistic regression was the multivariate analysis method used because of the categorical nature of the outcome variables. This method has been shown to be useful in a wide range of contexts in which the outcome variable is dichotomous (e.g. an event does or does not occur), and the set of predictor variables are continuous and/or categorical. Binary logistic regression was used in this study to predict the odds that (based on intake factors and service referrals) an AFY member would enter one of the outcome groups (juvenile justice outcome, court involvement outcome, and type of conviction). In order to use the binary logistic regression model, each of these outcome variables were recoded so that they represented the dichotomous outcomes of that event occurring (=1) or not occurring (=0) for each individual (Abu-Bader, 2010). In addition, categorical predictor variables that had more than two categories had to be recoded into separate ("dummy") variables each coded as 1 or 0. The number of dummy variables is always one less than the number of categories in the original variable. The last category is the "reference" category and it is the value that the other values are

compared to when determining statistical significance. SPSS version 18 automatically creates these new variables when the predictor variables are specified as categorical in the model.

The models in this study were run as forward-stepwise selection. A stepwise model was chosen because of the collinearity between many of the predictor variables, making it difficult to separate their effects when they are all entered simultaneously. Starting with a model that contains only the constant, the forward-stepwise procedure selects at each step the variable from the list of available predictor variables that has the smallest observed significance level if added (as long as it is less than the chosen cutoff value of $p<.05$) and enters it into the model. After it is in the model, all variables previously entered are examined to see if they meet criteria for removal (e.g. have significance levels above the chosen cutoff of $p>.1$). This process continues until no other variables are suitable for either inclusion or exclusion in the final model (Abu-Bader, 2010). Predictor variables were specified as being available to be entered into the models in blocks, as specified in the conceptual model in Figure 4. Thus, sociodemographic variables were added first, followed by clinical descriptors, and finally service referrals.

Final models are presented, along with B coefficients, odds ratios and probability levels for variables that are statistically significant. The B coefficient is an estimate of the contribution that its corresponding variable makes to the prediction of the outcome. Coefficients greater than zero indicate a positive contribution (e.g. predicts the occurrence of the event), while negative coefficients indicate a negative contribution (e.g. predicts the event not occurring). Exp (B) is indicative of the predicted change in the odds ratio of the event occurring vs. not occurring for each increment of the value of the predictor value. An odds ratio greater than one indicates an increased likelihood of the event; an odds ratio less than one indicates a decreased likelihood of the event. Overall significance of each block in the model is also included.

CHAPTER IV
RESULTS

I . Sociodemographic and Clinical Characteristics of AFY Youth

Table 1 provides all the demographic characteristics of AFY youth and families. As can be seen in Table 1, AFY participants were primarily male (56.5%), White (58.6%), and had a median age of 15 years. The majority of the youth (97.6%) and their parent(s)/ legal guardian(s) (87.3%) were English speaking and lived in a home owned by a parent(s)/ legal guardians(s) (57.1%). Approximately one third of the youth were living with their biological mother and father. More than half of the youth were living with single mothers or single fathers.

Table 1:Demographic Characteristics (N=573)

Variable		Frequency	Percent	Valid Percent
Gender				
	Male	324	56.5%	56.6%
	Female	248	43.3%	43.4%
	Missing	1	0.2%	
Ethnicity				
	White	336	58.6%	59.3%
	Black	103	18.0%	18.0%
	Hispanic	129	22.5%	22.8%
	Other	2	0.4%	<.1%
	Missing	3	0.5%	

Table 1:Demographic Characteristics (N=573)

Variable		Frequency	Percent	Valid Percent
Age				
	7	2	0.3%	0.4%
	9	1	0.2%	0.2%
	10	3	0.5%	0.6%
	11	4	0.7%	0.8%
	12	25	4.4%	4.7%
	13	48	8.4%	9.0%
	14	108	18.8%	20.3%
	15	153	26.7%	28.8%
	16	144	25.1%	27.1%
	17	43	7.5%	8.1%
	18	1	0.2%	0.2%
	Missing	41	7.2%	
Age Categories				
	7-11	10	1.7%	1.7%
	12-16	478	83.4%	89.8%
	17-18	44	7.7%	8.3%
	Missing	41	7.2%	
Primary Language Youth				
	English	559	97.4%	98.6%
	Spanish	8	1.4%	1.4%
	Missing	6	1.0%	
Primary Language Parent Guardian				
	English	500	87.3%	88.7%
	Spanish	60	10.5%	10.6%
	Other	4	0.7%	0.8%
	Missing	9	1.6%	

Table 1:Demographic Characteristics (N=573)

Variable	Frequency	Percent	Valid Percent
Marital Status Parents			
Divorced	230	40.1%	40.9%
Married	192	33.5%	34.1%
Never Married	79	13.8%	14.1%
Separated	47	8.2%	8.3%
Widow/er	15	2.6%	2.7%
Missing	10	1.7%	
Who Living With			
Bio Parents	186	32.5%	33.6%
Single Mother	268	46.8%	48.5%
Single Father	49	8.6%	8.9%
Parent/ Step	20	3.5%	3.6%
Other family	27	4.7%	4.9%
Other	3	0.5%	0.5%
Missing	20	3.5%	
Family Housing			
Own Home	327	57.0%	64.0%
Rent	172	30.0%	33.7%
DSS housing	4	0.7%	0.8%
Live w/Relative	8	1.4%	1.6%
Missing	62	10.8%	

Education & School Districts

The youth included in this sample came from 88 communities/zip codes and 44 school districts across Suffolk County, N.Y. Sixteen Towns had 10 or more AFY youth representing 55.4% of the AFY participants. The Town of Brentwood (8.9%) and the Brentwood School District (11.2%) had the highest number of youth represented. The complete table of towns/schools is provided in Appendix C. Table 2 shows the grade and school placement status of AFY participants. Almost half the youth reported their current grade as 9th or 10th grade, and

two thirds reported a regular education placement. It is important to note that 10.6% (61) of "current grade" and 9.1% (52) of "educational placement" responses were missing from the data.

Table 2: Grade/ Educational Placement Status (N=573)

Variable	Frequency	Percent	Valid Percent
Current Grade			
2	1	0.2%	0.2%
3	1	0.2%	0.2%
4	2	0.3%	0.4%
5	3	0.5%	0.6%
6	13	2.3%	2.5%
7	40	7.0%	7.8%
8	49	8.6%	9.6%
9	133	23.2%	26.2%
10	141	24.6%	27.5%
11	102	17.8%	19.9%
12	27	4.7%	5.3%
Missing	61	10.6%	
Educational Placement			
Regular Education	383	66.8%	73.4%
Special Education	138	24.1%	26.4%
Missing	52	9.1%	

Clinical Descriptors

The clinical descriptor predictor variables are self reported behavior descriptors provided by the youth and/or the parents/caregivers during the intake interview. An official clinical diagnosis was not required for these responses. These descriptor variables, listed in Table 3, are: aggression, substance abuse, runaway, truancy, suicidal, and fire play behaviors. As indicated in Table 3, aggression and truancy behaviors were most frequent followed by substance abuse and

runaway behaviors. The high numbers of responses for most of the clinical descriptors are typical behaviors for both PINS and JD youth.

Approximately 45.4% of youth stated they had been in some type of outpatient mental health treatment, and 46.2% of AFY youth reported some type of psychotropic medication treatment.

Table 3: Clinical Descriptors

Variable		Frequency	Percent	Valid Percent
Clinical Descriptors				
Aggressive				
	Y	360	62.8%	62.8%
	N	213	37.2%	37.2%
Substance Abuse				
	Y	297	51.8%	51.8%
	N	276	48.2%	48.2%
Runaway				
	Y	293	51.1%	51.1%
	N	280	48.9%	48.9%
Truancy				
	Y	379	66.1%	66.1%
	N	194	33.9%	33.9%
Suicidal				
	Y	131	22.9%	22.9%
	N	442	77.1%	77.1%
Fire play				
	Y	139	24.3%	24.3%
	N	434	75.7%	75.7%
Mental Health Hx				
Outpatient Tx				
	Y	260	45.4%	45.4%
	N	313	56.6%	56.6%
Medication Tx				
	Y	265	46.2%	46.2%
	N	308	53.8%	53.8%

Table 3: Clinical Descriptors

Variable		Frequency	Percent	Valid Percent
Prior Psychiatric Hospitalizations				
	Y	85	14.8%	14.8%
	N	488	85.2%	85.2%
Prior Psychiatric ER visits				
	Y	96	16.8%	16.8%
	N	477	83.2%	83.2%
Any MH Tx or Hx				
	Y	394	68.8%	68.8%
	N	179	31.2%	31.2%
Abuse Hx				
Victim of Physical Abuse				
	Y	78	13.6%	13.6%
	N	495	86.4%	86.4%
Victim of Sexual Abuse				
	Y	40	7.0%	7.0%
	N	533	93.0%	93.0%

A clinical diagnosis was required for the variable “Clinical Diagnosis”, resulting in two thirds of youth having no prior diagnosis (66.1%). Most data obtained for this variable was self-reported at the AFY intake; however, some of the diagnoses were entered from the data extraction form used with Probation case records. As can be seen in Table 4, youth presented with diagnoses of Behavioral Disorders (Conduct, Oppositional Defiant Disorder, ADHD or other Behavioral Disorder), Mood/Bipolar Disorders, or other (e.g. Anxiety/Psychotic Disorders). Too few AFY participants reported any type of clinical substance abuse disorder to be used as a variable in the study.

Table 4: Clinical Diagnosis

Variable	Frequency	Percent	Valid Percent
Behavioral Disorders	97	16.9%	16.9%
Mood Disorders/ Bipolar	84	14.7%	14.7%
Other	58	10.1%	10.1%
No diagnosis	334	58.3%	58.3%

II. Services, Referrals and Outcome Variables

Table 5 shows the types of services and referrals made for the youth. Three quarters of the youth (74.9%) had at least one mental health referral, 26.0% were referred to a substance abuse provider, 40.3% were referred to parenting or mediation services and 54.5% were referred to aftercare services. The majority of youth (57.8%) had between 4-10 referrals to the various categories of service providers and 190 youth had between 1-3 referrals. The mean number of referrals was 3.84, and both the mode and the median were 4 referrals.

Table 5: Services/ Referrals

Intervening Variables		Frequency	Percent	Valid Percent
Type of Service				
Mental Health				
	Y	429	74.9%	74.9%
	N	144	25.1%	25.1%
Substance Abuse				
	Y	149	26.0%	26.0%
	N	424	74.0%	74.0%
Parenting/Mediation				
	Y	231	40.3%	40.3%
	N	342	59.7%	59.7%
Educational				
	Y	321	56.0%	56.0%
	N	252	44.0%	44.0%

Table 5: Services/ Referrals

Intervening Variables		Frequency	Percent	Valid Percent
Aftercare				
	Y	312	54.5%	54.5%
	N	261	45.5%	45.5%
Number of Referrals				
0		52	9.1%	9.1%
1		24	4.2%	4.2%
2		52	9.1%.	9.1%.
3		114	19.9%	19.9%
4		118	20.6%	20.6%
5		98	17.1%	17.1%
6		64	11.2%	11.2%
7		33	5.8%	5.8%
8		13	2.3%	2.3%
9		2	0.3%	0.3%
10		3	0.5%	0.5%
Categorical Number of referrals				
0		52	9.1%	9.1%
1-3		190	33.2%	33.2%
4-10		331	57.8%	57.8%

Outcome Measures

Of the 573 youth who were participants of the AFY program from October, 2005 until October, 2006, 84.8% (486 youth) did not require any additional court intervention, placement, juvenile justice or criminal justice services (Table 6). Of the 87 youth who had court involvement or placement, 71 were JD's and 16 were deemed PINS. Of the 87 court involved youth, 11 were placed in an OCFS facility, 29 were sentenced to Probation or Juvenile Drug Treatment Court, and 41 had felony or misdemeanor pending at the time of the data extraction.

Property crimes (31 convictions) were the most frequently identified delinquent acts followed by acts of violence (21) and Drug/DWI (14).

Table 6: Juvenile Justice Involvement, Court Involvement Outcomes and Types of Conviction (N=573)

Variables		Frequency	Percent
Juvenile Justice Involvement			
JD		71	12.4%
PINS		16	2.8%
None		486	84.8%
Court Involvement Outcome			
OCFS		11	1.9%
Placement/Jail Probation/JTC		29	5.1%
Felony/Misd. Pending		41	7.2%
Dismissed/Fine		1	0.2%
PINS Diversion		5	0.9%
None		486	84.8%
Types of Convictions			
Property			
	Y	31	5.4%
	N	542	94.6%
Assault			
	Y	13	2.3%
	N	560	97.7%
PINS			
	Y	16	2.8%
	N	557	97.2%
Drug/DWI			
	Y	14	2.4%
	N	559	97.6%
Violent			
	Y	21	3.7%
	N	552	96.3%

III. Bivariate Relationships between Demographic Characteristics and Clinical Descriptors/Service Referrals

Gender, Ethnicity, Age & Clinical Descriptors

Bivariate associations between demographic variables and clinical descriptors was explored in this study since there were important significant relationships cited in the literature with juvenile justice involved youth. Associations between gender and clinical descriptor variables (Table 7) include the significant association of females reporting a history of sexual abuse (71.1%) compared to males (28.9%). Male AFY participants were more likely to report aggressive behavior (63.2%), substance abuse (61.1%) and fire play (76.8%). Females had a higher number of runaway behaviors (52.1%) and suicidal behavior (54.2%). No significant associations between ethnicity and any other variable were found in this analysis.

No significant associations were found among the sociodemographic predictor/descriptor variables and services/referrals intervening variables.

Table 7: Clinical Descriptors and Gender

Variables	n	Gender		X2	Df	Sig.
		Male (n=324)	Female (n=248)			
Clinical Descriptors						
Phys.Abuse				0.009	1	0.924
Y	77	57.1%	42.9%			
N	495	56.6%	43.4%			
Sex Abuse				14.874	1	0.000
Y	40	28.9%	71.1%			
N	533	58.8%	41.2%			
Aggressive				17.037	1	0.000
Y	360	63.2%	36.8%			
N	213	45.5%	54.5%			
Sub Abuse				5.07	1	0.024
Y	297	61.1%	38.9%			
N	276	51.8%	48.2%			

Table 7: Clinical Descriptors and Gender

Variables	n	Gender		X2	Df	Sig.
		Male (n=324)	Female (n=248)			
Runaway				18.378	1	0.000
Y	293	47.9%	52.1%			
N	280	65.7%	34.3%			
Truancy				6.325	1	0.012
Y	379	52.9%	47.1%			
N	194	63.9%	36.1%			
Suicidal				8.133	1	0.004
Y	131	45.8%	54.2%			
N	442	59.9%	40.1%			
Fire play				30.124	1	0.000
Y	139	76.8%	23.2%			
N	434	50.2%	49.8%			

Simple analysis of variance (ANOVA) was performed to examine the relationship between age (interval level variable) and other important nominal or categorical level variables. The results (Table 8) shows the difference of the mean age to the outcome variables and clinical diagnosis.

Table 8: ANOVA Analysis by Age, Ethnicity and Clinical Variables

Variables	Mean Age	Sum of Squares	df	Mean Square	F	Sig.
Ethnicity		1.345	2	672	314	0.731
White	14.83					
Black	14.88					
Hispanic	14.73					
Clinical Diagnosis		4.167	3	1.389	0.649	0.584
Behavior	14.64					
Mood	14.92					
Other	14.91					
None	14.82					

Table 9 is the T –test independent sample analysis by age and clinical descriptors. The data shows the outcome after comparing the means of the two groups of the clinical descriptor variables. A significant finding (at $p<.05$) is the mean age of AFY youth who reported substance abuse behaviors (15.15 years old) to those who did not (14.40). Other significant findings included the mean age of AFY youth who reported runaway behavior (14.98) and truancy (14.43).

Table 9: T-Test Independent Samples by Age and Clinical Descriptors

Variable		N	Mean	T	df	Sig
Clinical Descriptors						
Aggressive				1.826	530	0.061
	Y	355	14.98			
	N	177	14.73			
Substance Abuse				-5.909	415.054	0.000
	Y	291	15.15			
	N	241	14.40			
Runaway				-2.829	481.797	0.008
	Y	289	14.98			
	N	243	14.62			
Truancy				-3.575	233.762	0.000
	Y	373	14.43			
	N	159	14.98			
Suicidal				0.622	530	0.174
	Y	129	14.74			
	N	403	14.84			
Fire play				2.438	530	0.780
	Y	136	14.90			
	N	396	14.55			

IV. Intake Characteristics, Services and Outcomes

Sociodemographic, Clinical Descriptors, Services and Juvenile Justice Involvement

Of all the bivariate associations analyzed, the relationships with significant results were the ones associated with gender (Table 10). Outcome findings suggested that JD's were more likely to be male (81.7%), females were more likely to be PINS (62.5%). No significant associations were found among the services/referrals intervening variables and outcome variables.

Table 10: Sociodemographic Variables and Juvenile Justice Involvement

Variables		JD (n=71)	PINS (n=16)	None (n=486)	X2	df	Sig.
Gender					22.343	2	0.000
	Male	81.7%	37.5%	53.6%			
	Female	18.3%	62.5%	46.4%			
Ethnicity					0.901	4	0.9254
	White	60.9%	56.3%	59.1%			
	Black	18.8%	25.0%	17.6%			
	Hispanic	20.3%	18.8%	23.2%			
Age					2.326	4	0.676
	7-11	0.0%	0.0%	2.2%			
	12-16	93.0%	93.8%	89.2%			
	17-18	7.0%	6.3%	8.5%			
Lives With					5.886	6	0.436
	Bio Parents	34.3%	35.7%	33.5%			
	Single Mother	47.1%	35.7%	49.0%			
	Single Father	12.9%	21.4%	7.9%			
	Other	5.7%	7.1%	9.6%			
Primary Language Parents					1.118	10	1.000
	English	87.3%	87.5%	87.2%			
	Spanish	13.3%	12.5%	10.3%			

Table 10: Sociodemographic Variables and Juvenile Justice Involvement

Variables		JD (n=71)	PINS (n=16)	None (n=486)	X2	df	Sig.
Marital Status					9.887	10	0.450
	Married	23.9%	18.8%	38.9%			
	Divorced	43.7%	62.5%	35.4%			
	Never Married	14.1%	6.3%	14.0%			
	Separated	11.3%	12.5%	7.6%			
	Widow/er	4.2%	0.0%	2.5%			
Ed Placement					3.719	4	0.445
	Regular Education	59.2%	81.3%	67.5%			
	Special Education	31.0%	12.5%	23.5%			
	Missing	9.9%	6.3%	9.1%			

The results of Table 11 show the difference of the mean age to outcome variables and age. The mean age of youth with a JD, PINS charge or no involvement in the juvenile justice system are within the range of 14.50-14.96 years of age. Although not a significant finding, youth who were placed in residential placement (OCFS) were almost a year younger (14.09 years old) than those receiving probation (15.07).

Table 11: ANOVA by Juvenile Justice Involvement and Court Involvement Outcomes

Variables	Mean Age	Sum of Squares	df	Mean Square	F	Sig.
Juvenile Justice Involvement		3.106	2	0.1553	0.726	0.484
JD	14.96					
PINS	14.50					
None	14.80					

Table 11: ANOVA by Juvenile Justice Involvement and Court Involvement Outcomes

Variables	Mean Age	Sum of Squares	df	Mean Square	F	Sig.
Court Involvement Outcomes		10.395	4	2.559	1.218	0.302
OCFS	14.09					
Prob	15.07					
Pend	15.02					
PINS	14.40					

There were some behavioral differences found between the PINS youth and the JD youth when looking at the clinical descriptors and disorders (Table 12). PINS youth disclosed a higher percentage of serious behavioral issues compared to their JD counterparts, for all clinical descriptors including aggressive, substance abuse, runaway, truancy, suicidal, fire play, and a history of sexual and physical abuse. Reaching statistical significance for youth with a JD or PINS outcome were associations of a history of sexual abuse, reporting substance abuse and fire play behaviors. Another significant association was between juvenile justice involvement and clinical diagnoses.

Table 12: Clinical Variables and Juvenile Justice Involvement

Variables	n	JD (n=71)	PINS (n=16)	None (n=486)	X2	df	Sig.
Clinical Descriptors							
Sex Abuse Victim							
Y	40	5.6%	31.3%	6.4%	14.983	2	0.001
N	533	94.4%	68.8%	93.6%			
Phys. Abuse Victim							
Y	78	15.5%	25.0%	13.0%	2.152	2	0.341
N	495	84.5%	75.0%	87.0%			
Aggressive							
Y	360	63.4%	75.0%	62.3%	1.073	2	0.585
N	213	36.6%	25.0%	37.7%			

Table 12: Clinical Variables and Juvenile Justice Involvement

Variables		n	JD (n=71)	PINS (n=16)	None (n=486)	X2	df	Sig.
Sub Abuse								
	Y	297	64.8%	68.8%	49.4%	7.776	2	0.020
	N	276	35.2%	31.3%	50.6%			
Runaway								
	Y	293	50.7%	75.0%	50.4%	3.754	2	0.153
	N	280	49.3%	25.0%	49.6%			
Truancy								
	Y	379	71.8%	81.3%	64.8%	3.039	2	0.219
	N	194	28.2%	18.8%	35.2%			
Suicidal								
	Y	131	23.9%	25.0%	22.6%	0.103	2	0.95
	N	442	76.1%	75.0%	77.4%			
Fireplay								
	Y	139	36.6%	37.5%	22.0%	8.761	2	0.013
	N	434	63.4%	62.5%	78.0%			
Outpatient								
	Y	260	52.1%	25.0%	54.9%	3.999	2	0.135
	N	313	47.9%	75.0%	45.1%			
On Meds								
	Y	265	52.1%	37.5%	45.7%	1.538	2	0.463
	N	308	47.9%	62.5%	54.3%			
Any MH Tx or HX								
	Y	394	73.2%	68.8%	68.1%	0.76	2	0.684
	N	179	26.8%	31.3%	31.9%			
Clinical Diagnosis								
	Behavioral Disorders	97	19.7%	31.3%	16.0%	19.657	6	0.003
	Mood Disorders	84	26.8%	31.3%	12.3%			
	Other	58	8.5%	6.3%	10.5%			
	No Diagnosis	338	45.1%	31.3%	61.1%			

Sociodemographic, Clinical Descriptors and Court Involvement Outcomes

Outcome findings of Court Involvement Outcomes were consistent with other research. Male JD's were more likely to be placed in residential facilities (72.7%). A considerable number of females received probation/juvenile treatment court (46.4%) as an outcome of court involvement.

Given the small number of youth in placement, on probation or PINS, it was not surprising that there were no other significant associations between demographic and Court Involvement Outcomes variables (Table 13). AFY youth who received a court mandated residential placement, were more likely to be male, Again, although race/ethnicity was not a significant finding, White AFY youth represented 58.6% of the population in placement and 36.4% of the court involvement outcomes while Black and Hispanic AFY youth consisted of 36.4% and 27.3% respectfully. Important to highlight is the percentage of Black and Hispanic youth placed in residential facilities. It was not a significant association but the percentage of placements for Black and Hispanic youth compared to the placements for White youth was disproportionate to the number of White, Black and Hispanic AFY participants. The issue of disproportionality will be discussed further in the discussion chapter.

Table 13: Sociodemographic and Court Involvement Outcomes

Variables		OCFS Pl./ jail (n=11)	Prob./ JTC (n=29)	Pend/ dism/ fine (n=41)	PINS Div. (n=5)	None (n=486)	X2	df	Sig.
Gender							22.823	4	0.000
	Male	72.7%	53.6%	90.4%	60.0%	53.5%			
	Female	27.3%	46.4%	9.5%	40.0%	46.5%			

Table 13: Sociodemographic and Court Involvement Outcomes

Variables		OCFS Pl./ jail (n=11)	Prob./ JTC (n=29)	Pend/ dism/ fine (n=41)	PINS Div. (n=5)	None (n=486)	X2	df	Sig.
Ethnicity							6.613	8	0.579
	White	36.4%	71.4%	57.5%	80.0%	59.0%			
	Black	36.4%	14.3%	17.5%	20.0%	17.8%			
	Hispanic	27.3%	14.3%	25.0%	0.0%	23.2%			
Age							2.640	8	0.955
	7-11	0.0%	0.0%	0.0%	0.0%	2.2%			
	12-16	90.9%	92.9%	92.9%	100.0%	89.2%			
	17-18	9.1%	7.1%	7.1%	0.0%	8.5%			
Lives With							10.379	12	0.583
	Bio Parents	45.5%	37.0%	26.8%	50.0%	33.6%			
	Single Mother	27.3%	37.0%	56.1%	50.0%	48.9%			
	Single Father	18.2%	18.5%	12.2%	0.0%	7.9%			
	Other	9.1%	7.4%	4.9%	0.0%	9.6%			
Primary Language Parents							7.504	20	0.995
	English	72.7%	92.9%	90.5%	80.0%	84.8%			
	Spanish	27.3%	3.6%	9.5%	20.0%	10.5%			
	Other	0.0%	3.6%	0.0%	0.0%	2.5%			
Martial Status							33.172	20	0.032
	Married	9.1%	25.0%	26.2%	20.0%	35.3%			
	Divorced	27.3%	50.0%	54.8%	20.0%	38.8%			
	Never Married	36.4%	7.1%	9.5%	0.0%	14.2%			
	Separated	18.2%	14.3%	4.8%	40.0%	7.6%			
	Widow/er	9.1%	0.0%	2.4%	20.0%	2.5%			
Ed Placement							3.295	8	0.914
	Regular Ed.	72.7%	67.9%	57.1%	60.0%	67.6%			
	Special Ed.	18.2%	25.0%	33.3%	20.0%	23.4%			
	Missing	9.1%	7.1%	9.5%	20.0%	85.9%			

Consistent with the juvenile justice involvement outcome associations, many of the same clinical descriptors and diagnosis variables were significantly associated with Court Involvement Outcomes ($p < .05$). AFY participants who were placed in residential facilities, received probation, juvenile drug treatment court, or deemed a "PINS", had significant associations with substance abuse, runaway and fire play behaviors (Table 14).

Table 14: Clinical Descriptors and Court Involvement Outcomes

Variables	n	OCFS Pl./ jail (n=11)	Prob./ JTC (n=29)	Pend/ dism/ fine (n=41)	PINS Div. (n=5)	None (n=486)	X2	df	Sig.
Clinical Desc.									
Sex Abuse Vic.							12.034	4	0.017
Y	40	9.1%	21.4%	2.4%	20.0%	6.4%			
N	533	90.9%	78.6%	97.6%	80.0%	93.6%			
Phys. Abuse Vic.							2.038	4	0.729
Y	78	9.1%	17.9%	19.0%	20.0%	12.9%			
N	495	90.9%	82.1%	81.0%	80.0%	87.1%			
Aggressive							1.234	4	0.872
Y	360	72.7%	64.3%	64.3%	80.0%	62.2%			
N	213	27.3%	35.7%	35.7%	20.0%	37.8%			
Sub Abuse							10.339	4	0.035
Y	297	54.5%	60.7%	66.7%	60.0%	49.5%			
N	276	45.5%	39.3%	33.3%	40.0%	50.5%			
Runaway							9.758	4	0.045
Y	293	72.7%	71.4%	38.1%	60.0%	50.5%			
N	280	27.3%	28.6%	61.9%	40.0%	49.5%			
Truancy							4.254	4	0.373
Y	379	72.7%	75.0%	69.0%	100.0%	64.9%			
N	194	27.3%	25.0%	31.0%	0.0%	35.1%			
Suicidal							3.313	4	0.678
Y	131	9.1%	21.4%	26.2%	40.0%	22.8%			
N	442	90.9%	78.6%	73.8%	60.0%	77.2%			

Table 14: Clinical Descriptors and Court Involvement Outcomes

Variables	n	OCFS Pl./ jail (n=11)	Prob./ JTC (n=29)	Pend/ dism/ fine (n=41)	PINS Div. (n=5)	None (n=486)	X2	df	Sig.
Fireplay							10.415	4	0.018
Y	139	27.3%	32.1%	40.5%	60.0%	22.0%			
N	434	72.7%	67.9%	59.5%	40.0%	78.0%			
Outpatient							994	4	0.911
Y	260	45.5%	42.9%	52.4%	40.0%	45.0%			
N	313	54.5%	57.1%	47.6%	60.0%	55.0%			
On Meds							1.105	4	0.893
Y	265	54.5%	46.4%	52.4%	60.0%	45.6%			
N	308	45.5%	53.6%	47.6%	40.0%	54.4%			
Any MH Tx / Hx							1.397	4	0.845
Y	394	63.6%	75.0%	73.8%	60.0%	68.2%			
N	179	36.4%	25.0%	26.2%	40.0%	31.8%			
Clinical Diag.							23.478	12	0.024
Behavioral Dis.	97	18.2%	25.0%	16.7%	40.0%	16.2%			
Mood Dis.	84	18.2%	21.4%	33.3%	40.0%	12.3%			
Other	58	9.1%	10.7%	7.1%	0.0%	10.5%			
None	334	54.5%	42.9%	42.0%	20.0%	61.0%			

Clinical Descriptors and Types of Convictions

Table 15 represents the findings of only those types of conviction variables that demonstrated significance. Youth who were convicted of property offenses had significant associations with the variables of clinical diagnosis; a history of (psychotropic) medications; outpatient mental health services and reports of any of mental health treatment or history. Youth who were convicted of a DWI or drug related offense had associations with reported substance abuse, suicidal behaviors, and clinical diagnoses. The only significant result of youth who were charged with a violent crime was an association with a clinical diagnosis.

Table 15: Clinical Descriptors and Types of Convictions

Variables	n	Property (n=31)		X2	df	Sig.
		Y	N			
Clinical Diagnosis				12.016	3	0.007
Behavioral Disorders	97	19.4%	16.8%			
Mood Disorders	84	32.3%	13.7%			
Other	58	16.1%	9.8%			
No Diagnosis	334	32.3%	59.8%			
On Meds				4.4	1	0.036
Y	265	64.5%	45.2%			
N	308	35.5%	54.8%			
Outpatient				6.615	1	0.010
Y	260	67.7%	44.1%			
N	313	32.3%	59.8%			
Mental Health HX				5.13	1	0.024
Y	394	87.1%	67.7%			
N	179	12.9%	32.3%			
		PINS Petition (n=16)				
		Y	N			
Sub Abuse				14.93	1	0.00
Y	40	31.3%	6.3%			
N	533	68.8%	93.7%			
Clinical Diagnosis				7.393	3	0.06
Behavioral Disorders	97	31.3%	16.5%			
Mood Disorders	84	31.3%	14.2%			
Other	58	6.3%	10.2%			
None	334	31.3%	59.1%			
		Drug/DWI (n=14)				
		Y	N			
Sub Abuse				6.599	1	0.010
Y	297	85.7%	51.0%			
N	276	14.3%	49.0%			
Suicidal				5.993	1	0.014
Y	131	50.0%	22.0%			
N	442	50.0%	77.8%			

Clinical Diagnosis				9.881	1	0.02
Behavioral Disorders	97	14.3%	17.0%			
Mood Disorders	84	42.9%	14.0%			
Other	58	0.0%	10.4%			
No Diagnosis	334	42.9%	58.7%			
		Violent (n=21)				
		Y	N			
Clinical Diagnosis				11.725	3	0.008
Behavioral Disorders	97	23.8%	16.7%			
Mood Disorders	84	28.1%	13.8%			
Other	58	4.8%	10.3%			
No Diagnosis	338	33.3%	59.2%			

V. Services Provided With/Without Mental Health Diagnosis

Clinical Descriptors and Type of Service

Table 16 lists only the significant findings after all the referral types (mental health, substance abuse, parent/mediation, education and aftercare) were analyzed against the clinical variables. Although Mental Health referrals were the most frequent type of referral (n=429), significant associations only occurred with the substance abuse descriptor (54%) and history of outpatient treatment (47.8%).

Table 16: Clinical Descriptors and Type of Service

Variables	n	Referral Type		X2	df	Sig.
Clinical Descriptors		MH (n=429)				
		Y	N			
Sub Abuse				4.205	1	0.040
Y	297	54.3%	44.4%			
N	276	45.7%	55.6%			
Outpatient				4.001	6	0.045
Y	260	47.8%	38.2%			
N	313	52.2%	61.8%			

VI. Impact of a Mental Health Diagnosis on Outcome

Logistic Regression

Logistic regression models were performed for the predictor variables including, sociodemographic, clinical descriptors, clinical diagnosis against all outcome variables (juvenile justice involvement, court involvement outcomes, and types of convictions). The models were run as a forward stepwise (conditional) analysis. Tables 17-19 list only those findings from the models with significant predictor values. Table 17 includes the final model predicting the likelihood of JD/ PINS outcome for AFY youth. Gender, clinical diagnosis, and number of referrals were included in the final model. The final model demonstrated that males are more likely to have future juvenile justice involvement (JD/PINS) than females, and that those with behavior and/or mood disorders were more likely to have future juvenile justice involvement than those with no clinical diagnosis. Youth with a mood disorder had three times the odds of having a JD/PINS outcome than not having a disorder.

Another important finding was the significance of number of referrals, wherein the higher number of referrals decreased the odds of a JD/PINS outcome.

Table 17: Logistic Regression Table Predicting JD/PINS outcome

	B	S.E.	Wald	df	Sig.	Exp(B)	Sig. Block	Sig. Model
Block 1							0.000	0.000
Male	0.958	0.271	12.495	1	0.000	2.607		
Block 2							0.002	0.000
Male	1.000	0.276	13.135	1	0.000	2.717		
CD			14.756	3	0.002			
CD Behavior	0.785	0.322	5.944	1	0.015	2.192		
CD Mood	1.118	0.322	12.084	1	0.001	3.06		
CD Other	0.089	0.448	0.04	1	0.842	1.0094		

Table 17: Logistic Regression Table Predicting JD/PINS outcome

	B	S.E.	Wald	df	Sig.	Exp(B)	Sig. Block	Sig. Model
Block 3							0.011	0.000
Male	1.038	0.278	13.917	1	0.000	2.824		
CD			13.321	3	0.004			
CD Behavior	0.703	0.326	4.646	1	0.031	2.019		
CD Mood	1.068	0.025	10.819	1	0.001	2.909		
CD Other	-0.035	0.456	0.006	1	0.939	0.966		
Numreferrals	-0.176	0.07	6.26	1	0.012	0.839		
Constant	-.4.035	0.81	24.797	1	0.00	0.018		

In Table 18, the juvenile justice involvement outcome variable was recoded to predicting a juvenile deliquency outcome (no PINS). All sociodemographic, clinical descriptors and clinical diagnosis variables were included in the model. Table 18 is the final model for predicting a JD outcome. Similar to the previous model, being male and reporting a clinical mood disorders was found to be a predictor of a JD outcome.

Table 18: Logistic Regression Table Predicting JD outcome

	B	S.E.	Wald	df	Sig.	Exp(B)	Sig. Block	Sig. Model
Block 1							0.000	0.000
Male	1.334	0.323	17.023	1	0.000	3.796		
Block 2								
Male	1.370	0.327	17.54	1	0.000	3.937	0.020	0.020
CD			10.204	3	0.017			
CD Behavior	0.639	0.359	3.167	1	0.075	1.895		
CD Mood	1.033	0.348	8.806	1	0.003	2.810		
CD Other	0.048	0.481	0.01	1	0.92	1.050		
Block 3							NS	NS

Table 19 includes the final logistic regression model where the juvenile justice involvement outcome variable was recoded to predicting a “PINS” (no JD). All sociodemographic, clinical descriptors and clinical diagnosis variables were included in the model. Reporting sex abuse was found as a predictor in Block 2, however when the number of referrals was added, this eliminated that variable as a predictor. Again, the higher number of referrals was found to decrease the likelihood of in predicting a PINS outcome.

Table 19: Logistic Regression Table Predicting PINS outcome

	B	S.E.	Wald	Df	Sig.	Exp(B)	Sig. Block	Sig. Model
Block 1							NS	NS
Block 2							0.020	0.014
Sex Ab Vic	1.352	0.68	3.955	1	0.047	3.867		
Block 3							NS	NS
Sex Ab Vic	1.120	0.704	2.534	1	0.111	3.066		
numreferrals	-0.354	0.155	5.177	1	0.023	0.702		

CHAPTER V
DISCUSSION

Sociodemographic & Clinical Characteristics of AFY Youth

Sociodemographic Characteristics

The demographic description of AFY youth in this study is consistent with the New York State Youth Assessment & Screening Instrument (YASI) data of Suffolk County juvenile justice involved youth screened in 2007. AFY youth were predominantly male (56.5%) with a mean age of 14.81. YASI data describes the PINS youth involved in the Suffolk County Juvenile Justice System as more than half male (55.3%) with the majority of youth (54.5%) being 14-15 years old (YASI, 2007).

When examining the ethnic composition of AFY participants, there were significant differences when compared to the ethnic composition of Suffolk County, New York. According to the U.S. Census Bureau (2010), Suffolk County is comprised of 74.3% White, 7.8% Black and 14.0% persons of Hispanic or Latino origin. The ethnicity of AFY youth (2005-2006) consists of 58.6% White, 18.0% Black, and 22.5% Hispanic. This finding supports the claim that minority youth are disproportionately represented in the juvenile justice system. White youth still represent the majority of youth arrested and referred to juvenile court; however, youth of color are disproportionately arrested, processed and detained in local and state facilities (National Council on Crime and Delinquency, 2007).

An important sociodemographic variable to note is the large number of youth living with single mothers. It was not surprising to discover that many of the AFY youth (55.4%) were living with a single parent (46.8% specifically with a single mother) at the time of the intake. According to the 2010 Census data for Suffolk County, only 20.5% of the households reported

living with a spouse. The same data reports that only 30.5% of married coupled families consist of a household with children less than 18 years of age (U.S. Census Bureau, 2010).

Given the large number of educational issues of PINS and JD youth, it was surprising to find that only 24% of AFY youth had reported a Special Education track in their school districts. The majority of youth (66.8%) were in a regular education setting. For the AFY youth who did report special education services, the specific disability or reason for placement was not indicated. Research has shown that for juvenile justice involved youth who had a history of special education services, it was primarily for an emotional disability (Morris & Thompson, 2008). The literature shows the prevalence of youth with disabilities represented in the juvenile justice system from 20 to 100 percent. The wide spread difference in the percentage values has been believed to be due to the discrepancy in the state and federal definition of what qualifies as a disability and/or the classification system used in certain studies. The difference assessment and evaluation measures has also been acknowledged as a possible reason for the variation in the number (Morris & Thompson, 2008).

Further research should be done exploring the educational needs of youth high risk for involvement in the juvenile justice system. The overlap with education and mental health issues should be explored as they clearly overlap. Youth with a history of problematic behavior in the educational setting may drop out at age 16 years old and then are in danger for other problematic life circumstances (i.e. teen pregnancy, criminality, dependency of welfare). Providing mental health treatment as an intervention for youth can be a viable solution for some of the educational issues many of these youth experience.

Clinical Characteristics

It has been well-documented in the literature that youth in the juvenile justice system have an abundance of mental health issues (Cocozza & Skowyra, 2007; Teplin et al., 2003; Otto et al., 1992). Mood Disorders, Behavior Disorders, Substance Abuse and Anxiety Disorders were the most frequently diagnosed clinical mental health disorders for males and females involved in the juvenile justice system (Cocozza & Skowyra, 2007). Among the youth who reported a mental health diagnosis, Behavior Disorders and Mood Disorders were predominant, supporting current literature that these are the most common disorders found with the juvenile justice population (Teplin et al., 2003). These common disorders were also found with the AFY population.

Once referred to AFY, a large percentage (from 51.1% to 66.1%) reported problems with the clinical descriptors of aggressive behavior, substance abuse, truancy and running away. These self reported clinical behavior descriptors are all consistent behavior problems of juvenile justice involved youth (Sedlak & McPherson, 2010). Despite the findings that the majority of AFY youth (58.2%) did not have a prior clinical mental health diagnosis, this factor, along with the high number of self reported behavior problems, supports previous research which indicates that contact with the juvenile justice system is often the first opportunity troubled youth have to receive necessary treatment and help (Cocozza & Skowyra, 2007).

Although few AFY participants having a "clinical" substance abuse disorder, (considered clinical only if diagnosed and treated by a professional), many of the AFY participants (51.8%) self reported "substance use" in the clinical descriptor category. It is common for adolescents to deny a substance abuse "problem", although most will admit to using substances (even if the usage is frequent). Since the AFY intake is often completed with the parents/guardians present,

we can assume that majority of the self- reported substance use behavior may be an underestimation. A more appropriate assessment instrument for AFY should improve the substance abuse data collected for this population.

Services Provided

It is important to note that most of the youth and families (74.9%) were provided a referral for mental health services. Almost half (49.4%) of the AFY participants were provided with 1-3 referrals, and 40.3% were presented with 4-10 referrals including mental health, substance abuse, parenting/mediation, education and aftercare. Many (36.5%) were provided with both individual and family mental health referrals. The services to which they were referred demonstrate the identified problems that are common among PINS and juvenile justice youth specifically in New York State (OCFS, 2008).

Regardless of a prior clinical diagnosis, AFY youth present a large number of behavior problems and issues. The services and treatments provided by the agencies used by the AFY program are intended to target these behavioral issues which are typically symptomatic of a larger problem. The clinical descriptor variables such as aggressive behavior, substance use, truancy, running away, suicidal ideation, and fire play which were often self reported of AFY participants, have been identified in psychiatric research as symptomatic of numerous clinical mental health disorders. Addressing these behaviors in a constructive manner by offering troubled youth assistance and intervention is consistent with the fundamental (and original) goal of the juvenile justice system.

Outcome Variables

Current research demonstrated the effectiveness and cost savings associated with the appropriate diversion of youth with mental health and substance abuse needs to home and community based programs (Greenwood, 2008; US Department of Justice, n.d.). The AFY program was designed as a diversion program and it should be acknowledged that, as demonstrated by the outcome data, the majority of AFY youth from 10/2005 until 10/2006 (85%) did not have further court involvement and placement and were redirected to community based programs. Only 15% of AFY participants (n=87) required further juvenile justice or court involvement. The majority of these youth (n=71) were deemed a juvenile delinquent and only 2.8% of the AFY participants were eventually adjudicated a "PINS" by Suffolk County Family Court. This is clearly an important finding of this study and for the AFY program. This statistic demonstrates that only a small percentage of AFY participants had additional problems or issues with the court system. AFY was designed as a PINS diversion program and only 16 out of 573 youth were eventually deemed PINS in Suffolk County. This finding has important policy implications that will be discussed later on in the chapter.

The outcome data shows that only 1.9% or 11 youth (n=573) were placed in a residential facility. Only 4.9% (n=28) of the AFY youth received probation. The limitations of the study will be discussed shortly, (specifically the follow-up data from AFY youth with the specific community based programs they were referred to). However it can be inferred from the probation data that the AFY program can demonstrate the effectiveness and cost saving approach it provides to its' participants. This finding also has great implications for New York State given the past and current developments of the closing of DJJOY residential facilities. This finding will also be discussed further in policy implications of this research.

Bivariate Associations of Gender, Ethnicity & Age

Gender, Outcome and Clinical Variables

The most significant bivariate associations occurred when looking at gender and other important variables. The relationships between gender and various behavioral and clinical issues support the literature on gender differences of youth involved in the juvenile justice system. The literature typically reports differences in the types of offenses with females committing more status offenses (PINS) and males committing more aggressive offenses resulting in a juvenile delinquency (JD) charge (Zahn et al, 2010; Shufelt & Cocozza, 2006; Snyder & Sickmund, 2006). This was supported through the outcome data with the AFY population as well.

AFY youth whose outcome was PINS, were more likely to be female (62.5%) than male (37.5 %) and those youth whose outcome included a JD charge, were more likely to be male (81.7%) than female (18.3%) where $p < .000$. Although status offenses predominate among the female youth, it has been shown that the minor offenses mask the serious problems that the female youth are experiencing (Zahn et al., 2010). Research looking at gender differences of delinquent youth found that female problem behavior often develops from a history of abuse and trauma, where juvenile delinquent male behavior often reflects a "delinquent lifestyle" (Nordness et al., 2002).

When examining the clinical descriptors and characteristics AFY youth, those who were female, were found to have significantly higher rates of sexual abuse, runaway and suicidal behavior. Minor offenses predominate among female delinquent offenders (Zahn et al., 2010, Snyder & Sickmund, 2006) and females in the juvenile justice system are more likely to be victims of sexual abuse and assault than their male counterparts (Zahn et al., 2010). The result that more females (71.1%) than males (28.9%) were found with a significant association of a

history of sexual abuse (p<.000) is consistent with the research of sexual abuse victims (Zahn et al, 2010; Shufelt & Cocozza, 2006). Studies of girls who have been chronic runaways demonstrate significant levels of sexual and physical victimization typically running away from serious problems and victimization (Zahn et al., 2010).

AFY males reported significantly higher rates of aggressive, substance abuse, truancy and fire play behaviors. Conversely, more males (63.2%) than females (41.2%) reported aggressive behaviors and more females (54.2%) than males (45.2%) reported suicidal behaviors which is also a frequently reported difference in the behaviors of adolescent males and females. Some research indicates that females have a tendency to internalize their aggressive behavior with suicidal behavior and males are more likely to externalize the aggressive behavior (Zahn et al, 2010; Shufelt & Cocozza, 2006).

There have also been studies examining the gender differences of male and female youth exploring the biological and psychological traits which may account for behavior differences (Klein & Corwin, 2002). However, there is a lack of research specific to understanding these biological and psychological differences between male and female juvenile justice involved youth which prohibits any conclusions (Zahn et al., 2010).

Gender and Placement

In examining the association between socio demographic variables and placement, the only significant finding was again, that of gender. Consistent with the gender difference of JD and PINS, males were found to be institutionalized at a higher percentage rate (72.7%) than females (27.3%) at p<.000. National statistics have shown that for those females who are placed in residential facilities, it is more likely to be for status offenses as compared to males (Raviora, 2010). Again, research has shown that females are more likely referred for status offenses such

as running away and truancy. Many believe that it is not necessary to place status offenders in residential facilities. Although risky and harmful to the youth, status offenses are personal problems rather than public safety issues (Casey, 2008). For those females who are placed in residential facilities, it is often the courts attempt to "protect" or provide services while in state custody, however, the detention centers were never intended or designed to provide effective treatment (Casey, 2008). The implication of this finding once again supports the belief that placement and detention is not an effective solution to the problem of juvenile offenders. Community based treatment and services will identify and provide the necessary remedy in an attempt to improve the youth's behavior and situation.

Ethnicity and Placement

As previously mentioned, the ethnicity of AFY youth consisted of 58.6% White, 18.0% Black, and 22.5% Hispanic. Although the association between ethnicity and institutionalization was not significant given the small sample size, it is important to note that the percentage of Black (36.4%) and Hispanic(27.3%) youth placed in a residential facility compared to White youth (36.4%) is disproportionate based on the ethnic composition of the AFY participants. Again this finding supports the extensive research of the differential treatment of youth of color in the Justice System and in New York State (National Council on Crime and Delinquency, 2007; Salich et al., 2008). This has an important policy implication for this study. The disproportionate number of ethnic and minority youth being placed in institutions and involved in the court system is still an alarming number. Recommendations for future research and policy issues of minority and juvenile justice involved youth will be discussed later in this chapter.

Age and Clinical Descriptors

As this study examines the population of adolescents with problematic behavior, it was found that even in the significant outcomes, the mean differences between age and certain variables are slight. The measures of central tendency of age for the AFY population was 13.75 years -old for the mean age, and 15 years -old for median and mode. Most of the findings of age were between these ages

Clinical Descriptors and Juvenile Justice Involvement Outcome

In the chi-square analysis of clinical descriptors and outcome variables of juvenile justice, there was an association between self reported sexual abuse (n=40) and juvenile justice status. Sexual abuse victims were reported at a much higher number for PINS (31.3%) than JD's (5.6%). Since females were more likely deemed PINS, than JD's, this finding is connected to the association of gender and outcome as well. These findings also support previous research regarding PINS youth and sexual abuse.

The analysis presented an association between juvenile justice outcomes (JD/PINS) and a clinical diagnosis (specifically Mood and Behavior disorders). This finding also supports claims that juvenile justice involved youth often have numerous complex mental health needs. This is supported by the specifically by the frequencies of the number of PINS youth reporting Mood and Behavior Disorders. While PINS youth represented only 16 of the 573 (2.8%) AFY youth, they reported 31.3% of the Mood disorders and 31.3% of the Behavior disorders.

The significant problem of substance abuse among AFY youth was also clear in the analysis. As stated earlier, although there was a low report of a clinical diagnosis of a substance abuse disorder, there was in fact a high percentage of both PINS (68.8%) and JD's (64.8%) reporting a substance abuse problem (n=297). As presented in the literature review, studies

have documented the prevalence of substance use among juvenile offenders (Caldwell et al., 2010; Chassin, 2008). Juvenile offenders, who continue to use drugs, are more likely to continue with criminal or delinquent behavior (Teplin et al., 2005). Substance abuse issues are an important aspect of understanding juvenile delinquent behavior and are often a comorbid diagnosis with mental health disorders among adolescent offenders. The reason that substance abuse issues were not explored further in this study is that Suffolk County, New York is one of 23 counties in New York where there is an adolescent drug treatment court to manage juvenile delinquents with substance abuse problems. This specialized court is another innovative approach that Suffolk County has implemented to contend with the complex needs of adolescents in the juvenile justice system (Kluger, 2009). One of the outcomes in the placement variable includes "Probation/JTC" where "JTC" refers to "Juvenile Treatment Court." Some of the AFY youth were directed to the Suffolk County Juvenile Drug Treatment Court for additional assistance and intervention.

Juvenile treatment court is an alternative to placement programs where youth addicted to drugs and/or alcohol can receive appropriate treatment and services as opposed to being referred to placement or institutionalization. Juvenile drug treatment courts are not offered in every county, however the specialized courts are providing young offenders an opportunity to get the help that is necessary to avoid a lifetime of crime.

Clinical Descriptors and Court Involvement Outcomes

Since the "court involvement outcomes" variable was closely related to the "juvenile justice involvement" variable, many of the same clinical descriptors and diagnosis variables had similar relationships in the analysis. Court involvement outcomes had an association with variables concerning reporting of sexual abuse, substance abuse, runaway and fire play behavior.

Since juvenile justice outcomes and court involvement outcomes were closely related to gender, much of the explanation of these differences is the same as that concerning the gender differences in types of behaviors and outcomes.

Clinical Descriptors and Types of Conviction

Property crimes were the most frequent type of conviction charge (n=31) and an association of a clinical diagnosis of a mood disorder was found with this variable. Although it would seem a conviction of a violent crime may involve youth with a tendency for behavioral disorders, a significant association of violent crime and mood disorder was also found in the results. As mentioned earlier in the methods chapter, AFY participants were recoded to have a diagnosis other than a Behavior disorder if more than one diagnosis was reported. Therefore, those youth who also reported a Mood disorder had a co-morbid diagnosis with a Behavior Disorder. Therefore, we can conclude that many of the youth who were convicted of a violent crime had both a clinical Behavior and a Mood disorder diagnosis.

This finding also lends itself to many theories that mood disorders are more prevalent in males than previously believed and often misdiagnosed and missed. As discussed earlier, some studies have found that the tendency for females is to direct their anger inward with forms of depression and bipolar disorder, which lends itself to the "classic" symptoms of depression, isolation, sadness, withdrawal. Males however, have a tendency to externalize their anger, with rage, and violent outward behavior which lends it to symptoms of behavior disorders (Zahn et al, 2010; Shufelt & Cocozza, 2006). The difference in how the symptoms are expressed leads to males being misdiagnosed and not treated for what could be an underlying mood disorder.

For those familiar with the literature on substance abuse and juvenile behavior, the findings will support previous studies. AFY Youth who were convicted of a DWI or drug related

offense had reported substance abuse and suicidal behaviors, and have had a diagnosis of a clinical mood disorder. This supports current research about youth who have substance abuse disorders often have co-occurring mental health disorders specifically, mood disorders (Teplin et al., 2005). Youth with co-occurring mental health disorders tend to have more severe substance abuse disorders, greater family dysfunction, and poorer treatment outcomes (Rowe et al., 2004).

Clinical Descriptors and Referrals

From October, 2005 until October, 2006 AFY caseworkers made approximately 1,442 referrals for mental health, substance abuse, parenting, mediation, aftercare and educational services for their program participants. After all the variables were analyzed against clinical variables, the mental health referrals showed a significant association with substance abuse, and prior outpatient treatment. This finding again supports the theories on the co-occurring relationship between substance use and mental health disorders in adolescent offenders (Teplin et al., 2005).

It is important to mention that as the numerous intervening variables were analyzed for many different associations, all but a few were significant. These negative results has important implications for the AFY program. As the one of the main objectives of the program to provide services and referrals to the youth and families, it is important that they demonstrate some associations between their services and the outcome. The specific recommendations for the program to improve this aspect of their program will be discussed later.

Mental Health Outcomes

The focus of this exploratory study was to examine the impact of mental health issues on outcome. Although it cannot be concluded that having mental health issues directly affect the outcome of AFY youth, the logistic regression analysis did show that having certain mental health diagnosis increased the likelihood of having juvenile justice involvement. To some, it may come as a surprise that it was the mood disorders that increased the likelihood of a JD/PINS outcome as compared to the behavior disorders. However, again the AFY youth in this study who reported a Mood disorder also have a Behavior Disorder, so consequently, the results demonstrate that having both disorders increase your likelihood of a JD/PINS outcome.

It is important however to discuss the relationship between types of clinical disorders and diagnosis and treatment issues. Previous studies have shown that in the general population, youth with disruptive (behavior) disorders are more likely to obtain mental health services than those with mood disorders (AACAP, 2008; Stiffman, et al., 1997). It has also been presumed that young men often suffer with mood disorders at higher rates than reported and diagnosed, and their behaviors and symptoms of the mood disorders are frequently unnoticed and misdiagnosed (AACAP, 2008). It is important for those working with male adolescents, not to disregard the possibility of a identifying symptoms of a Mood disorder when their behavior is aggressive and typical of the Disruptive disorders.

The logistic regression model also found that as the number of referrals a youth received, increased the odds of having a juvenile justice outcome decreased. It can be asserted that this result supports the goals of the AFY program. If youth with mental health issues are being diverted to treatment and services, then they will be less likely to require further juvenile justice involvement. Since the majority of youth report behaviors and symptoms consistent with mental

health disorders (aggressive, substance abuse, runaway, truancy, suicidal and fire play behavior) by intervening and providing a number of services, the AFY program attempts to get youth and families the services they need to avoid court involvement and placement.

Another important finding was the logistic regression analysis performed to predict a PINS outcome. Although reporting sex abuse was found to be a significant predictor in the second block of the analysis, once the "number of referrals" variable was added, the predictor value of sex abuse was no longer significant. We can assume that youth with a history of sexual abuse will be assessed by the AFY worker for referrals to a number of necessary services and treatment, thereby decreasing the likelihood of a PINS outcome.

As has been noted, AFY was designed as a PINS diversion program, intended to connect high risk youth and their families to necessary services and treatment to avoid court involvement and placement in the juvenile justice system. The obvious limitations of a pre-experimental design (including lack of a control group) prevent the ability of this study to claim that the AFY program prevented the placement or any court involvement of its participants. It can be asserted, however, that the majority of youth, who participated in the AFY program from October 2005 until October 2006, did not have court involvement and placement after their case was opened by AFY. Since the "number of referrals" was a variable that had a significant predictor value on the overall juvenile justice outcome, it can be inferred that the AFY program was an effective way to prevent youth from court involvement or placement.

Limitations

Using an exploratory pre-experimental descriptive design, the limitations of this study are clear. A control group was not used for this study, and as a result the findings cannot be generalized outside of the AFY program participants. The data analyzed were information

gathered and used in the course of business and provided to the researcher from the first year that the AFY program was in operation. The problems concerning the missing and inconsistent entries into the AFY data base, along with the lack of outcome and follow up information on the AFY participants are major impediments to the efficacy of this study. These are consistent with the limitations inherent to using a secondary data source. It is essential for the longevity of the AFY program for its outcome data to demonstrate that their participants receive treatment and services at the agencies that they provided referrals for.

Another limitation of the study was the absence of an effective assessment tool to measure behavior and mental health needs at the start of the program. The Child Adolescent Needs Survey or CANS (the assessment instrument that the program chose at the onset of the program) was not an appropriate tool for the nature of this program. The intention of the CANS was to measure behavior change over a period of time; however, the lack of participation in the follow up process made this an ineffective tool. Given that AFY was intended to be a short term, crisis intervention program, an assessment instrument not requiring continued follow up measures should have been implemented. Recommendations for an effective assessment tool will be discussed later in this chapter.

The data obtained from the Department of Probation was also a limitation in this study. While extracting case records from the Probation Department, it was observed that many records had different types of information and some cases were still pending. As a result, there was missing and incomplete data with the extraction. The Department of Probation has a number of wonderful opportunities for future and follow up research with the juvenile justice population, however, data extraction from case records from juveniles should be conducted with caution.

In the bivariate and multivariate analysis conducted in the study, many of the significant findings were discounted since the predictive value was too low based on the missing number of entries. All of these limitations can be addressed by the program and can lead to a more stringent research design.

Recommendations

Recommendations for the AFY program center around the improvements that need to be made in the data collection process, assessment, and follow up. These recommendations will create a better way to document and measure the important services and outcomes that the AFY caseworkers provide the youth and families. The first recommendation is based on the changes in the data collection process of the AFY program. AFY caseworkers should be trained on the importance of consistent entries and how to appropriately complete the intake interview even if the answers are not documented completely or at all. Improvements to the database need to provide for string variables and an increase in the number of fields for the answers to be provided. This will eliminate the need for answers to be left blank when the response to a question does not "fit" into the response tab. Blank responses should not be accepted in the database and this will require the worker to enter a response, even if it is "no response". This will eliminate the question of differentiating a true "no" answer versus a default "no" in the missing entries. This will eliminate the need to disregard all missing entries and values and lead to a more consistent database. The new database will provide an ability to examine and explore all the important variables that are asked within the AFY intake.

The improvement of the entries to the database along with a more intentional attempt to obtain the status of the referrals for AFY participants should be required of the program. The AFY caseworkers have actively attempted phone calls and mailings in an effort to get follow up

information from their participants. These attempts did not prove successful however. A current AFY case worker recommended trying "emailing" follow up questionnaires on a regular basis to their participants. This is an important recommendation and a simplistic one to implement. The computerized response should also be done with the referring agencies, including in the emailed correspondence a signed release of information from the participants specifically requesting only details of their attending the programs, not specific details of the treatment services they provide. Using the internet to correspond with both participants and agencies may increase the referral status and outcome data considerably.

Another important recommendation for the AFY program is to change the assessment and screening instrument that is used. One of the most important things that can be done to effectively respond to the mental health treatment needs of youth in the juvenile justice system is to be able to specifically identify what their needs are (Skowyra & Cocozza, 2006). In order to do this, an effective screening instrument should be in place at the earliest point of their contact with the juvenile justice system (Skowyra & Cocozza, 2006). AFY provides a great opportunity to do such an assessment.

One of the most widely used mental health screening tools which has been developed, is the recently Massachusetts Youth Screening Instrument- Second Version (MAYSI-2) (Grisso & Barnum, 2006). This is a 52 item, self report instrument, which identifies potential mental health and substance abuse problems among youth. It has been adopted for use in 49 states and for statewide use in probation, detention and other juvenile correction programs. Appropriate training for those who are administering the instrument is also recommended, and a good mental health screening instrument should be able to be administered in the same way for all youth. Youth should understand the purpose of the screening tool, and it should be explained that it is

used to better understand them and their needs. The screening tools are not intended to be used as a psychiatric diagnosis, but as a way to identify symptoms and problematic behavior that needs further attention (Skowyra & Cocozza, 2009).

Collaboration/Coordination of Systems for Outcomes

The wraparound approach is based on a collaboration and coordination of systems working together to help clients and families. In order to better demonstrate the effectiveness of wraparound theory, it is essential that the numerous agencies involved have a procedure in place for measuring outcomes. It is important that all involved agencies can recognize the importance of their interventions and wraparound strategies by documenting the results of their collaboration. With understanding that this is a complicated recommendation, a committee of representatives from all the different agencies involved should organize and develop a plan for measuring outcomes which is consistent with their agencies policies and procedures. The protection and confidentiality of the participants will also be considered in this plan. Wraparound theory has demonstrated some successful outcomes and it would benefit AFY to be able to demonstrate with a more rigorous study that wraparound theory is an effective intervention with youth involved in the juvenile justice system in Suffolk County, N.Y.

Using wraparound theory as a framework for working with troubled youth and families is a valuable way to approach intervention and management of services. By assessing the needs of the entire family, and offering an array of necessary services, the outcome is more likely to be effective. It also takes the blame of the situation off the individual youth and views the problems as symptoms of a larger issue.

Looking at the needs of the entire family, and having the family involved in the process of deciding the appropriate intervention in a crisis are foundations of the wraparound approach. Limitations in the design of this study prevent the claim of the effectiveness of wraparound theory with AFY; however, more stringent and controlled studies should be done in the future to explore its relationship to the outcomes with the AFY. Past studies have demonstrated the effectiveness of this approach with juvenile justice involved youth (Pullman et al, 2006; Carney & Buttell, 2003; Burns et al 2000). Further research is necessary to demonstrate continued effectiveness with programs with a wraparound approach.

Policy Implications

Despite the limitations of this study, it can be asserted that AFY has important policy implications for the juvenile justice system. Out of 573 AFY participants, 84.8% did not have any additional court involvement or residential placement. When examining this program strictly from a cost – effectiveness standpoint, it can be deduced that a diversion program like AFY can save the county and state a significant amount.

With the focus on effective diversion programs and policy changes to find appropriate alternatives to placement, the juvenile justice system is attempting to meet the needs of these high risk youth. By targeting the issues the youth are struggling with, specifically mental health problems, diversion programs have better outcomes for youth. Keeping youth at home, coupled with the provision of supports and community based services, provides a foundation wherein the juvenile justice system will be more likely to decrease recidivism and thus the likelihood of adult criminality.

With the trend to decrease (and close) residential facilities for juvenile justice involved youth, this program presents a way to demonstrate to policy makers an option for helping at risk

youth with their complex problems. AFY is a program that can save agency administrators and parents the expense and stress of removing a child from their home. It has been demonstrated that young people who are served within their own communities have been shown to be more likely to succeed in their treatment (Vera Institute of Justice, 2009).

Future Research

There are many important research opportunities that should be considered for future studies with this population. In order to demonstrate more significant associations, a stringent and controlled research design is recommended for future research. Ideally, this study can be replicated with a comparison group. Although ethical considerations would necessitate the fact that a youth would never be denied program services, a possible comparison group could be status offenders in another nearby county with similar problems and behaviors. More rigorous design recommendations would also include a post test or a way to measure the outcome of behavior change after participation in the program.

Status offenders should also be researched further. They often present a number of complex behavioral issues and additional information should be gathered in an attempt to provide more effective interventions. When youth are deemed status offenders, this is often the first phase into the juvenile justice system for many at risk youth. It would be beneficial to the youth and community to improve the ability to identify the needs and provide effective solutions; this would be an important way to prevent recidivism and escalation of behavior

Future research should also focus on the important demographic differences of youth involved in the juvenile justice system. Studies exploring gender differences in behavior and clinical disorders would be extremely beneficial in understanding the needs of juvenile delinquent and status offenders. Understanding these needs would also provide the opportunity

to provide more consistent and effective services. Research demonstrating ethnic differences, especially when it is relevant to arrests, detainment and incarceration is also a necessary component of improving the juvenile justice system. The disproportionate number of youth of color being detained and placed should be concerning to all those who work in the juvenile system and more research is required in an attempt to ameliorate this problem.

The last recommendation of future research is specific to AFY and the wraparound approach. A more stringent, controlled design accounting for outcomes and measures in behavior changes would be an important next phase of research for the AFY program. It could be a measure of the effectiveness of the wraparound approach and how to better improve the services and treatment the participants receive.

Conclusion

The purpose of this study was to describe an innovative diversion program which provides services and treatment to youth at risk for court intervention, adjudication, and placement in to the juvenile justice system. The results of this study have some important policy implications for those who work with youth involved in the juvenile justice system. Since the majority of youth had no further involvement in the juvenile justice system, this program certainly indicates a measure of success. Child welfare and juvenile justice agencies have initial evidence of how to effectively address and attempt to resolve the adolescent's behavioral and emotional challenges. AFY's effort to coordinate and integrate services for youth in the juvenile justice systems, may serve as a model for other county agencies.

Young people involved in the juvenile justice system have a multitude of problems, including problematic behavior and a number of mental health issues. Programs which attempt to help the young people and their families by providing them appropriate treatment and services

will have long lasting positive effects beyond the cost benefit and budgetary savings. Young people will learn how to understand and manage their behavior and problems and ideally learn many other skills to be successful, self sufficient adults.

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APPENDIX A

Alternatives For Youth
Intake Form

Date Referred to the AFY Program: _____

Date of **FIRST** contact (*phone call or other*):
Was the referral contacted within one business day? ~~**Y N**~~

If no, why? Not Home
Did not return call
Other

Date of **Intake**:

_____

Demographic Information:

Last Name: _____ **First Name:** _____

Date of Birth of referred Youth: _____

Gender: Male Female

Hispanic: Yes No

Race/Ethnicity of juvenile:

African American Caucasian Asian Native American Other:

Primary Language spoken by juvenile:

English Spanish Other:

Primary Language Spoken by parent(s): English Spanish Other:

Parents Marital Status:

Married Separated Divorced widowed never married

Is the child currently in foster care: **Y** **N**

Health Insurance **Y** **N** If yes, Name of Insurance:

Medicaid: **Y** **N**

_____

Contact Information

Contact 1

Parent or Guardian Name:

Street Address: _____

Town: _____

Zip Code: _____

Phone Number Home: AREA CODE ( ) _____

Other Phone Number: AREA CODE ( ) _____

Contact 2
Parent or Guardian Name: _____

Street Address: _____

Town: _____

Zip Code: _____

Phone Number Home: AREA CODE ( ) _____

Other Phone Number: AREA CODE ( ) _____

If Child not living with contact person

Name: _____

Street Address: _____

Town: _____

Zip Code: _____

Phone Number Home: AREA CODE ( ) _____

Other Phone Number: AREA CODE ( ) _____

INCOME/HOUSING

1. Is household income from any of the following sources?
2. Family Member amount (annual)
    a. Paid employment NO YES_____
    b. Social security (SSA) NO YES_____
    c. Social security Disability income (SSDI) NO YES_____
    d. Supplemental security income NO YES_____
    e. Public assistance/home relief NO YES_____
    f. Child Support NO YES_____
    g. Veteran's Benefits NO YES_____
    h. Pension NO YES_____
    i. Other

3. At the time of the referral, what was the family's housing status?

    Own Rent emergency housing other_____

4. At the time of the referral, where is the child living?

    Home with parents

    With friends

    With relatives other than parents

    Other_____

CLINICAL DESCRIPTORS

	CURRENT Last 30 days	PRIOR
Physically aggressive or violent	Y N	Y N
Substance Abuse	Y N	Y N
Runaway	Y N	Y N
Truant	Y N	Y N
Suicidal Gestures or Attempts	Y N	Y N
Fireplay	Y N	Y N
Sexually Abusive	Y N	Y N
Sex Abuse Victim	Y N	Y N
Physical Abuse Victim	Y N	Y N
Mental Health Outpatient Care	Y N	Y N
On Psychotropic Medication	Y N	Y N

See CANS for additional Information

Has this child ever had a psychiatric or psychological diagnostic evaluation?

YES NO

If yes, the date _____ Agency _____

# of psychiatric hospitalizations _____

# of psych Emergency room visits _____

Primary DSM IV Diagnosis: _____

Prior Out of Home Placement: Non-secure detention
Foster Home
Group Home
RTC
RTF

Prior OMH Services: CRF Teach Family Homes Family Based Treatment

SCHOOL HISTORY

1. What is the youth's school district?_____
   (name of District)

Educational Placement:
Please check appropriate box

Type of Educational Placement			
	Regular Education		Parochial School
	District Special Education		Home Tutoring
	BOCES		Other:
	Day Treatment		

2. If a child is placed out of district. Name the placement (i.e. BOCES, James E. Allen Learning Center) _____
3. Current School Grade 4 5 6 7 8 9 10 11 12 ungraded

4. Is the youth in special education? YES NO

If yes, Handicapping Condition:

1-Autism
2-Deafness
3-Deaf-Blindness
4-Emotional Disturbance
5-Hearing Impaired
6-Learning Disabled
7-Mental Retardation
8-Multiple Disabilities
9-Orthopedic Impairment
10-Other Speech Impairment
11-Speech or Language Impairment
12-Traumatic Brain Injury
13-Visual Impairment

5. If yes, when was the date of the last CSE _____

IQ Test Score:
Date of most recent test scores:_____
Full scale Score_____Performance Score_____Verbal Score_____

See CANS for additional school information

CANS MODULE SCORES:

	INTAKE	6 MONTHS	1 YEAR
Problem Presentation			
Risk Behaviors			
Functioning			
Care Intensity & Organization			
Family/Caregiver Needs & Strengths			
Strengths			
Criminal & Delinquent Behaviors			
Substance Abuse Complications			
Child Abuse Permanency Exploitation			

SERVICES RECOMMENDED:

1. Mental Health YES NO

   _____ Individual Counseling
   _____ Family Therapy
   _____ Substance Abuse Counseling

2. Educational Assistance (LIAC) YES NO

3. Referral to NYS Child Abuse YES NO

4. Youth at risk of foster care? YES NO

5. Youth Bureau Outreach YES NO

Services Recommended for:

Family & Youth Individual Youth

DATE OF FIRST SERVICE APPOINTMENT:_____

REFERRAL INFORMATION

DATE OF REFERRAL	TYPES OF SERVICES NEEDED*	AGENCY	NAME OF THE CONTACT PERSON AT THE AGENCY	AGENCY PHONE NUMBER

*****Types of services: Individual counseling, substance abuse treatment, family counseling, educational services, social services, youth bureau services

DATE OF FIRST SERVICE APPOINTMENT:_____

REFERRAL INFORMATION

DATE OF REFERRAL	TYPES OF SERVICES NEEDED*	AGENCY	NAME OF THE CONTACT PERSON AT THE AGENCY	AGENCY PHONE NUMBER

*****Types of services: Individual counseling, substance abuse treatment, family counseling, educational services, social services, youth bureau services

Outcome or Follow Up Data

Please also see CANS section for additional outcome data

DATE OF FIRST SERVICE APPOINTMENT:_____

REFERRAL INFORMATION

Follow-up Questions	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Follow-up contact completed?				
Did Family Follow Service plan?				
Did Family drop out?				
Did family file PINS?				
Where is child living?	Home Foster care RTC RTF Grp Home Diag. Facil.	Home Foster care RTC RTF Grp Home Diag. Facil.	Home Foster care RTC RTF Grp Home Diag. Facil.	Home Foster care RTC RTF Grp Home Diag. Facil.

ANY OBSTACLES TO SERVICES:

First Quarter:

DATE:_____

_____
_____
_____

Second Quarter:

DATE:_____

_____
_____
_____

Third Quarter:

DATE:_____

_____
_____
_____

Fourth Quarter:

DATE:_____

_____
_____
_____

APPENDIX B

Data Extraction Form

Client ID #: Sentencing Year:

Age: Sex: Race:

I. Demographic:

1. Place of Birth _____
2. Citizenship_____(status)_____
3. English Primary Language : Y N
4. Gang affiliation_____
5. Employed: Y N

_____

_____

_____

II. Legal Issues:

6. Present Court Conviction:_____
7. Custody status: Detention/liberty/ror/bail_____
8. Plea:
9. YO: Eligible Verified Not Recommended
10. Juvenile: Yes no

JD PINS
JO DF

III . Family HX

11. Family Members: Relation: Age: Occupation:

_____

_____

_____

_____

_____

_____

_____

_____

12. Currently living arrangements?_____

13. Intact/Divorced/ Separated/Never married?_____--

14. Current Contact w fthr? Y N cCurrent contct w,Mthr? Y_____N

IV Education:

15. Last school attended_____

16. Last grade completed _____

19. Currently attending?

V. Health/MH

20. Physical Health good fair poor

_____

21. Mental Health no hx prior hx

(explain)_____

current

involve?_____

22. Tx History :Year

_____

a) Agency:

_____

b) Diagnosis outline: _____

VI. Substance Use

23. Current Al

24. Past Al

25. Current Ill Drug Use

26. Past Ill Drug Use

27. Impact present offense Yes No type

28. Tx history :_____

a) BAC/refused_____

29) Tx information: none date(s):

a)Detox/ tx agency_____

b) Diagnosis outline_____

VII. Gang Involvement

a) Admission Y N

explain:_____

_____

_____

codefendants?_____-

VIII. Legal Hx

Year	Arrest/Conviction	Sentence/Dispo/ and Year

HX of: Foster care? Y N

CPS reports? Y N (Y), please explain :

_____

IX. Psychosocial Information

a)Description of Prior/current behavior :

b) Description of Present Offense :

c) Evaluative Analysis (hx of abuse, hx of MI):

APPENDIX C :

Tables of Towns/School Districts

Variable	Frequency	Percent	Valid Percent
Town			
Amityville	16	2.8%	2.8%
Aquebogue	1	0.2%	0.2%
BayShore	29	5.1%	5.1%
Bayport	1	0.2%	0.2%
Bellport	8	1.4%	1.4%
Bluepoint	1	0.2%	0.2%
Bohemia	8	1.4%	1.4%
Brentwood	51	8.9%	8.9%
Calverton	4	0.7%	0.7%
Center Moriches	2	0.3%	0.3%
Centereach	9	1.6%	1.6%
Centerport	2	0.3%	0.3%
Central Islip	27	4.7%	4.7%
Cold Spring Harbor	1	0.2%	0.2%
Commack	3	0.5%	0.5%
Copaigue	9	1.6%	1.6%
Coram	15	2.6%	2.6%
Cutchogue	2	0.3%	0.3%
Deer Park	7	1.2%	1.2%
Dix Hills	4	0.7%	0.7%
East Hampton	2	0.3%	0.3%
East Islip	4	0.7%	0.7%
E Marion	1	0.2%	0.2%
E Moriches	3	0.5%	0.5%
E Northport	11	1.9%	1.9%
E Patchogue	3	0.5%	0.5%
E Quogue	2	0.3%	0.3%
E Setauket	2	0.3%	0.3%
Farmingdale	2	0.3%	0.3%
Farmingville	11	1.9%	1.9%
Flander	1	0.2%	0.2%
Greenlawn	1	0.2%	0.2%
Greenport	2	2.3%	2.3%
Hampton Bays	4	0.7%	0.7%
Hauppauge	2	0.3%	0.3%
Holbrook	7	1.2%	1.2%
Holtsville	1	0.2%	0.2%
Huntington	11	1.9%	1.9%
Huntington Station	20	3.5%	3.5%
Islip	3	0.5%	0.5%
Islip Terrace	3	0.5%	0.5%
Jamesport	1	0.2%	0.2%
Kings Park	1	0.2%	0.2%

Variable	Frequency	Percent	Valid Percent
Lake Grove	5	0.9%	0.9%
Lake Ronkonkoma	4	0.7%	0.7%
Lindenhurst	16	2.8%	2.8%
Manorville	3	0.5%	0.5%
Mastic	17	3.0%	3.0%
Mastic Beach	20	3.5%	3.5%
Mattituck	3	0.5%	0.5%
Medford	22	3.8%	3.8%
Melville	3	0.5%	0.5%
Middle Island	6	1.0%	1.0%
Miller Place	5	0.9%	0.9%
Moriches	2	0.3%	0.3%
Mt Sinai	1	0.2%	0.2%
Neconset	1	0.2%	0.2%
No Babylon	12	2.1%	2.1%
Northport	7	1.2%	1.2%
Patchogue	16	2.8%	2.8%
Port Jefferson	2	0.3%	0.3%
Port Jefferson Station	2	0.3%	0.3%
Ridge	6	1.0%	1.0%
Riverhead	10	1.7%	1.7%
Rocky Point	6	1.0%	1.0%
Ronkonkoma	10	0.5%	0.5%
Sag Harbor	3	0.3%	0.3%
St James	5	0.9%	0.9%
Sayville	6	1.0%	1.0%
Selden	8	1.4%	1.4%
Setauket	3	0.5%	0.5%
Shinnecock	2	0.3%	0.3%
Shirley	23	4.0%	4.0%
Shoreham	3	0.5%	0.5%
Smithtown	6	1.0%	1.0%
Sound Beach	2	0.3%	0.3%
Southhampton	2	0.3%	0.3%
Southhold	3	0.5%	0.5%
Speonk	2	0.3%	0.3%
Stony Brook	1	0.2%	0.2%
Wading River	4	0.7%	0.7%
West Babylon	9	1.6%	1.6%
West Islip	6	1.0%	1.0%
West Sayville	2	0.3%	0.3%
Wyandanch	4	0.7%	0.7%
Yaphank	2	0.3%	0.3%
School District			
Amityville	9	1.6%	1.7%
BayShore	9	1.6%	1.7%
Bellport	12	2.1%	2.3%

Variable	Frequency	Percent	Valid Percent
Bluepoint	2	0.3%	0.4%
Brentwood	64	12.0%	12.0%
Center Moriches	1	0.2%	0.2%
Central Islip	28	4.9%	5.3%
Cold Spring Harbor	1	0.2%	0.2%
Commack	5	0.9%	0.9%
Comsewogue	2	0.3%	0.4%
Connetquot	12	2.1%	2.3%
Copaigue	13	2.3%	2.4%
Deer Park	6	1.0%	1.1%
East Islip	5	0.9%	0.9%
E Northport	6	1.0%	1.1%
E Patchogue	3	0.5%	0.5%
Elwood	2	0.3%	0.4%
Greenport	3	0.5%	0.6%
Half Hallow Hills	6	1.0%	1.0%
Hampton Bays	10	1.7%	1.9%
Harborfields	3	0.5%	0.6%
Hauppauge	1	0.2%	0.2%
Huntington	16	2.8%	3.0%
Lindenhurst	15	2.6%	2.8%
Mattituck	4	0.7%	0.8%
Middle Country	23	4.0%	4.3%
Miller Place	7	1.7%	1.3%
No Babylon	13	2.3%	2.4%
Northport	9	1.6%	1.7%
Patchogue-Medford	34	5.9%	6.4%
Port Jefferson	1	0.2%	0.2%
Riverhead	26	4.5%	4.9%
Sachem	29	5.1%	5.5%
Sag Harbor	3	0.5%	0.6%
Sayville	7	1.2%	1.3%
Shoreham-Wading River	8	1.4%	1.5%
Smithtown	12	2.1%	2.3%
South Huntington	13	2.3%	2.4%
Southhold	3	0.5%	0.6%
Three Village	5	0.9%	0.9%
West Babylon	10	1.7%	1.9%
West Islip	7	1.2%	1.3%
William Floyd	45	7.9%	8.5%
Wyandanch	3	0.5%	0.6%
Missing	41	7.2%	7.2%

APPENDIX D

6. 1 Offense Category Definitions and Specific Offenses for All Inmates

Violent* ** from NYS Division of Criminal Justice Services*	**Assault** – aggravated assault upon a peace office; assault 1st &2nd; gang assault 1st & 2nd; assault upon a peace officer, police, fireman or emergency medical services professional; stalking 1st **Homicide –**manslaughter 1st; murder 1st & 2nd; **Sex Offenses** – rape 1st; sodomy 1st; aggravated sexual abuse 1st, 2nd, 3rd; sexual abuse 1st; course of sexual conduct against a child 1st &2nd; **Burglary** – burglary 1st & 2nd; **Robbery** – robbery 1st & 2nd; **Weapon Offenses** – criminal possession of a weapon 1st,2nd,3rd; criminal use of a firearm 1st & 2nd; criminal sale of a firearm 1st & 2nd; criminal sale of a firearm with the aid of a minor; **Other Violent Felony Offenses** – kidnapping 1st & 2nd; arson 1st & 2nd; intimidating a victim or witness 1st & 2nd
Drug	Criminal possession of a controlled substance 1st – 7th; use of child to commit a controlled substance offense; criminal sale of a controlled substance 1st – 5th; possession of hypodermic instrument; criminal injection of a narcotic drug; criminal use of drug paraphernalia; unlawful possession of marijuana; criminal possession of marijuana 1st – 5th; criminal sale of marijuana 1st – 5th
DWI	Driving while ability impaired (alcohol or drug); operating a motor vehicle(alcohol or drugs); driving while intoxicated;
Property	Trespass; criminal trespass; burglary 3rd; possession of burglary tools; criminal mischief 1st – 4th; criminal tampering 1st – 3rd; arson 3rd – 5th; petit larceny; grand larceny 1st – 4th; unauthorized use vehicle 1st – 3rd; auto stripping 1st – 3rd; criminal possession of stolen property 1st – 5th;
Sex Offenses	Sexual misconduct; rape 2nd & 3rd; criminal sexual act; forcible touching; sexual abuse 2nd & 3rd; aggravated sexual abuse 4th;
Assaults	Assault 3rd; menacing 1st-3rd; hazing; reckless endangerment; stalking 2nd-4th; tampering with a witness; criminal contempt 1st & 2nd; aggravated harassment; criminal interference; Robbery 3rd.
Violations	Violation of Probation; Violation of Parole; revocation of parole; Violation of Family Court Act; Family Court Warrant; failure to register as sex offender; FOA Warrant, FUG Just.
Other	All other charges not specified above