

2008

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Recommended Citation

Marciniak, Liz and Marsh, Diane T. (2008) "Assessment Practices in Residential Treatment Facilities for Juvenile Offenders," *Contemporary Issues in Juvenile Justice: Vol. 2 : Iss. 1* , Article 2.

Available at: <https://digitalcommons.pvamu.edu/cojpp-contemporaryissues/vol2/iss1/2>

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Cover Page Footnote

The authors express appreciation to Jennifer Zajak for early consultation on the project; to research assistants Loriann Fetter, Julie Loffredo, and Danielle Reinke for help with data collection; and to Valerie Kubenko for administrative assistance. Correspondence concerning this article should be addressed to Liz Marie Marciniak, PhD, Powers Hall 131, University of Pitts-burgh at Greensburg, 150 Finoli Drive, Greensburg, PA 15601. Telephone: 724-836-7484. Fax: 724-836-7133. E-mail: elm21@pitt.edu.

Assessment Practices in Residential Treatment Facilities for Juvenile Offenders

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Abstract

Given the high prevalence of mental disorders among juvenile offenders, as well as the link between untreated disorders and delinquent behavior, there is a critical need for standardized, cost-effective, and clinically effective procedures to identify youth with mental health problems. Surveys were sent to staff in juvenile residential facilities throughout Pennsylvania to examine statewide assessment practices, including the background and training of staff, the standard intake procedures used in these facilities, and the role of assessment in treatment planning. Although results provide evidence of some common statewide assessment practices, there was significant variability in the use of specific procedures. Suggestions are offered for enhancing mental health screening and assessment in juvenile justice facilities.

In contrast to past neglect, there is increasing recognition that the mental health needs of youth in the juvenile justice system are an important focus of intervention. Several well-designed studies have documented the high prevalence of mental disorders in this population (Skowrya and Coccozza, 2007 and Teplin et al., 2002). As many as 65% of these juveniles have a diagnosable mental disorder (Desai et al., 2006), a rate that is estimated to be two or three times higher than that among adolescents in the general population (Grisso, 2005). Moreover, a majority of those who are diagnosed with a mental disorder also meet the criteria for one or more co-occurring mental or substance use disorders (Abram, Teplin, McClelland, and Dulcan, 2003), a high rate of comorbidity that complicates both diagnosis and treatment. The death rate from suicide also appears to be significantly higher among juvenile offenders than among nonoffenders (Ryan and Redding, 2004; Sheras, 2000).

In spite of the evidence of significant mental health problems among these adolescents, there is general agreement that the juvenile justice system has not been effective in meeting their needs in the past (Desai et al., 2006). There is a compelling rationale for providing juvenile offenders with mental health services (Wasserman, Ko, and McReynolds, 2004). Their untreated mental disorders may contribute to their delinquent behavior, interfere with their rehabilitation, increase the likelihood of an adverse reaction to confinement, and

undermine their ability to participate in programs designed to address their mental health, physical, and academic needs. All of these factors may increase the risk of recidivism. In contrast, as Ryan and Redding (2004) have affirmed, appropriate mental health services may lead to improvements in psychosocial functioning, interpersonal relationships, academic performance, and decreases in delinquent, disruptive, and suicidal behaviors.

In fact, researchers have found that providing mental health services may reduce recidivism (Lipsey, Wilson, and Cothorn, 2000; Skowrya and Coccozza, 2007). The challenge is to provide accessible, innovative, and effective treatments to incarcerated youth, a population that is often beyond the reach of traditional mental health services (Teplin, Abram, McClelland, Washburn, and Pikus, 2005). Grisso and Underwood (2004) have pointed out that identifying troubled youth is the first step in providing them with appropriate intervention. Thus, there is a critical need for standardized, cost-effective, and clinically effective procedures to identify these adolescents so that they can receive the appropriate services. Such procedures must also meet the requirements of juvenile justice settings (Bailey, Doreleijers, and Tarbuck, 2006).

Wasserman and her colleagues (Wasserman, et al., 2003; Wasserman, Ko and McReynolds, 2004) have discussed, assessment practices for obtaining mental health information vary enormously across settings, such as detention, court, placement, and diversion, and also across jurisdictions, even within the same state. Further-more, current practices frequently do not employ evidence-based, scientifically sound instruments, and they often do not reflect the highest standard of care. Although a common practice has been to rely on prior use of mental health services as an indicator of current needs, many juveniles with mental disorders have not previously received services. Too often, their needs have

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gone unrecognized and untreated because of inadequate screening and assessment.

The present study was designed to provide additional information regarding assessment practices in juvenile residential facilities. Specific objectives were to obtain information about the background and training of staff, to explore the standard intake procedures used in these facilities, and to examine the role of assessment in treatment planning.

Method

The data came from surveys completed by staffs who were in charge of assessment at juvenile residential programs in the state of Pennsylvania. A comprehensive list of statewide juvenile residential placements was obtained from a resource directory published by the Center for Juvenile Justice Training and Research of the Pennsylvania Juvenile Court Judges' Commission. The sample included only those placements in the following categories: (a) general residential, (b) secure placement, (c) mental health residential, (d) drug and alcohol, and (e) sex offender. The sample excluded nonresidential drug and alcohol placements, nonresidential sex offender placements, and short-term detention facilities in which juveniles are placed temporarily and/or prior to juvenile court dispositions.

Participants were asked questions about their background and education. They were also asked to circle all standard intake procedures used for assessing incoming youth from a list of 51 procedures and to list any additional procedures used at their facility. In addition, facility staff was asked how soon after placement the assessment occurred and whether the type of assessment varied from one youth to another. Finally, they were asked how the results of assessment were used in treatment planning and which staff determined the treatment plan.

If surveys were not received within 3 weeks, trained research assistants made follow-up calls to the facilities, encouraged assessment staff to return the survey, and offered to send an additional survey if needed. Of the 188 surveys sent to residential placements, 58 were returned, reflecting a 31% response rate. There were some missing data due to unanswered survey questions.

Results

As indicated in Table 1, survey participants included a similar number of males ($n = 31$) and females ($n = 27$). Their highest level of education ranged from associate's degree to doctoral degree; a majority (65.5%) had a master's degree or higher. Most (81.0%) reported they had received special training in assessment.

Table 1.

Characteristics of Survey Participants from Residential Treatment Facilities (N = 58)

Variable	<i>n</i>	Percentage
Gender		
Male	31	53.4
Female	27	46.6
Highest level of education		
Associate's degree	1	1.7
Bachelor's degree	19	32.8
Master's degree	35	60.3
Doctoral degree	3	5.2
Special training in assessment		
Yes	47	81.0
No	9	15.5
Missing	2	3.4

Assessment Procedures

Table 2 lists the percentage of facilities using specific assessment procedures in the following categories: (a) interviews and clinical evaluations (100% used these procedures); (b) records (100%); (c) measures of cognitive and academic functioning (86.2%); and (d) measures of child, adolescent, and family functioning (84.5%). Of the 43 measures of child, adolescent, and family functioning listed in the survey, 33 were used by at least one facility.

As indicated in Table 2, there was substantial variability across facilities in their use of specific measures. Only the Global Assessment of Functioning was used by at least half of the facilities ($n = 30$). At least one fourth of facilities reported the use of three other measures: the Chemical Dependency Screen ($n = 26$), the Child Behavior Checklist ($n = 19$), and the Child and Adolescent Functional Assessment Test ($n = 16$). The remaining measures were used by fewer than 20% of facilities, and numerous instruments ($n = 18$) were used in three or fewer facilities.

Although listed on the survey, the following procedures were not used by any of the residential facilities: Center for Epidemiology-Depression Scale, Client Engagement in Child Protective Services, Conflict Tactic Scale, Exposure to Abuse and Supportive Environments- Parenting Inventory, Neighborhood Risk Assessment, Ohio Youth Scales, Parenting Sense of Competence, Practical Adolescent Dual Diagnostic Intervention, Texas Christian University (TCU) Motivation Scales, and Trauma Symptom Checklist (used with the Child Behavior Checklist).

Table 2

Percentage of Juvenile Residential Facilities Using Various Assessment Procedures (N = 58)

Assessment procedure	Percentage
Interviews and clinical evaluations	
Interviews	93.1
Psychiatric evaluations	93.1
Psychological evaluations	91.4
Records	
Juvenile court records	98.3
Official school records	86.2
Mental health records	96.6
Measures of cognitive and academic functioning	
Intelligence tests	72.4
Tests of academic achievement	72.4
Measures of child, adolescent, and family functioning	
Global Assessment of Functioning	51.7
Chemical Dependency Screen	44.8
Child Behavior Checklist	32.8
Child and Adolescent Functional Assessment Test	27.6
Child Trauma Questionnaire	19.0
Substance Abuse Screening Test	17.2
Massachusetts Youth Screening Instrument	15.5
Caregiver Substance Abuse Use	13.8
Family Experiences Questionnaire	13.8
Behavioral and Emotional Rating Scale	12.1
Child Endangerment Risk Assessment Protocol	12.1
Children Living with a Domestic Violence Perpetrator	8.6
Child Development Inventory	8.6
Social Skills Rating System	8.6
Children's Global Assessment Scale	6.9
Adolescent and Adult Parent Inventory	5.2
Brief Symptom Inventory	5.2
Emotional and Physical Abuse Questionnaire	5.2
Million Adolescent Clinical Inventory	5.2
Parent Evaluation of Development	5.2
Parenting Scale	5.2
Things I've Seen and Heard	5.2
CAGE	3.4
Functional Social Support Questionnaire	3.4
Stress Index for Parents and Adults	3.4
Domestic Violence Screening Tool	1.7
Family Resources Scale	1.7
North Carolina Family Assessment Scales	1.7
Parenting Stress Index	1.7
State Trait Anger Expression Inventory	1.7
The Danger Assessment	1.7
Trauma Symptom Checklist for Children	1.7
Trauma Symptom Inventory	1.7

Many participants reported they used instruments other than the 51 procedures listed in the survey, such as the Child and Adolescent Needs and Strengths (n = 4), the Columbia University TeenScreen (n = 4), the Beck Depression Inventory (n = 3), and the Estimated Risk of Adolescent Sexual Offender Recidivism (n = 3). Some agencies also reported they used generic procedures, such as a biopsychosocial history or neuropsychological test, mentioned an instrument developed by the agency (e.g., a gang/culture survey), or cited a clinical resource, such as the *Diagnostic and Statistical Manual-IV-TR* (American Psychiatric Association, 2000).

Treatment Planning

A majority of participants indicated that the assessment occurred within 30 days of placement (87.9%) and that the type of assessment varied from one youth to another, depending on the presenting symptoms and history (67.2%). When asked how the results of assessment were used in treatment planning, all facilities reported that they used the results in developing a treatment or service plan. Some facilities also used the results for other purposes, such as school placement, medication determination, referrals to ancillary services, discharge planning, and collaboration with aftercare providers. In addition, many facilities reported they used other information in treatment planning, such as reports from referring agencies and the court, input from the client and family, and psychiatric and/or psychological evaluations.

All facilities reported that numerous staff were involved in developing treatment or service plans, including the clinical supervisor (81.0%), caseworker (77.6%), counselor (75.9%), probation officer (72.4%), psychiatrist (60.3%), and psychologist (50.0%). A majority (86.2%) also listed others who participated in formulating the treatment plan. These included family, parents, or caregivers (n = 17), the juvenile (n = 9), and various other individuals, including facility staff (n = 21), mental health and substance abuse counselors (n = 18), educational staff (n = 7), medical staff (n = 4), and others (n = 4), such as a referral source, child advocate, or child welfare worker.

Discussion

Results of the survey provide evidence of some common assessment practices in juvenile residential facilities. A majority of staff had a master's degree or higher, and most had received special training in assessment. All facilities reported they use interviews and/or clinical evaluations, as well as case records, and they make use of results of assessment in treatment planning. In addition, all facilities used a multidisciplinary team approach to treatment planning, sometimes including the youth and/or family as members of the treatment team.

On the other hand, there is strong evidence that uniformity is lacking in the use of specific procedures. For example, although most facilities reported they administer some measures of cognitive and academic functioning and of child, adolescent, and family functioning, their use of specific instruments varied widely. Only the Global Assessment of Functioning was used by half of the facilities, and many instruments were used in only one or a few settings. The absence of standardized procedures undermines communication across agencies and prevents meaningful statewide data collection and analysis. Clearly, there is a need for a more standardized approach to assessment, which is recommended in the *Report of the Consensus Conference* (Wasserman et al., 2003), along with other recommendations that reflect best practices.

Firstly, it is essential to employ sound instruments for screening and assessment (Grisso and Underwood, 2004). Namely, the instruments should be reliable (yield consistently similar results) and valid (measure what they claim to measure); be appropriate for use with the juvenile justice population; be suitable for use with youth of diverse ethnic, cultural, and linguistic backgrounds; and offer relevant age- and gender-based norms. In addition, mental health assessments should be based on multiple methods of evaluation and on the input of multiple informants, including parents. Instruments should also meet practical criteria for specific settings, such as financial cost, reading ability, response format, administration time, and level of education and expertise required of staff.

Secondly, evidence-based mental health screening should be provided within the first 24 hours of a youth's arrival at a facility. Screening is a relatively brief process designed to identify those who are at increased risk of having disorders or conditions that warrant immediate attention, who are at risk for suicide or harm to others, who are currently on any type of psychotropic medication, or who require further evaluation or assessment. Essentially, screening is a triage process that is designed to identify any urgent mental health concerns and that is generally administered by nonclinical staff.

Thirdly, juveniles who have been identified during the initial screen should be referred for assessment, which involves a more comprehensive and individualized examination of the psychosocial needs and problems identified during the initial screening, including the nature of mental health and substance use disorders. In contrast to screening, assessment is more time-consuming and expensive, requires the expertise of a mental health professional, and may include contacts with parents or teachers, psychological testing, clinical interviewing, and review of past records from other agencies. The resulting report generally provides recommendations for intervention.

Fourthly, reassessment should be undertaken as needed. Appropriate candidates for reassessment might include youth whose mental health problems require close monitoring, those whose disorders may worsen

under the stress of confinement, or those who are preparing to leave a postadjudicatory secure facility and return to their communities.

Finally, it is important to provide training for staff appropriate to their role for in screening and assessment. All mental health staff should be professionally credentialed or directly supervised by credentialed staff. In light of the limited number of mental health professionals, however, appropriate training should also be provided for other gatekeepers, including judges, probation officers, and detention workers. Such training can enhance communication and collaboration between these gatekeepers and mental health professionals.

As Coccozza and Skowrya (2000) have observed, many challenges must be addressed before these recommendations can be fully implemented. Problems include the confusion across multiservice delivery and juvenile justice systems, at both the policy and practice levels, as to who is responsible for providing services to these juveniles; the lack of funding and clear funding streams to support services; and the absence of training, staffing, and programs necessary to deliver mental health services for this population. They also note the tendency to label externalizing disorders as "behavior problems," which ignores the underlying causes of the behavior, as well as the absence of sufficient research that adequately addresses the effectiveness of treatment models and services in the juvenile justice system. Other challenges include the lack of information on mental health history, limited parental involvement, short lengths of stay, unpredictable release dates, and fear of compromising the legal case (Desai et al., 2006).

In spite of these challenges, there is much reason for optimism. Researchers have repeatedly documented the high prevalence of mental disorders among juvenile offenders (e.g., Skowrya and Coccozza, 2007) and established the link between these disorders and offender behavior (e.g., Wasserman et al., 2004). There is also general agreement regarding the services that should be provided, as well as evidence for their effectiveness. In their recent report, Skowrya and Coccozza noted that numerous reviews of evidence-based treatment interventions, such as Multisystemic Therapy, Functional Family Therapy, and Multidimensional Treatment Foster Care, have consistently found positive outcomes associated with their use with juvenile offenders, including decreased psychiatric symptomatology and reduced long-term rates of recidivism.

Based on his review of the literature, Redding (2000) concluded that the best programs are based on empirically demonstrated effective treatments; simultaneously address the multiple risk factors contributing to the delinquency (e.g., child, family, school, and neighborhood variables); are tailored to each adolescent by considering the personal and environmental risk and protective factors; are of sufficient duration; and maintain high program quality in terms of staff recruitment and training, supervision, accountability for outcomes,

and ongoing program monitoring and evaluation. In addition, many excellent screening and assessment instruments are now available. For example, a comprehensive resource guide for practitioners (Grisso and Underwood, 2004) describes more than 50 screening and assessment instruments.

In summary, there is general agreement regarding best practices for screening and assessment in the juvenile justice system (Wasserman et al., 2003), as well as an expanding array of procedures that meet psychometric and practical criteria. As Grisso and Underwood (2004) have asserted, screening should be performed for all youth as they enter the juvenile justice system, assessment should be performed for those who require further evaluation, care should be taken to identify the most appropriate instruments, and need and risk levels should be carefully balanced. Only when we address the underlying problems of juvenile offenders, including their mental health problems, will the juvenile justice system be able to fulfill its mission of enhancing their prospects for a satisfying and productive future, of reducing recidivism rates, and of promoting community safety.

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