Distinguishing Between Higher and Lower Risk Youth Offenders: Applications for Practice

Kenneth M. Coll, Roger A. Stewart, Gersld A. Juhnke, Patti Thobro, and Robin Haas

The authors report the development of an assessment process for distinguishing between higher and lower risk youth offenders through the use of 3 measures. Preliminary results and applications for practice are included.

Although the overall juvenile crime rate has steadily decreased since 1994, the current serious and violent crime rate among juveniles is 60% higher than the 1980 rate for youth younger than 15 years and 41% higher for youth 15 years and older (Coll, Juhnke, Thobro, & Haas, 2003; Puzzanchera, 1998). Recent juvenile offender studies confirm that there are small groups of youth responsible for a large proportion of serious and violent delinquency (Bilchik, 1999; Coll, Thobro, & Haas, 2004; Moody, 1997). Several authors have called for increased investigations into the understanding of these problem behaviors with the goal of increasing the efficacy of the treatment planning process (Hawkins, Catalano, & Miller, 1992; Hawkins et al., 2000; Huizinga, Loeber, Thornberry, & Corthen, 2000). They specifically recommended methodically assessing and contrasting the frequency and intensity of major risk factors among individual youth offenders. This was the goal of the current study.

This study focused on the systematic assessment of youth offenders in a residential treatment program to discern their higher and lower risk for mental health and delinquency-related problems. Following a brief review of the literature that looks at the recognized risk factors associated with adolescents who offend, this article describes the development of a unique, comprehensive risk assessment process that included both self-report and clinical assessment measures. This assessment process, aimed at distinguishing those major risk factors that lead adolescents to offend, was then tested and revised. Implications for clinical work with offending adolescents and directions for future research are then discussed.

Kenneth M. Coll, College of Education and Department of Counselor Education, and Roger A. Stewart, Department of Literacy, both at Boise State University; Gerald A. Juhnke, Department of Counselor Education, University of Texas at San Antonio; Patti Thobro and Robin Haas, both at Cathedral Home for Children, Laramie, Wyoming. Correspondence concerning this article should be addressed to Kenneth M. Coll, College of Education, Boise State University, 1910 University Drive, Boise, ID 83725-1746 (e-mail: kcoll@boisestate.edu).

© 2009 by the American Counseling Association. All rights reserved.

Journal of Addictions & Offender Counseling • April 2009 • Volume 29
Much has been written about the factors that contribute to adolescent delinquency. Hawkins et al. (1992) and Hawkins et al. (2000) found mounting evidence that adolescents who are most at risk for committing serious and violent crimes tend to display high levels of risk factors, such as alcohol and other drug (AOD) abuse or addiction, lack of parent–child closeness, family conflict, beliefs and attitudes favorable to criminality, early childhood aggressiveness, antisocial behavior, and poor peer acceptance. Additionally, juvenile delinquency has long been associated with certain societal ills, such as easy access to AODs and family splintering (Hawkins et al., 2000). Huizinga et al. (2000) noted serious delinquency with co-occurring AOD abuse and mental health problems. Common clinical practice, however, is to provide broad-based assessment, with heavy reliance on clinical judgment without a self-report component. This practice is now deemed a major limitation to distinguishing higher and lower risk youth offenders (Huizinga et al., 2000).

It is not uncommon for youth offenders who commit serious and violent crimes to find themselves in therapeutic communities and/or residential treatment facilities (Coll et al., 2004; LeCroy & Ashford, 1992; Lyons, Kisiel, Dulcan, Cohen, & Chesler, 1997). Indeed, MacKenzie (1999) found that out-of-home placements for delinquent adolescents grew 51% between 1987 and 1996. Not surprisingly, adolescents treated via out-of-home placements were more likely to report higher levels of AOD abuse and more severe behavioral problems than were adolescents treated via outpatient programs (Coll et al., 2003). Despite the severity of initial problems, however, youth offenders in out-of-home placements typically reported significantly reduced drug use and criminal activities and improved psychosocial development and interpersonal functioning outcomes after at least 6 months of treatment (Coll et al., 2003; Hanson, 2002). Indeed, the professional literature is replete with reports of beneficial outcomes of residential treatment for adolescents and society in general, including reduction in recidivism (reoffending), cost-benefit savings for communities and society, increases in academic performance, and enhanced psychological adjustment (French, McCollister, Sacks, McKendrick, & De Leon, 2002; Grietens & Hellinckx, 2003). Consistent with recommendations by Huizinga et al. (2000) and Hawkins et al. (2000), Lyons et al. (1997) noted that to successfully determine the appropriateness of care for those in residential settings, the needs of youth must be assessed in a systematic, reliable, and clinically relevant manner. Child welfare funding sources are now demanding such information, recommending a thorough assessment process that covers a number of known risk areas (Mordock, 2000). Other studies with residential youth offenders have also indicated that carefully assessing major risk behaviors and promoting intensive, individualized treatment should become the preferred practices for working with youth in residential treatment (Bursdal, Force, & Klingsporn, 1990; Grimley et al., 2000). Individualized comprehensive assessment processes are considered paramount for producing positive outcomes.
As noted earlier, the purpose of this study was to specifically describe a comprehensive assessment process for distinguishing higher and lower risk youth offenders across key mental health factors in a residential treatment setting. The following question was addressed: Will higher risk offenders be significantly lower in functioning related to major risk factors when compared with lower risk offenders as measured by key mental health factors? As suggested in the professional literature, a primary goal of this investigation was to provide needed information to counselors and other staff members (e.g., teachers, youth workers) to enhance the intentionality of their treatment and to increase their ability to appropriately customize treatment plans.

Method

Research Site

The adolescent residential treatment site used in this study was a 50-bed facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) with an on-site accredited school located in the Rocky Mountain region of the United States. The facility received court-referred adolescents, most of whom had been involved in serious and violent crimes. Often, these referrals are perceived by officers of the court, parents, and the adolescent offenders themselves as their “last chance” treatment before being placed in long-term and highly restricted juvenile detention. The residents, ages 11 to 18 years, were court mandated for a variety of offenses ranging from running away to homicide. Treatment at the facility typically consists of a full school day; recreational, outdoor, and equine therapy; and individual, group, and family counseling. Residents average 1 hour per week of individual counseling, 4 hours of group counseling, and 30 minutes of family counseling. In general, recidivism (re-arrests requiring out-of-home placement) in the program is approximately 7%.

Although efforts to provide objective evidence of treatment efficacy have always been made by professional staff, pursuit of JCAHO accreditation made this imperative. Case reviews of residents who did not succeed in the program suggested prominent factors of substance abuse, aggression, and running away. On the basis of these early findings and professional literature reviews, more formal assessment procedures were instituted by professional staff, which ultimately led to the development of a comprehensive risk assessment process.

Participants

Participants were 97 adolescents in treatment at the facility, 47% of whom were girls (n = 46) and 53% boys (n = 51). The ethnic composition of those receiving the intervention was 90% Caucasian, 5% Hispanic, and 5% African American. The average age was 14.5 years (range = 12–17, SD = 2.0). The adolescents were assessed during the 1st month of their stay by a team of licensed professional counselors, psychologists, and social workers.
Development of a Comprehensive Risk Assessment Process and Instrumentation

Efforts of the staff at the adolescent treatment facility to respond to the aforementioned trends and recommendations began approximately 10 years ago. Specifically, professional staff investigated the presence of common factors among adolescent and child clients who did not successfully complete their residential treatment programs. Case reviews suggested that the most prominent prediction factors for program failure included high runaway risks, multiple prior placements, aggression, substance use, and poor family resources.

On the basis of these early findings and literature recommendations for individualized comprehensive assessment (Lyons et al., 1997), more formal assessment procedures were instituted as part of the treatment process. Increased early assessment efforts (at admission) were designed to ascertain those areas around which youth were the most troubled, needed longer treatment, required greater supervision, and posed a higher risk to self and others. Additionally, it was hypothesized that these efforts would help predict which youth would improve better and/or faster in treatment and what additional information might be needed about each youth to further enhance treatment efficacy. Treatment staff in residential treatment facilities have historically disagreed on who was “more troubled or less troubled,” creating clinical discrepancies, gaps, and inconsistencies. Thus, consistent with suggestions from the professional literature to discern frequency and intensity of risk factors, an identification process was developed to contrast those residents who scored high or “yes” in chemical abuse, conduct disorder behaviors, criminal thinking, and low family bonding with those who did not. This identification process was deemed important because staff often disagreed on treatment approaches, as well as which residents were at higher risk, needed more help, or functioned most poorly.

To this end, standardized self-report instruments were selected, including the Substance Abuse Subtle Screening Inventory for Adolescents–Second Edition (SASSI-A2; F. Miller, 2001) and the Family Adaptability and Cohesion Evaluation Scale III (FACES III; Olson, 1985). Additional clinical judgment information was gathered at admission and included the presence of any conduct disorder behaviors (American Psychiatric Association [APA], 2000) and the extent of criminal thinking patterns, which was based on Samenow’s (1998) 17 errors of criminal thinking behavior. Instruments used in this investigation adhered to Morlock’s (2000) recommendations that child and youth assessment processes include both sound clinician-rated measures and standardized client-completed measures. Experience and clinical judgment were used to establish a 4-point checklist to discern higher risk from lower risk residents. The four points were (a) a chemical-dependent profile per the SASSI-A2, (b) the number of conduct disorder behaviors within the past 3 to 6 months equal to or greater than three, (c) a criminal thinking score of “half the time” based on Samenow’s (1984, 1998) thinking errors (1-5 scale), and (d) a “disengaged” cohesion score.
of 31 or below (as standardized by Olson, 1985). This grouping variable of high-risk versus low-risk students was used to test the current study's research question (see Table 1). A detailed discussion of the measures used in this study follows.

**Standardized client-completed measures.** To measure chemical addiction/abuse, we used the SASSI-A2. The SASSI-A2 has been shown to be useful in a broad array of contexts, including court systems and mental health settings (F. Miller, 2001). According to F. Miller, the adolescent version of the SASSI was developed for youth 12 to 18 years old. The SASSI-A2 consists of 52 true/false questions and 26 items (0–3 scoring format), allowing for self-report of negative consequences of use of AODs. Through research and clinical trials conducted over 16 years (F. Miller, 2001), the test has exhibited greater than 90% accuracy in identifying those with chemical

**TABLE 1**

**Youth Comprehensive Risk Assessment (YCRA) Risk Factors, Supporting Assessments, and Higher/Lower Risk Identification Checklist**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Higher/Lower Risk Identification Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>YCRA&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1. Risk to self (including risk for suicide or self-harm, risk taking, and risk for victimization)</td>
</tr>
<tr>
<td></td>
<td>2. Risk to others (including aggression, sexually inappropriate behavior, and destruction of property)</td>
</tr>
<tr>
<td></td>
<td>3. Social and adaptive functioning (including developmental disorders, disabilities, cognitive disorganization, and social skills)</td>
</tr>
<tr>
<td></td>
<td>4. Substance abuse/dependency (including attitudes regarding chemicals)</td>
</tr>
<tr>
<td></td>
<td>5. Family resources (including family’s ability to meet child’s needs)</td>
</tr>
<tr>
<td></td>
<td>6. Degree of structure needed (including frequency of out-of-home placements and need for supervision)</td>
</tr>
<tr>
<td>Supporting assessments for the YCRA</td>
<td>1. Standardized client-completed measures: SASSI-A2, FACES III</td>
</tr>
<tr>
<td></td>
<td>2. Clinician-rated measures, conduct disorder checklist, criminal thinking assessment</td>
</tr>
<tr>
<td>Higher/lower risk identification checklist&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1. A chemical-dependent profile per the SASSI-A2</td>
</tr>
<tr>
<td></td>
<td>2. The number of conduct disorder behaviors within the past 3 to 6 months equal to or greater than three</td>
</tr>
<tr>
<td></td>
<td>3. A criminal thinking score of “half the time” based on Samenow’s (1984, 1988) thinking errors (1–5 scale)</td>
</tr>
<tr>
<td></td>
<td>4. A “disengaged” cohesion score of 31 or below was used to discern higher risk from lower risk residents.</td>
</tr>
<tr>
<td>Lower risk (n = 50)</td>
<td>1. Thirteen residents indicated none of the risk factors present at high levels.</td>
</tr>
<tr>
<td></td>
<td>2. Nineteen residents indicated one risk factor present at a high level.</td>
</tr>
<tr>
<td></td>
<td>3. Eighteen residents indicated two risk factors present at high levels.</td>
</tr>
<tr>
<td>Higher risk (n = 47)</td>
<td>1. Twenty-seven residents indicated three risk factors present at high levels.</td>
</tr>
<tr>
<td></td>
<td>2. Twenty residents indicated all risk factors present at a high level.</td>
</tr>
</tbody>
</table>

Note. SASSI-A2 = Substance Abuse Subtle Screening Inventory for Adolescents—Second Edition; FACES III = Family Adaptability and Cohesion Evaluation Scale.

<sup>a</sup>The YCRA uses a nonequal interval Likert scale of 1 to 4 x 2 (8), with 1 being slight, 2 being mild, 3 being moderate, and 4 x 2 (8) being severe and requiring immediate treatment interventions. <sup>b</sup>A 4-point checklist specifically noted.
dependency. F. Miller indicated that items on the SASSI-A2 touch a broad spectrum of topics seemingly unrelated to chemical abuse, which makes the instrument less threatening to youth who abuse substances. Other studies have validated such findings (see Coll et al., 2003).

Olson’s (1985) FACES III was used to measure family functioning and specifically family bonding. The FACES III is intended for members of families across the life cycle. The 20 items (scored on a 1–4 Likert scale) were developed to be readable and understandable to youth as young as 12 years old. For the purpose of the current study, the Cohesion scale was used; Olson defined cohesion as the emotional bonding that family members have toward one another. According to Olson, internal reliability for the Cohesion scale is .77 and test–retest reliability is .83. Content validity is reported to be very good (Olson, 1985).

Clinician-rated measures. Behaviors symptomatic of conduct disorder were assessed by the staff counselors (all holding master’s degrees in counseling or social work and holding state licenses) using previous records and a Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; APA, 2000) conduct disorder checklist. These interviews were conducted after the adolescent was on-site for at least 2 weeks. A conduct disorder checklist using the DSM-IV-TR criteria has been recommended in the literature as an effective way for assessment and monitoring conduct disorder behaviors (D. Miller, Trapani, Fejes-Mendoza, & Eggleston, 1995; Zoccolillo & Rogers, 1992).

Criminal thinking was also rated by staff counselors using a scale based on Samenow’s (1984, 1998) 17 errors in thinking. On two occasions, Samenow (1984, 1998) visited the facility and trained staff in using his criminal thinking assessment process. A sample inquiry follows:

For each of the following characteristics, please rate (the youth) on the extent to which he demonstrates these tendencies or thinking patterns: pride (e.g., refusal to back down, even on little points), victim stance (e.g., conveying a sense of the “poor me” attitude), and anger (e.g., using anger to try and control people).

A Likert scale was used to assess each thinking error (1 = almost not at all, 2 = some, 3 = half the time, 4 = frequent, and 5 = almost all the time). Assessing criminal thinking patterns and errors using Samenow’s (1998) approach has been in clinical use for many years (Coll et al., 2003; Coll et al., 2004). Examples of such thinking errors include power tactics, refusing to accept responsibility, and lack of empathy (Samenow, 1984, 1998).

Youth Comprehensive Risk Assessment (YCRA)

These assessments were initially pilot tested and reported under an “umbrella” assessment that was used as a comprehensive risk factor summary based on the six factors developed from the professional literature (listed in the following paragraph). This summary was then used to make level-of-care decisions (i.e., residential, group home, outpatient care). In the piloting phase, scores from the SASSI-A2 and the FACES III, as well as historical and anecdotal information from the client’s record, were included. Additionally, the staff assessments of clients’ criminal thinking patterns and history of conduct disorder behaviors
were also included in the risk assessment. This group of assessments and the protocol followed in the administration and interpretation of the total package became a comprehensive risk factor and social functioning summary called the YCRA (Coll et al., 2004). See Table 1 for an overview of the instrument.

The YCRA was submitted and approved as a performance measurement system with the JCAHO (1998). Per the JCAHO-approved definition, the YCRA is specifically defined as a clinical assessment process used by trained mental health professionals to systematically gather information and make clinical judgments related to six risk areas: (a) risk to self (including risk for suicide, self-harm, becoming a victim, and risk taking), (b) risk to others (including aggression, sexually inappropriate behavior, and destruction of property), (c) social and adaptive functioning (including developmental disorders, disabilities, cognitive disorganization, and social skills), (d) substance abuse/dependency, (e) family resources, and (f) degree of structure needed (frequency of out-of-home placements and need for supervision; see Table 1). Subscales and individual items from the SASSI-A2, the conduct disorder checklist, and the criminal thinking assessment, as well as historical and anecdotal information, were used to determine scores in five of the six areas (risk to self, risk to others, social and adaptive functioning, substance abuse/dependency, and degree of structure needed). The FACES III and historical/anecdotal information were used to measure the level of family resources.

The YCRA has met the rigorous criteria necessary for inclusion on JCAHO’s list of approved performance measurement systems. The YCRA has met or exceeded system adherence to all of the JCAHO quality principles, including sampling, standardization, monitoring, documentation, feedback, education, and accountability (JCAHO, 1998). The YCRA uses a nonequal interval Likert scale of 1 to 4 × 2 (8) on the basis of the recommendations of child welfare experts (Child Welfare League of America Roundtable, personal communication, June 7, 2000), with 1 being slight, 2 being mild, 3 being moderate, and 4 × 2 (8) being severe and requiring immediate treatment interventions. The distinction between 3 and 8 (4 × 2) was deemed very important to bring immediate treatment foci to these severe areas. A pilot study found that the YCRA predicted adolescent offenders’ struggles with poor social skill development and life meaning (Coll et al., 2004). Currently, clinicians at the adolescent treatment facility where the YCRA was developed systematically gather information from these assessments and develop treatment goals and interventions related to the six risk areas. At 6-month intervals, the residents undergo a reevaluation, which is designed to make adjustments in treatment planning and decisions about discharge (including time frame and placement options).

As the aforementioned set of instruments was implemented and their use refined through the YCRA process, it was discovered by the clinical staff that residents fell into two distinct groups: those who thrived in the treatment milieu and those who were resistant to the treatment process. Four problem areas were
identified that discriminated between these two groups. Those in the resistant group tended to be chemically dependent, emotionally disengaged to family, conduct disordered, and reliant on criminal thinking errors to avoid responsibility. Thus, the current study investigated the utility of the YCRA process in distinguishing youth offender risk factor patterns. Once this difference was determined, we intended to use the information to provide more intentional and individualized treatment planning and implementation strategies.

Results

Forty-eight percent (n = 47) of the participants were classified as chemically dependent per the SASSI-A2. Sixty-two percent (n = 60) met at least the minimum criteria (three or more conduct disorder behaviors within the past 6 months) for the conduct disorder diagnosis. Fifty-eight percent (n = 56) were classified as engaging in criminal thinking at least “half the time” (total scores greater than 44), and 51% (n = 49) were classified as disengaged from their families (scores less than 31).

In using the 4-point higher/lower risk identification checklist, we found that 13 residents indicated none of the risk factors present at high levels, 19 residents indicated one risk factor present at a high level, and 18 indicated two risk factors present at high levels. These 50 residents were categorized as lower risk. Twenty-seven residents indicated three risk factors present at high levels, and 20 indicated all risk factors present at a high level. Because clinical and other professional staff (e.g., teachers, administrators) strongly agreed that three of four indicators warranted high-risk status, these 47 residents were categorized as higher risk (see Table 1). These two groups were used in the following analyses.

The 47 higher risk residents were compared with the 50 lower risk residents. T-test analyses and effect size calculations (Cohen, 1988; Dunlop, Cortina, Vaslow, & Burke, 1996) ascertained statistically significant differences and the magnitude of the differences between the two groups on clinical perceptions from professional staff on the six YCRA areas.

The higher risk residents were reported by staff to have significantly more problems with social functioning (t = 2.95, df = 95, p = .004; d = .70) and substance abuse (t = 2.12, df = 95, p = .037; d = .44) and needed a significantly higher degree of structure in treatment (t = 2.94, df = 95, p = .005; d = .74). They also exhibited a significantly higher risk to self (t = 2.20, df = 95, p = .03; d = .48) and to others (t = 3.98, df = 95, p = .000; d = .93). Analyses indicated that higher and lower risk youth were not significantly different in family resources available, with both groups reporting a high need for such resources (see Table 2 for descriptive statistics).

Cohen (1988) suggested that effect sizes (d) of .20, .50, and .80 be considered small, medium, and large, respectively. On the basis of these criteria, effect sizes fell in the medium to large range. The conclusion can thus be made that these results have not only statistical significance but also practical
### Table 2
Significant Mean Differences Between Higher Risk and Lower Risk Youth Offenders

<table>
<thead>
<tr>
<th>Variable</th>
<th>Higher Risk (n = 47)</th>
<th>Lower Risk (n = 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Risk to self&lt;sup&gt;a&lt;/sup&gt;</td>
<td>14.0</td>
<td>5.1*</td>
</tr>
<tr>
<td>Risk to others&lt;sup&gt;a&lt;/sup&gt;</td>
<td>12.3</td>
<td>5.9***</td>
</tr>
<tr>
<td>Social and adaptive functioning&lt;sup&gt;a&lt;/sup&gt;</td>
<td>11.0</td>
<td>4.5**</td>
</tr>
<tr>
<td>Substance abuse/ dependency&lt;sup&gt;b&lt;/sup&gt;</td>
<td>5.2</td>
<td>2.9*</td>
</tr>
<tr>
<td>Family resources&lt;sup&gt;b&lt;/sup&gt;</td>
<td>6.3</td>
<td>2.4*</td>
</tr>
<tr>
<td>Degree of structure needed&lt;sup&gt;b&lt;/sup&gt;</td>
<td>14.7</td>
<td>4.1**</td>
</tr>
</tbody>
</table>

Note. Professional staff assessed the six risk areas. Two-tailed t tests for between-groups differences were computed. *1–24 scale with 24 = highest severity. *1–8 scale with 8 = highest severity.

<sup>*</sup>p < .05, <sup>**</sup>p < .01, <sup>***</sup>p < .001.

significance. Another way to interpret effect sizes is by transforming them into percentiles (Gall, Borg, & Gall, 1996). The range of reported effect sizes equates to percentile differences ranging from 17 to 42 percentile points. The large percentile point differences between the groups support the practical significance of these findings.

**Discussion and Recommendations: Applications for Practice**

The goal of this investigation was to provide information to the counselors and other staff (e.g., teachers, youth workers) so that they could increase the intentionality of treatment and customize their treatment plans appropriately. Whereas this study was done to improve services at one facility, it also may inform treatment procedures beyond the results of this study as indicated by the identification of key mental health risk factors.

Higher risk residents (those exhibiting high levels of at least three of the risk factors) are significantly more likely to demonstrate risky attitudes and behaviors toward self and others and to have poor social and adaptive functioning. They also seem to need much more structure, supervision, and treatment intensity. On the basis of these results, treatment strategies at the facility have been implemented to better address these issues. For the higher risk residents, intensive treatment in these areas can be especially fruitful. The following is an overview of the treatment provided.

Most of the referrals to the facility from the county court systems did not indicate a high need for substance abuse assessment and treatment (typically, only approximately 20% to 30% of the referrals indicated a possible chemical dependency problem). The results of this investigation prompted the facility to change its policy of comprehensive chemical abuse assessment from “when indicated” to “mandatory.” Facility staff found Prochaska...
and DeClemente’s (1992) Stages of Change Model particularly helpful in conceptualizing high-risk offenders, particularly the five stages of change: precontemplation, contemplation, preparation, action, and maintenance. Often, high-risk offenders were identified in the precontemplation stage of motivation for change, defined as not considering change in problem behaviors and lacking significant awareness related to these behaviors, even though such behaviors have brought a great deal of trouble. Such conceptualization has assisted staff in providing consistent interventions on the basis of motivational enhancement therapy (W. R. Miller & Rollnick, 2002; e.g., Change Plan Worksheet, rolling with resistance) as well as in reducing personal frustration and impatience.

Higher risk to others (e.g., assault, sexual aggression, destruction of property) and poor social and adaptive functioning are often directly related to conduct disorder behavior and criminal thinking (Kazdin, 1993). Facility staff benefited from information provided via a videotape about conduct disorder and criminal thinking as social interactive dysfunctions that continue across generations and that have severe consequences for others. This social-historical context within which the youth with a conduct disorder functions is often overlooked, frequently leading to failed treatment (Kazdin, 1993). Richters and Cicchetti (1993) emphasized the importance of early identification and treatment of conduct disorder, which can occur with tools such as the YCRA. Some effective strategies for reducing such risk, according to Hawkins et al. (2000), are being incorporated at the facility, including encouraging youth involvement in active classroom instruction, emphasizing interactive teaching and cooperative learning, using tutoring of the socially rejected youth, and providing assertiveness training. Solution-focused counseling and WDEP (wants, doing, evaluation, plan) approaches are also being implemented as sound practices to promote insight and behavior change (Corey, 2001).

In terms of treatment strategies for higher risk to self, Coll et al. (2004) noted that adolescents who are depressed show very different symptomatology than do adults who are depressed, typically with fewer verbal expressions of depression and with much more disruptive behaviors. As Capuzzi and Gross (1996) indicated, depressive behavior in adolescents is commonly found in irritable mood rather than depressed mood and in somatic complaints and social withdrawal. Interventions now being implemented for helping adolescents with depression include asset building, focusing on increasing sense of self-worth and reducing isolation, teaching stress management, encouraging better communication and problem-solving skills, helping promote inner directedness (e.g., through journaling), and providing appropriate psychotropic medications (Jongsma, Peterson, & McInnis, 1996).

The results of this study also reveal poor family resources (including low bonding) as a major treatment issue for all youth investigated. Bowlby’s (1988) therapeutic tasks for building better attachment and healthy human development are currently being infused into family, group, and individual interactions at this facility. Two key therapeutic tasks identified for building a secure base are
exploring various unhappy and painful aspects of life with a trusted facilitator and providing consistent encouragement; sympathy; and, on occasion, guidance.
In terms of the risk factors of social and adaptive functioning and need for supervision, the facility staff is currently integrating social skill feedback and intensive supervision (e.g., one-on-one supervision) within the context of life space intervention (Brendtro, Brokenleg, & Van Bockern, 1998). Life space intervention is a humanistic, developmental approach that accents one-on-one interactions at teachable moments (e.g., when processing recent antisocial behaviors) by getting the youth’s perspective, clarifying perceptions, and helping the youth develop strategies to succeed. Challenge is inherent in delivering effective treatment strategies for youth offenders. Progress can be a slow process, and the aforementioned interventions require consistent and compassionate involvement.

Limitations and Future Research

Participants were drawn from a single institution. Future research should include a larger number of participants from a diversity of offender settings. Additionally, a limited number of variables were explored in this study. Other variables could be investigated, which may also discern higher risk youth offenders (e.g., prior arrests, nature of crime or crimes committed). Finally, no longitudinal data on the participants in this study were collected to measure the effectiveness of the subsequent interventions. Future research should follow participants longitudinally to measure treatment outcomes. Because of these limitations, generalizability is limited in this study. Thus, care must be taken when applying the results to other populations and settings. For example, no particular subgroup within the sample was large enough to make sound conclusions at that disaggregated level. For example, neither Hispanic nor African American youth were heavily represented in the sample, which was overwhelmingly Caucasian. Thus, results may not be similar when working with larger numbers of these minority groups.

The limitations point to important areas for future research. Longitudinal data exploring treatment efficacy over time are critical as are larger sample sizes so that subgroup stratification is possible. Applying the model in a variety of settings and following clients over significant periods of time will lead to further critique of the model and possible positive adjustments to it.

Conclusion

This investigation provided evidence for the value of formally assessing risk factors via clinical observation and self-reports. Most important, the investigation demonstrated the importance of identifying higher risk youth offenders in therapeutic communities and the need for more intentional treatment planning with this population. One could surmise that more intensive treatment of these risk factors will reap benefits in effectively
reducing other risks, such as self-harm, acting out toward others, and sexually inappropriate behavior.

This emerging process needs to continue to be empirically tested. Yet it can be argued that a more efficient system of care is developing for adolescents at this particular facility. The use of the YCRA has added consistency at this treatment facility. Lyons et al. (1997) noted that the current youth offender assessment procedures rely too heavily on subjective ratings that are strongly influenced by clinicians’ idiosyncratic approaches. The assessment process described in this study reduces such subjectivity. The results of this investigation are now being used in more effective training of caregivers, clinicians, teachers, families, and others to understand the individual needs and strengths of youth.

References


