Treatment Outcome Differences Between Youth Offenders From a Rural Joint Commission Accredited Residential Treatment Center and a Rural Non-Accredited Center

KENNETH M. COLL, PhD
College of Education, University of Nevada, Reno, Reno, Nevada, USA

MARGARET SASS, EdD
Center for Instructional Excellence, Purdue University, West Lafayette, Indiana, USA

BRENDA J. FREEMAN, PhD
Colleges of Education and Cooperative Extension, University of Nevada, Reno, Reno, Nevada, USA

P. THOBRO, MS and NICOLE HAUSER, LCSW
Cathedral Home for Children, Laramie, Wyoming, USA

This study was undertaken to investigate the treatment outcome differences between youth offenders from the joint commission accredited residential treatment center (RTC) and youth from a non-accredited center. Results showed that youth from the accredited center reported significantly more progress.

KEYWORDS: residential treatment center, youth offenders, non-accredited center, treatment outcome, YCRA

Considerable attention in the professional literature has been given to investigating and discussing children and adolescent residential treatment center criteria and guidelines for operations. Scholarly texts and research articles recently have dedicated attention to this topic (Coll, Thobro, & Haas, 2004).

Some authors have suggested specific and appropriate guidelines for all residential treatment centers (RTC) (START, 2012). Specific criteria and guidelines for RTC operations are found in the Joint Commission's accreditation standards (The Joint Commission [TJC], 2012) for example.

Address correspondence to Kenneth M. Coll, PhD, University of Nevada, Reno 1664 N. Virginia Street, Reno, NV 89557, USA. E-mail: kcoll@unr.edu
To date, however, few empirical studies related to the value of accreditation for RTCs have been generated in published sources.

The Joint Commission's various accreditation/certification programs are increasingly recognized and relied on by many states as quality oversight. As there is a dearth of studies related to the value of such accreditation for RTCs, this may leave such agencies at a disadvantage in these times of increased pressure for accountability and evaluation with unless value of accreditation can be shown (ASTART, 2012). Indeed, many writers believe that RTCs are in an insecure position and are highly vulnerable to budget cuts, chiefly because of this fact (Child Welfare League of America, 2012). Additionally, without showing clear value of accreditation, there is often trepidation when choosing the appropriate agency (Herman, Leff, & Palmer, 2009).

THE JOINT COMMISSION (TJC) ACCREDITATION GUIDELINES FOR RTCS

Accreditation of RTC services is a relatively recent phenomenon. It has its roots in the accreditation of hospital institutions and programs. TJC accreditation strives to evaluate activities of an operation or program, on an ongoing basis, and seek an independent judgment to confirm the achievement of its objectives. TJC accreditation functions to promote consistency and excellence through the development of criteria and guidelines for assessing effectiveness through the encouragement of improvements through self-study and planning. TJC qualified RT centers throughout the United States and Canada. Over 19,000 health care organization and programs are currently accredited (TJC, 2012). The expressed major purpose is to help centers develop and deliver high quality services.

TJC accreditation criteria and guidelines for operations in summary call for development and ongoing evidence of (a) appropriate training of the staff (including previous and current supervision of practice); (b) activity and participation in professional organizations; (c) adherence to criteria for high standards of professional practice (specifically related to ethics, testing); (d) in-place and appropriate professional development plans for each counselor/therapist; (e) appropriate youth/staff ratios; (f) systematic client record-keeping; (g) participation in staff decision-making; (h) in-place and effective accountability and evaluation systems; and (h) specific and thorough procedures and policies (i.e., referral policy and procedures, crisis intervention policy and procedures, policy and procedures for release of records).

YOUTH OFFENDER RISKS

Many factors are involved when juveniles turn to high risk behaviors and delinquency, causing them to enter the juvenile justice system and/or seek
intensive professional treatment. Juveniles have a higher chance of becoming a delinquent member of society if certain factors, such as internal issues (e.g., depression) and familial problems, increase (The Justice Youth Board, 2005; Wasserman et al., 2003).

Hawkins et al. (2000) found evidence that adolescents who are most at risk for needing intensive professional treatment 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, poor peer acceptance, and deficient social connections (Cunningham, Duffee, Huang, Steinke, & Naccarato, 2009; Mason et al., 2010). Additionally, problematic juvenile behavior and delinquency has long been associated with certain societal ills, such as easy access to AODs and family splintering (Hawkins et al., 2000). According to Duke, Borowsky, Pettingell, and McMorris (2011), adolescents that suffer from a higher level of hopelessness are also prone to delinquent and other problematic behavior.

It is not uncommon for youth offenders who commit serious crimes to find themselves in residential treatment centers (Coll et al., 2004; Bastiaens, 2004; LeCroy & Ashford, 1992; Lyons, Kislis, Dulcan, Cohen, & Chelsea, 1997), and adolescents treated via out-of-home placements were much more likely to report higher levels of AOD abuse and more severe behavioral problems than were adolescents treated via outpatient programs (Coll, Freeman, Bugerele, Thobro, & Haas, 2012; Coll, Julimke, Thobro, & Haas, 2003). Despite the severity of initial problems, however, youth offenders in out-of-home placements typically reported significantly reduced drug use and major behavior problems, improved psychosocial development and interpersonal functioning outcomes after at least 6 months of treatment (Coll, Stewart, Juhaske, Thobro, & Haas, 2009; Coll et al., 2003; Hanson, 2002). Indeed, there is compelling evidence in professional literature of 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, 2002; Grietens, Rink, & Hellinckx, 2003). Consistent with recommendation by Huizinga, Loebere, Thornberry, and Cothen (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 (Burdsal, Force, & Klingsporn, 1990; Coll et al., 2009). Individualized comprehensive assessment processes are considered paramount for producing positive outcomes. The purpose of this study was to discover whether accreditation, specifically TJC accreditation increase the probability that these factors are present.

RESEARCH SITES

The two adolescent residential treatment sites used in this study were matched by rural location (communities of under 30,000 people in the Rocky Mountain region of the United States), gender (boys), and common placement criteria, and therapeutic experiences. Both facilities receive court-referred adolescents, most of who had been involved in criminal activity. Often, these referrals are seen 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 from both sites, ages 12 to 18 years, were court mandated for a variety of offenses ranging from running away to assault. Treatment at these facilities typically consists of a full school day; recreational, and outdoor 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.

Participants

Participants were adolescents in treatment at the facilities (n = 97 at the accredited agency) and (n = 62 at the non-accredited agency) pretreatment and (n = 83) and (n = 30) posttreatment. The ethnic composition of those in treatment at both sites was 90% Caucasian, 5% Hispanic, and 5% African American. The average age at both sites was 14.5 years (range = 12 to 17, SD = 2.0). The adolescents were assessed during the first month of their stay by a team of licensed professional counselors, psychologists, and social workers at both sites.

Instrumentation

The Youth Comprehensive Risk Assessment (YCRA) is utilized at both facilities as an "umbrella" assessment to produce a comprehensive risk factor summary based on the six factors developed from the professional literature (listed in the following paragraph). This summary is then used to make treatment plan decisions. This comprehensive risk factor and social functioning
summary is called the Youth Comprehensive Risk Assessment (YRCA) (Coll et al., 2004; Coll et al., 2009; Coll et al., 2012). This tool meets the criteria for a "best practice" tool as over 10 peer-reviewed journal articles have been published indicating its utility and value.

The YCRA has been approved as a performance measurement system with TJC for over 15 years. Per TJC-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 of 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).

The YCRA has met the rigorous criteria necessary for inclusion on TJC’s list of approved performance measurement systems. The YCRA has met or exceeded system adherence to all of TJC quality principles, including sampling, standardization, monitoring, documentation, feedback, education, and accountability (JCAHO, 1998). The YCRA uses a non-equal interval Likert scale of 1 to 4 × 2 (8) on the basis of the recommendations of child welfare experts (Child Welfare League of America, 2012). With 1 being slight, 2 being mild, 3 being moderate, and 4 × 2 (8) being severe and requiring immediate treatment interventions. The distinction between 2 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; Coll, Juhnke, Thobro, Haas, & Smith, 2008).

Procedures

Clinicians at both adolescent treatment facilities where the YCRA is utilized 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 re-evaluation, which is designed to make adjustments in treatment planning and decisions about discharge (including time frame and placement options).

RESULTS

Concerning severity of risk factors at admission, the youth at TJC facility indicated significantly higher risk in 4 of the six risk areas in total risk per t test analyses although both groups indicate high risk in all areas. The youth
from TJC facility indicated significantly higher risk at admission specifically in risk to self, risk to others, social skill deficits, family resources problems. Means and standard deviations for the admission scores are indicated in Table 1.

Post t test analysis showed significant differences between TJC and non-TJC on four of six risk factor scales. Even though TJC youth began treatment with significantly higher risk, they were at significantly lower risk than the non-TJC youth in the areas of risk to self, social/adaptive functioning, substance abuse risk, and family resources. These results are indicated in Table 2.

**DISCUSSION**

The purpose of this study was to investigate the differences between TJC youth offenders and non-TJC across risk factors at admission and after at least 5 months of treatment (Figure 1 and Figure 2). The study produced some findings with potential relevance to the value of TJC accreditation.
FIGURE 1 Significant differences at admission and after at least 5 months of treatment for the nonaccredited agency versus the accredited agency. Variables: self harm, other harm. (Color figure available online.)

FIGURE 2 Significant differences at admission and after at least 5 months of treatment for the nonaccredited agency versus the accredited agency. Variables: social/interpersonal skills, family resources. (Color figure available online.)

However, it is important to note that these findings should be interpreted cautiously.

RTC operations that have TJC accreditation may simply have more financial support, more support staff, and better working conditions. With these possibilities in mind, some speculation follows related to the value
of adherence to accreditation guidelines and lower youth risk. However, the seriousness of these delinquent behaviors by juveniles (e.g., crimes, aggression, and drug/alcohol abuse) stipulates the need for such intensive treatment suggested by TJC accredited RTCs. By following such stringent guidelines, research shows recidivism reduction and reduced costs to the community (French et al., 2002).

It should be duly noted that the TJC accredited center had higher admission scores (Figure 3). This may suggest that this particular center, located in a less dense population that the non-accredited center, initiates adolescents to find other forms of entertainment involving deviant activities. It can also be speculated that the non-accredited location involves as higher amount of the Mormon population whose beliefs consist of abstinence from alcoholic beverages which negatively affect unlawful behavior.

Adhering to the specific TJC guidelines related to high standards of professional practice and thorough procedures may explain the significant differences in risk after at least 5 months of treatment even though youth from TJC facility were at high risk at admittance.

Youth from accredited centers may experience more consistent agreed-upon best practices for day-to-day duties, for example, specifically outlined and training for professional practices and ethical behaviors. Some of those practices include an appropriate youth and staff ratio allowing more individual attention, continual assessment for improvements among residents, and accountability among staff. Specific and proven procedures for certain practices (e.g., crisis intervention and holds) may also contribute to
the differences. In addition, participation in operational decision making is a requirement for TJC accreditation may be a contributing factor (TJC, 2012). Following TJC guidelines for systematic client record-keeping and for having accountability and evaluation systems in place may further explain the differences. TJC facilities may be better able to advocate for support with this kind of quantifiable information. For example, helping to increase or maintain staff size has been upheld as an advantage to TJC accreditation.

Other advantages of TJC accreditation have been reported to include producing more evidence about quality of services and adding credibility, status, and image to a facility (TJC, 2012). These advantages may contribute to higher trained staff, more resources, and thus a significant difference in results after at least 5 months. It is possible that a RTC’s ongoing adherence to the specific criteria and guidelines related to professional practice, thorough policies and procedures, and articulation communicates professional behaviors related to roles, duties, and functions.

The accreditation and re-accreditation process for TJC may also be a factor in the significant differences found in this study. This process involves ongoing comprehensive self study through the collection of extensive amounts of data related to current functions and roles, relationships with community, accountability and evaluation, and ethical standards and practices. The process also includes objective auditing from an accreditation team of professionals.

Although there are other feasible reasons for lower risk in youth from accredited RTCs as compared to those from a nonaccredited center, TJC accreditation may help develop a value-added clearer and more consistent focus. Promoting excellence in operational clarity and promoting consistency are the highest values of accreditation. The benefits of such clarity and consistency for youth may be more effective and efficient change.

LIMITATIONS

Similar to research associated with delinquent adolescents, limitations should be acknowledged in this study accordingly. The amount of participants at the nonaccredited agency decreased from 83 participants to 30, perhaps not providing an accurate representation. Participants in TJC accredited centers may have provided supplementary treatments of effective therapy not suggested or incorporated in TJC guidelines. Additionally, further analysis on whether our findings can be generalized to other similar residential treatment populations should occur.

Though there are limitations in any form of research, we are hopeful that our findings will encourage other residential treatment centers to become accredited under the TJC guidelines. It is critical that residential treatment centers provide the best overall care to these troubled adolescents.
FURTHER RESEARCH

This research has identified that TJC accredited residential treatment centers may have a better outcome than nonaccredited centers. Further research suggests a longitudinal study defining whether such high standards established by TJC provide a lasting and positive effect on delinquent juveniles’ mental stability, drug use and abuse, and recidivism.

REFERENCES


