

# Rehabilitating and Reintegrating Youth Offenders: Are Residential and Community Aftercare Colliding Worlds and What Can Be Done About It? \*

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## **Abstract**

*This paper will identify how and why the worlds of residential and aftercare services can diverge, exploring the implications these have on both the youth offenders themselves and public safety. Evidence-based strategies and promising practices that directly address the divergences will be described and discussed. There are valuable lessons to learn from research and experience, which will be highlighted.*

## **About the Author**

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## **Rehabilitating and Reintegrating Youth Offenders: Are Residential and Community Aftercare Colliding Worlds and What Can Be Done About It?**

### **Introduction**

Bridging residential and aftercare services is often regarded as a key problem for the youth offenders who move between these two worlds (Altschuler 2005; Altschuler, Armstrong and MacKenzie 1999; Center for Substance Abuse Treatment 1998; Steinberg, Chung and Little 2004). This is reflected in the view of staff and others who work or volunteer in each of these worlds. The problems faced by youth offenders who move from residential to aftercare services and the challenges and frustrations confronting staff and workers who inhabit these two worlds as well are part and parcel of the same phenomenon. Discontinuities of care have long plagued youth corrections, where residential or facility-based services frequently bear little direct connection to aftercare services based in the community (Center for Substance Abuse Treatment 1999a; Dembo, Livingston and Schmeidler 2002; Whittaker 1979). Much can be learned from closely examining why it is that staff and others who volunteer or assist in residential programs and community-based aftercare tend to find it so challenging to foster and implement an integrated strategy that is characterized by continuity of care (Altschuler and Armstrong 2001; Center for Substance Abuse Treatment 1998; Lipsey and Wilson 1998; Listwan, Cullen and Latessa 2006).

It should not be a surprise that what it takes to “succeed” specifically in a residential setting is generally speaking not what it takes to “succeed” back in the community. Even the definition of success is not the same. Many residential facilities regard compliance with facility rules and requirements as an indication of, or key to

success. Of course, the extent and nature of the various rules and requirements in a structured group-living setting are understandably geared toward expectations of behavior and programmatic progress while the offender resides in the facility. There is little doubt that the setting (in this case the residential facility) exerts a powerful influence that shapes and gives meaning to the rules and requirements on the one hand, and to the youths adherence to these rules and requirements on the other hand. For example, the daily time schedule, required classes and sessions, meals, free time, and even personal hygiene and attire expectations all reflect what is uniquely the requirements of a group-living setting.

Adherence to the rules and requirements is also in the context of a group-living setting, where, for example, the structure, consequences and rewards, staff and other residents can influence or condition the extent of adherence. Some youths handle such settings exceedingly well, but this does not necessarily translate to success in the community. Others have difficulties adjusting to such settings, but that too does not mean failure upon release is likely. Still others tend to do well in such settings until shortly before their release is imminent, when all of a sudden they become unruly or defiant.

The point is that adjustment and compliance in a residential setting is just that: adjustment and compliance to a residential setting. The extent to which it translates to adjustment and success in the community is another matter entirely. Behavioral conditioning in a residential setting can actually backfire in several very different ways. Blind obedience, for example, would be considered undesirable when the authority figure or superior is anti-social, criminal or otherwise negative. When impulse control or self-

esteem improves in the context of a highly structured, controlled and regimented setting, some individuals may become less capable of functioning autonomously and self-sufficiently when back in the community where the structure and day-to-day routine is looser.

Once back in the community on aftercare, the rules of conduct and requirements are typically strikingly different than those of the group-living setting, and in addition, adherence to rules and requirements do not carry with it the same contingencies. That William is better obeying his teacher in school or his employer at the job site than he is in listening to his mother, girlfriend or other friends, is a function of what he is being asked to do, who is doing the asking and what is the motivation to cooperate. Adjustment to aftercare in the community likely involves many more competing sources of influence and temptation than in the group-living setting and the dynamics encouraging pro-social, law abiding behavior in aftercare constitute a whole other element to consider.

In short, the residential setting and aftercare in the community are not the same and never will be. At the same time, there are numerous aspects of residential and aftercare services that can serve to bridge the two worlds as opposed to creating or fostering inconsistency and disconnection that can actually jeopardize public safety and increase recidivism. There are four building blocks that form the foundation on which residential services and aftercare services can be linked together. First, integrating residential and aftercare services requires a commitment to continuity of care in the design and operation of the department. Second, cognitive-behavioral approaches involving family and community supports cut across and need to inform the continuity of care components in residential and aftercare services. Third, staffing, personnel practices

and training are a critical ingredient to the successful implementation of continuity of care. Fourth, overarching case management identifies the programmatic aspects of implementation from which policy, regulations and procedures emerge. Each will be discussed below.

### **Overarching Program Design Considerations**

It is frequently the case that residential and aftercare services are driven by competing priorities and concerns and are not linked together in practice by an overarching strategy reflecting a common orientation and approach. This overarching strategy can be boiled down to what some term “continuity of care.” Much like it sounds, **continuity of care** refers broadly to an orderly and sequenced process in which each and every step is linked to both the preceding steps and successive steps. Typically, residential and aftercare services operate largely on their own, without much consideration of what has occurred beforehand or what will happen afterwards. Even when institutional corrections and aftercare are lodged within a single department or branch, they have proven remarkably resistant to even communicating, much less actively cooperating, coordinating and collaborating. This need not be the case however, particularly if continuity of care is incorporated into the daily operation of both residential and aftercare services

Continuity of care has major implications for: 1) the guiding philosophy and evidence-base governing residential and aftercare services; 2) the timetable and factors associated with visitation in and outside the facility along with release to aftercare; 3) personnel practices, staffing and training; and 4) case management practices across residential and aftercare services.

Continuity of care includes five discrete operational components (Frederick 1999): 1) continuity of control, 2) continuity in the range of services, 3) continuity in program and service content, 4) continuity of social environment, and 5) continuity of attachment. Underlying these components is the assumption that any positive changes experienced by juveniles in residential care can have little long-lasting value if they do not directly relate to pressing concerns in the daily lives of these young people when they re-enter the community (Altschuler 1984; Altschuler, Armstrong and MacKenzie 1999). The components can be regarded alternatively as barriers to, or enabling factors in establishing continuity of care. It all depends on whether and how each component is part of the implemented approach.

**Continuity of control** refers to the extent and nature of the structure, control, and regimentation experienced by adolescents as they move through a program or system. Adolescents returning to the community from residential care sometimes face an abrupt and disorienting reentry experience. High levels of structure and control that are not gradually reduced can produce great anxiety and stress, as well as excessive and extreme behaviors. A gradual transition process is often recommended, with decompression explicitly built-in to the reentry (see, for example, Altschuler and Armstrong 1997; Center for Substance Abuse Treatment 1998). This could be accomplished through the use of a step-down stage relying on a less structured group home, an intensive day treatment program, or a phased reduction in supervision requirements and restrictions keyed to demonstrated progress. Graduated incentives and positive reinforcements designed to complement graduated sanctions and consequences should be incorporated into a comprehensive response capability.



**Continuity in the range of services** provided is often of concern, in part because adolescents in residential care receive services that meet a variety of needs. Often when they return to the community, some of these services are no longer available (Dembo, Livingston and Schmeidler 2002; Center for Substance Abuse Treatment 1999a). For example, when no appropriate schooling, vocational training, or employment is provided, housing or food is inadequate, or psychotropic medication is not maintained, the risks for failure are elevated. Adolescents with co-occurring disorders (also known as dual diagnosis) especially require attention on multiple fronts (GAINS Center 1997), as do “high risk” adolescents who by definition have multiple problems (Altschuler and Armstrong 1994). The reasons that services may not be available in the community, as opposed to inside residential or institutional programs, include funding restrictions and levels, governmental policy and insurance limitations, availability of providers, access to treatment, and treatment appropriateness or quality. Early identification of barriers and impediments such as these is essential in order to formulate a strategy for addressing each. Creating new partnerships and obtaining funds through previously untapped sources are examples of how some jurisdictions have proceeded.

**Continuity of service and program content** is also a concern. This is critically important when it comes to education, vocational and social skills taught, treatment/behavioral management approaches and principles, medications prescribed, and special needs addressed (e.g., mental health disorders, drug abuse, sex offending interventions). Many believe that reinforcing what offenders have accomplished in placement by employing the same treatment approach after they are released increases their likelihood of success in the community (Altschuler 1984; Coates, Miller and Ohlin

1978; Empey and Lubeck 1971; Haley 1980; Whittaker 1979; Wolfensberger 1972).

Triggers, negative influences, and temptations can be readily found in community settings. It is there that the lasting power of what was accomplished in placement is truly tested. Most experts do not regard reentry into the community as the time to dramatically change course or withhold treatment.

Few would argue with the premise that as setting, context, and social environment change, so does the way people conduct themselves. Adolescents are surely no exception. The real issue for the value of residential care is the extent to which it establishes a foundation on which young people may build when they return to the community. Adolescents have difficulty recognizing appropriate and acceptable interaction patterns in different settings. They also face powerful peer pressure, place a premium on social acceptance, and are likely to consider rebellion an imperative. As a result of these factors, the importance of family, peers, neighborhood and school have become central features of several different promising approaches (Altschuler and Armstrong 1994; Center for Substance Abuse Treatment 1998, 1999b; Lipsey and Wilson 1998; OJJDP 2001).

It is continuity of services and program content that emphasizes the importance of pursuing both in residential and aftercare services those so-called “criminogenic needs” (and strengths) that are highly correlated with criminal conduct (and law abidance). These commonly include: antisocial attitudes, feelings and values, skill deficiencies involving problem-solving, impulsivity, and poor self-control (Andrews and Bonta 2003; Gendreau 1996; Listwan, Cullen and Latessa 2006; Listwan, Van Voorhis and Ritchey, forthcoming; Van Voorhis 1997).

**Continuity of social environment** recognizes that the engagement and involvement of an adolescent's social network (e.g., family, antisocial and prosocial peers in the community, neighborhood hangouts, school and/or job) cannot be ignored or given short shrift, either during residential care or upon return to the community. Various family-focused and in-home oriented programs have been designed explicitly to engage family and other sources of pro-social support in the community.

**Continuity of attachment** refers to the adolescent developing a trusting relationship with responsible people in the community who are in a position to exert a positive influence. This may well require staff effort to locate prospects and assist in getting the connection started. It may involve nothing more than identifying who among the network of people already involved with the youngster may be willing and able to become such a person. Regardless, it will likely require the involvement of staff with the training and experience to understand what they will need to do to foster this type of continuity (Altschuler and Armstrong 2001). These kinds of objectives are being pursued by mentorship-type programs and by the involvement of various community systems of support such as faith-based groups and voluntary organizations.

### **Cognitive-Behavioral Interventions and Continuity of Care**

There is a substantial evidence base pointing to the value of using cognitive-behavioral approaches and interpersonal skill training with youth offenders. Broadly speaking, cognitive-behavioral approaches seek to develop pro-social patterns of reasoning by maintaining a focus on managing anger, assuming personal responsibility for behavior, taking an empathetic perspective, solving problems, setting goals, and acquiring life skills. A meta-analysis by Lipsey, Chapman and Landenberger (2001)

found that cognitive-behavioral demonstration programs with juveniles on probation, parole and in custodial institutions led to large reductions in recidivism. Generally, treated offenders exhibited one-third to two-thirds the recidivism rates of the untreated controls. Cognitive-behavioral approaches appear uniquely well suited to address the juvenile justice system's difficulties in treating young people and to permit the psycho-social maturation believed necessary for a successful transition from childhood to adulthood (Lipsey, Chapman, and Landenberger 2001; Pearson, Lipton, Cleland and Yee 2002; Steinberg, Chung and Little 2004).

In earlier work, Lipsey and Wilson (1998) looked separately at institutional and non-institutional programs and found among both that cognitive-behavioral oriented approaches and interpersonal skill training were producing reductions in recidivism. This overlap of effective treatment types between the institutional and non-institutional programs would certainly suggest the potential for stronger and more lasting recidivism reduction if effective institutional programs were followed up by quality non-institutional programs (Altschuler, Armstrong and MacKenzie 1999). The overlap of effective treatment types also support the argument for integrating community aftercare programs and their staff into the planning and treatment activities in the residential facility (Altschuler 2003).

**Table 1**

Specific Evidence Based Interventions Typically Producing Reductions in Recidivism
<ul style="list-style-type: none"><li>• Aggression Replacement Training (ART)</li><li>• Reasoning &amp; Rehabilitation (RR)</li><li>• Moral Reconnection Therapy (MRT)</li><li>• Thinking for a Change (TC)</li><li>• Interpersonal Social Problem Solving (ISPS)</li><li>• Multisystemic Therapy (MST)</li><li>• Functional Family Therapy (FFT)</li><li>• Multidimensional Family Therapy (MDFT)</li><li>• Adolescent Community Reinforcement Approach (ARCA)</li><li>• Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT)</li></ul>

*Source:* Dennis (2006)

There have been numerous reviews of the evidence and these point to specific interventions that typically perform well in reducing recidivism. As shown in Table 1 (Dennis 2006), ten well-known and packaged intervention approaches are fundamentally cognitive behavioral in assumptions and practice. Also of note is that a number of the interventions are family-based and address the recognized multiple determinants of adolescent antisocial behavior (e.g., individual adolescent characteristics, family functioning, caregiver functioning, association with deviant peers, indigenous family support network, neighborhood characteristics).

In terms of continuity in service and program content, the evidence points to cognitive- behavioral approaches and interpersonal skill training as being central to the programming in both residential and aftercare services with all staff, workers and providers having an understanding of the intervention. Particularly around home leave, it is critical that the level of supervision, duration and degree of restrictiveness while on leave be directly linked to performance on the prior home leave, if applicable, and that success on home leave be positively reinforced back in the facility. Circumstances in the

community that contribute to success or problems while on home leave are important to identify in a debriefing with the youth.

Additionally, a plan formulated with the offender on how community adjustment can be successful is essential. Problem solving and learning skills directly applicable to successfully managing the community are key to incorporating cognitive-behavioral principles and interpersonal skills into a continuity of care approach that bridges residential and aftercare services. For example, absconding while on home leave can sometimes indicate as much about the impact the residential facility is having on the youth as it does about how the youth is performing on home leave. Absconding in the absence of any other form of misconduct or antisocial activity is different than is absconding accompanied by other violations. It is important to use home leave and other outings in the community as a part of the cognitive-behavioral intervention. This requires the active engagement of both residential and aftercare staff in the leave. More frequent leaves, longer leaves and less restrictive leaves may be useful as an incentive to encourage cooperation both inside the residential facility and during leaves.

Release from a facility to aftercare is another critical element of continuity of care. It is not unusual for residential staff to utilize release to aftercare as a means to encourage conformity and obedience inside the residential facility. One effect is that youths who may be well situated to successfully manage the community in aftercare can be held longer because of behavior problems inside a residential facility, which underscores how facility adjustment and behavior can sometimes assume greater priority than likelihood to succeed in the community. There is no question that safety, security and behavior management inside a residential facility is crucial. It is understandable that

facility staff want to manage behavior by utilizing effective techniques, but relying on facility adjustment alone to set the timing of the release to aftercare suggests that more emphasis could be placed on using other consequences and that more emphasis could be placed on other positive reinforcements to encourage cooperation inside the facility.

### **Staffing, Personnel Practices, and Training**

Continuity of care and reintegration require thinking differently about how staff are used, what qualifications are required, what skills staff need, how training should be approached, and on what basis staff performance should be assessed. Veteran staff may not always be receptive to the kinds of changes suggested, but it can be very difficult to make personnel changes in many jurisdictions. Turnover, particularly among newer and younger staff is common, sometimes because starting salaries are low. Additionally, the red tape, as well as workplaces where resistance to a change in approach is widespread, can quickly affect morale. One solution that some jurisdictions pursuing reintegration are trying is the creation of specialized units, where the facility-aftercare teams become in effect small-scale, semi-autonomous operations (Altschuler and Armstrong 2001). Cross training is provided to all staff from the residential and aftercare services.

Aftercare staff need to begin work on a case early during the residential stay and this involves focusing on the youth, family and community. Family become actively engaged by the aftercare worker, beginning initially with sharing information, arranging for family visits and home leaves, and where appropriate, assisting families who need help or services themselves. This kind of role has implications for caseload size, workload, work hours, qualifications and training. It also can involve the formation of family support groups and family sessions held at facilities where the child and family

address issues relevant to law abiding community adjustment and planning. The aftercare worker may need to enlist the support of voluntary organizations, mutual aid groups or other volunteers and mentors that may be better able to establish rapport and trust with the family. In this role, the aftercare worker becomes a facilitator and intermediary, rather than the sole or primary worker. Residential staff must be partners in this continuity of care, which means that time, space and their cooperation is necessary. Residential staff have a key role to play in the activities and functions, as they can provide valuable insights about the youth. This kind of approach is consistent with addressing the youth's situation in a family and community context, which is consistent with a cognitive-behavioral and interpersonal skill orientation.

### **Case Management that Bridges Residential and Aftercare Services**

Continuity of care and its five components draw attention to the tasks and functions that cut across residential and aftercare services and require careful sequencing and alignment. Sequencing and alignment can become part of a program strategy and operational plan by way of “**overarching case management**,” which establish the process used to: identify the appropriate offenders who will participate in the different levels of aftercare; determine and integrate the services and supervision that will be provided both in the facility and in the community; and promote consistency and continuity through a collaborative team incorporating facility and aftercare staff. Included among the components are: 1) risk assessment and classification for establishing eligibility; 2) a consolidated facility and community case plan that incorporates a family and social network perspective; 3) a mix of intensive surveillance and enhanced service delivery focused on risk and protective factors; 4) a blending of graduated incentives and



consequences (i.e., graduated responses) coupled with the imposition of realistic, individualized and enforceable aftercare conditions; and 5) service brokerage with community resources and linkage to non-correctional youth serving agencies and groups.

It is the risk (of re-offending) principle that accompanies the notion of criminogenic needs discussed above and it is this risk principle that draws attention to those personal attributes and circumstances that identify which individuals are more likely to re-offend (Andrews et al. 1990; Lowenkamp and Latessa 2005; Listwan, Cullen and Latessa 2006). Among the subgroup of youth offenders in residential facilities, the risk principle relates to the potential for re-offending once back in the community. The likelihood to re-offend is not based on the perceived severity of the charged offense, but on a combination of factors that frequently include family dysfunction, negative peer group influences, school disciplinary problems, substance abuse, early (age of) onset in delinquency, and mounting numbers of justice system contact. Youth with few of these characteristics have been found less likely to re-offend upon release.

There are five critical implications to the risk principle. First, facility behavior and performance by themselves are not indicative of success potential in the community. This means that unruly and defiant residents are no more likely to re-offend once in the community than compliant and well-behaved residents. Second, risk characteristics can be assigned at admission to a residential facility and improvements made in any of the areas where change is possible can best be assessed for their sustainability once a youth is back in the community. Third, intensive aftercare--as opposed to a more standardized version--should be focused on identified high-risk (for re-offending) youth. Fourth, to the extent that intensive aftercare is used on lower-risk (for re-offending) youth, largely

because of technical violations they can end up doing worse in the community than if handled in a more routine fashion. Fifth, high-risk youth in a facility especially need the involvement of aftercare workers as early as possible and actively engaging with the youth and family.

A unified individual service plan incorporating family and community must involve in its formulation both residential and aftercare staff. Work on identified high-risk (for re-offending) cases should be initiated by residential and aftercare staff immediately, with aftercare staff assuming responsibility for maintaining family contact throughout and meeting with the youth regularly on planning for home leaves and release to aftercare. Residential staff need to be trained to implement cognitive-behavioral interventions where family and other mentors, volunteers and positive peers from the community can be incorporated into the intervention. While the point of contact for the family and others should be aftercare staff, the residential staff are no less important to facilitating the involvement of family and others with the youth when the interactions occur on facility grounds.

Graduated incentives and consequences (i.e., graduated responses) oftentimes have difficulty gaining a foothold in corrections programs where there is a view that youth will only learn a lesson with a “slap on the wrist” and that they are in corrections primarily to be punished. There is a growing body of research indicating that punitive interventions not incorporating incentives and positive reinforcement and not developing and fostering strength-based attributes in youth are not effective (Lipsey 1999; Lipsey 2003). Cognitive-behavioral interventions by their nature are as concerned with reinforcing accomplishment and achievement as they are with sanctioning infractions and

noncompliance. The key is incorporating both consequences and rewards, rather than focusing exclusively on one. Staff need to receive training and utilize techniques that reflect graduated responses.

One important reason for relying on graduated responses over retributive (punitive) responses is that youth tend to learn from punitive responses that it is best not to get caught engaging in anti-social conduct. Alternatively, when incentives are built into responses, youth can learn that there is satisfaction from pro-social conduct. When the basis for conformity is derived from inward satisfaction, it is less reliant merely on the fear of being caught to deter misconduct. While deterrence has its place, the problem is that if a major motivation to law abidance becomes avoiding punishment, the major lesson learned is not to get caught. In contrast, when a major motivation to law abidance is derived satisfaction from various benefits, there is a potential for youth to develop their own internal self-controls. This is critical because there becomes less of a need to rely as much on policing and punishment to maintain control. Moreover, given the prevalence of risk-taking and thrill-seeking behavior among youth, developing for them some positive outlets is preferable as a means to satisfy these needs than is their manifestation of risk-seeking by trying to escape detection for anti-social conduct.

### **Lessons and Implications for Integrating Residential and Aftercare Services**

Continuity of care and its five components require a degree of synchronization that in practice has been a tall order to accomplish. While in the abstract and philosophically both residential and aftercare services appear to embrace identical goals, all too often they operate largely on their own, understandably giving priority to the most immediate and pressing challenges confronting them. Residential services are typically

client-focused in the context of a group-living setting. Conformity to the rules and procedures of the facility and progress in the programmatic components constitutes the basis of success.

Continuity of care places a premium on transferring and generalizing gains achieved in the group-living setting to a community setting, which poses a very different set of challenges. Success in aftercare and the community is often defined as youths making the “right” choices among: the ebb and flow of competing positive and negative influences and temptations; meeting common adolescent and survival needs; and in some instances handling chronic or acute problems related to mental health, behavioral health and cognitive abilities. Additionally, youth offenders may confront resentment, fear, stigma, reprisals, and legal barriers to gainful employment. So what are the lessons and implications for bridging the two worlds and fostering continuity of care?

First, it is crucial to team up residential and aftercare staff so that while in residence, youths and all staff can be routinely exposed to the perspective of what community adjustment and success requires. The planning for home leave and aftercare services need to involve both residential and aftercare staff, along with the early introduction of family and community services and resources. Continuity of care in relation to program content is of utmost importance, particularly in relation to addressing criminogenic needs. Based on the evidence regarding the importance of criminogenic needs, neither residential or aftercare can be expected to produce lower recidivism and sustainable improvements in risks and strengths without both worlds tackling agreed-upon cognitive-behavioral benchmarks using similar techniques and practices. A common, mutually reinforcing curriculum is needed for this to happen. This requires

cross training of staff and a degree of coordination not commonly experienced in corrections, but essential for consistency in program content and services.

Second, the value of assessment and classification related specifically to the risk of re-offending is underscored by the evidence that focusing too much supervision and monitoring on lower risk for re-offending youth offenders can produce worse outcomes, particularly in relation to technical violations of conditions and rule infractions. Related, behavior within a residential facility has little bearing, by itself, on the risk of re-offending back in the community. Accordingly, the use of an empirically supported community risk assessment instrument initially administered at disposition or admission to a facility (and subsequently re-administered at set intervals) can aid in the decision making about the timing of release and the level of desirable community aftercare supervision.

Third, prolonging residential stay can increase recidivism if it means that high-risk youth offenders will receive less or no aftercare services. Related, prolonging the residential stay of lower risk youth offenders is not likely to reduce their recidivism, since they pose less of a risk to begin with. There is a possibility the youth offenders might be worse off in terms of recidivism.

Fourth, violations related to absconding from home leave may be indicative of problems in the community and/or inadequacies in the residential facility. It would be worthwhile to look not just at the rate of absconding, but performance on home leave in relation to overall functioning, as well as other delinquency and anti-social conduct. Absconding in the absence of other anti-social conduct or delinquency may not constitute “failure” in the community, meaning recidivism. In a similar vein, longer residential

stays that produce less absconding may ironically be indicative of too much dependence on the residential facility than would be desirable from a community adjustment point of view. In short, while absconding is undoubtedly illustrative of a problem, it is not clear what solution makes the most sense in terms of what can produce more success in the community.

Fifth, there is a limit to what can be accomplished with punishment and sanctions, particularly if they constitute most of the corrections response. While in the short-term, punishment can oftentimes extinguish particular behaviors, in the longer run it is through learning alternative responses to triggering circumstances and coping with high-risk situations that youth can gain self-management and impulse control. That is why cognitive-behavioral approaches depend at least as much on incentives and positive reinforcements promoting the learning of skills as on consequences and sanctions. Graduated response systems that are structured, formalized and written must apply both to residential and aftercare staff, they must be as focused on achievement and accomplishment as on failure and noncompliance, and there needs to be an entry-level and on-the-job training component directed toward all staff, including those who spend the most time with youth in the living units.

It will be because residential and aftercare services operate in lockstep that continuity of care can be well implemented. The administrators of residential and aftercare services respectively, the mid-level managers and supervisors, and the direct service workers, volunteers and providers need to routinely work together in ways that program design, staffing, and overarching case management components are uniform and consistent. Continuity of care and overarching case management provides a blueprint to

building the bridge between residential facilities and community, but unless there is commitment from the top down along with a structure and process (addressing, for example, funding, access to services and collaboration) in place to assure it will be well implemented throughout the chain of command, there is little reason to expect enhanced public safety and improved life chances for youth offenders.

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