UNDERSTANDING & RESPONDING TO CHRONIC YOUTH OFFENDING

JUVENILE INITIATIVES : LESS THAN 25%

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Introduction

My background includes many years working with (and in research and policy development) long-term unemployed young people 16-24 years old, learning and behaviour problem 15-17 years old in the school system, and with a range of other programs in the vocational education and training sector. In many different ways I have encountered the problems facing justice systems in effectively dealing with chronic and serious juvenile offenders.

I was fortunate to be a recipient of a Churchill Fellowship that aimed to identify initiatives programs or activities that have been proven to reduce recidivism and have been successfully implemented by justice systems. I looked at successful initiatives, how they are supported in justice systems and conditions that favour their success, the key conceptual models underpinning those initiatives and measures of recidivism have contributed to that success.

The programs considered included:

- Work programmes in French prisons;
- Joint interagency work in England to manage prolific and priority offenders and the process of having multi agency partnerships;
- Research in England, France and Canada on recidivism;
- Joint health and justice legislation and services to manage dangerous and severe personality disordered offenders and sex offenders;
- The nationwide implementation of Multi Systemic Therapy (MST) in Norway;
- Research and planning in Canada for services for Aboriginal offenders;
- Integrated youth and juvenile offenders services in Ottawa province;
- The initial development of the MST process at Columbia Missouri and structural issues for system wide adoption for a Western Australian context;
- MST program in St Louis for homeless, mentally ill and juveniles;
- Developing MST programs for juvenile sex offenders;
- Healing Lodges in Saskatchewan for Aboriginal offenders and the management of corrections in Aboriginal communities.

Most of the initiatives demonstrated reduced recidivism or provide significant research and policy information.

In particular, I considered 3 sub-populations:

- Aboriginal offenders
- Juveniles, and
- Mentally ill.

What's the trick?

Design Research – Sustained Innovation

Bereiter's view of design research has special relevance to the topic of "what works with chronic and serious juvenile offenders". We have worked many years on individual programs that are often successful, often not. Frequently programs are closed and there is no evidence that is persuasive enough to ensure the programs continue. Bereiter described design research as follows "Research that produces innovations and sustains their development has come to be called design research. It is any kind of research that produces findings that are fed back into further cycles of innovative design. Design research is not defined by methodologies but by the goals of the people who pursue it. Design research is constituted within communities of practice that have certain characteristics, innovativeness, responsiveness to evidence, connectivity to basic science, dedication to continual improvement".

I take the position that in contrast to the design research concept, in corrections:

- Developments evolve from history and practice, not science and evidence.
- Crime is seen as the problem – rather than individual behaviour.
- The individual is separated from community and required to change by self not in the context of their environment in which they live.
- History and practice is Anglo/Euro centric, which does cater well for cultural difference.

My aim today is in part to advocate for a stronger emphasis on design research.

Establishing Success – 80/20 Rule

In determining what was successful, I borrowed from the industry sector's reference to the 80/20 rule. If something is 80% right then you have the right solution, the other 20% is modified by fine tuning – a bit of a reference to the 'design research' concept. In relation to juvenile programs I looked for initiatives that had lower than 25% recidivism rates.

This rate of success, ie. 75% non re-offending rate is proposed as a success measure for even serious repeat juvenile offenders. The rate of return to corrections for the serious young offender group in Western Australia is as high as 94% and in the United Kingdom as many as 88% of 14-16 year old males re-offended within 12 months of being released from custody. (1)

Elements of Success

Across all of the programs and systems I reviewed, there were a consistent set of elements that were necessary precursors to successful programs and successful adoption of programs into mainstream services.

These are:

- Leadership – need a champion in the system.
- Research evidence and a strong theoretical base.
- Engaged in continuous improvement, performance monitoring and review.
- Quality controls in place on how it is delivered.

* A strong fit with the profile and needs of the offenders -culturally well matched.
* Flexibility to meet local circumstances - ability to innovate.
* Able to build relationships.
* Clarity around principles.
* Staff trained according to the needs of the program.
* Appropriate organisational structure to support initiatives.

Specific Juvenile Initiatives

In the Churchill study I reviewed research and programs for juveniles as follows:

* Recidivism research in England, France and Canada.
* Youth Justice Board, UK (YISPs, YIPs, YOTs).
* Norway's nationwide implementation of MST.
* Integrated youth and juvenile offenders services in Ottawa province.
* Development of MST at Columbia University, Missouri and systemic issues.
* MST program in St Louis for homeless, mentally ill and juveniles.

The most consistently effective juvenile intervention was the Multi-Systemic Therapy Program (MST). It has proven successful for individuals, for systems and for communities.

Evidence of Success - MST Programs

MST is a team based, psychological and sociological intensive intervention that interacts with all of the social and familial systems impacting on the young person's behaviour, hence the term multi-systemic. The interventions occur in the home or community locations. The therapists are supervised by a senior clinician and guided in a quality assurance mode to ensure maximum fit with the needs of the young person, the culture of the family and neighbourhood, and, the exhibited behaviours and criminogenic factors. It is time limited and progress is tightly monitored by an external management group that provides consultancy support and training.

It was developed By Professor Chuck Bourduin and Scott Hengeller initially and then further developed after Professor Bourduin moved to Columbia University in Missouri. His placement enabled further development of the program as part of the University's research program, with Professor Bourduin training and supervising PhD students who were already experienced clinical psychologists. This provided a substantial body of research evidence and capacity to continuously improve on the methodology. It also ensured continuous expert theoretical and methodological oversight of the developing program and practitioners.

The MST research base provides very comprehensive analyses of the impact of the intervention with follow up data over 15 years. The follow up records recidivism according to frequency of further offending, severity and timeframe for re-offending. The table below shows the effects of participating in MST in comparison to being referred to individual therapy programs. The study was conducted for 176 adolescent offenders, age 12-17 years, and their families, who had been referred to the Missouri Delinquency project (MST) from July 1983 through October 1986. (NB: includes 4 year recidivism rate).

The long term follow up gave the following results over the long term:

Long term follow up – av. 13.7 years

	MST (4 yrs)	**IT (4 yrs)**
Overall recidivism (includes dropouts)	50% (26%)	81% (71%)
Recidivism of completers of programs	45%	79%
Any violent offence	14%	30%
Any non-violent offence	36%	60%
Any drug offence	13%	33%
Number of offences (mean)	1.8	3.9
Number of violent offences (mean)	0.2	0.5
Number of non-violent offences (mean)	0.9	2.0
Number of drug related offences (mean)	0.2	0.5
Days sentenced to prison (mean)	82	1356.5
Days sentenced to adult probation (mean)	420	738.7

The data shows recidivism after 4 years and after mean of 13.7 years. This data shows that the youth in the Individual Therapy (IT) were:

Youth in IT
- 4.25 times more likely to be arrested
- 2.6 times more to have an arrest for violent or non-violent offence
- 3.3 times more likely to have an arrest for a drug offence

The average profile of this group is typical of a serious young offender:
- Average of 3.9 arrests for felonies (which is significantly fewer than actual felonies committed)
- 48% had at least one arrest for serious violent crime (sexual assault, assault with intent to kill, aggravated assault)
- Mean age of first arrest was 11.7
- Mean age at treatment was 14.5

Overall the data shows the high level of cost effectiveness of MST. Where there was re-offending there was a significantly lower mean number of days in prison (82 vs. 1356) and significantly fewer mean days sentenced to probation (420 vs. 738).

A Meta analysis of MST programs delivered that each had random control groups established showed the following:

Meta Analysis MST Programs

The meta-analysis programs (covering 708 participants and 35 therapies) shows the effect of MST across a range of programs and in comparison to several types of existing services. (All studies used had randomly assigned control groups). Overall the average MST participant achieved better outcomes than 70% of control group participants. Outcomes include individual and family behaviours, family and peer interactions, school attendance, arrests, day incarcerated and drug use.

MST was compared with the range of usual services in four studies:
a) juvenile justice agencies,
b) community mental health centre,
c) an outpatient substance abuse treatment program, and
d) an inpatient psychiatric hospital.

Across all studies youths in usual services received an average of 20 more hours of services that did youths in MST. Comparison with other treatment programs was undertaken in three studies, consisting of parent training and individual therapy. Across studies, the youths in individual therapy received an average of 6.3 more house of treatment.

The characteristics of the 7 combined groups are:

- Median age 14, ranging from 8 to 17
- 70% were male
- 81% lived with at least one parent
- 54% (380) were African American, 45% Caucasian (319), 0.7% were Hispanic (5), 0.5% were Asian American (4)
- 84% (593) had been arrested previously
- 59% (415) were classified as chronic at risk and/or violent juvenile offenders
- 17% (118) were classified as substance abusers
- 16% (116) required emergency psychiatric hospitalisation (including suicidal ideation, homicidal ideation and psychosis)
- 6% (43) were classified as abused and/or neglected
- 2% (16) were classified as sexual offenders

Multi-systemic Treatment:
A Meta-Analysis of Outcome Studies, Charles M Bourduin, Nicola M Curtis and Kevin R Ronan in *Journal of Family Psychology,* (pp411-419) 2004, Vol. 18, No. 3.

MST Implementation in Norway

I looked at how well MST was adopted in a different country with different underpinning values and cultural expectations.
Norway implemented 25 programs after holding a research conference with experts from around the world in response to media concern that problematic juveniles were not properly treated and unable to prevent further offending. The research conference recommended 3 programs:

- MST
- Parent Management Training (PMT)
- Oregon option

The CEO visited each program and discussed the development of each in situ. On his return to Norway he put in place the implementation of 25 MST programs in Norway. Evidence of its success is provided below:

NORWAY MST 1999-2003

Research data on 1666 finalised cases.
(Majority 2001-2003. Final status is 18 months later).

Criteria	At end of treatment	Final status (Full Data)
Lived at home	99%	83% (227)
At school or work	91%	79% (218)
Out of conflict with law	96%	91% (220)
Not using drugs	90%	85% 217
Not using violence	93%	89% (165)

This shows that over 18 months after treatment there was a better than 80% success against all measures.

An evaluation of 2004 outcomes of 695 actives cases, of which 333 were finalised in 2004, shows that only 4% of juveniles were placed in institutional care.

Cultural Transferability

Because of the highly individualised and family based nature of the MST program, it has proven to be transferable across different cultures. However the experience in Norway was that some of the cultural differences were at the system level and slightly different approaches were required in relation to staff selection and being more proactive around social networking. While the Norwegian system had a much stronger formal culture of social support and history of being child-centred, the Norwegian people were less likely to draw on informal social networks for support. There was more of a tendency to blame the formal social system for lack of support and independence and self-reliance was more highly valued. The therapists needed training in developing informal social networks in client families.

Conversely the Oslo teams had very high proportions of migrant and refugee families in their client groups and achieved good successes with these groups.

They found that:

- The alliances with parents were well established
- Parents were keen to be assisted with cultural differences and to know the truth of some cultural differences
- The bottom line for behaviours was able to be established that were appropriate for both cultures
- The migrants/refugees quickly adopted the practices of social networking

Mental Health Issues and MST Service Delivery

Some of the MST programs exclude juveniles with mental illness or mental health problems. One of the programs visited "Community Alternatives" in St Louis, Missouri had a focus on juvenile offenders with mental health problems.

Community Alternatives

Community Alternatives is a non-government organisation that started in 1995 out of work done by Gary Morse with homeless people, substance abusers and mentally ill adults. He developed an assertive community treatment approach which involved being in the community and not office based. In 1998 the city of St Louis Mental Health Board was seeking a different way of working with juvenile offenders with mental health problems. Gary's work was recommended on the basis of research and outcomes and his organisation contracted to deliver MST to these young people.

The target population consisted of the juveniles referred to courts with serious mental health problems. The data suggested that 50-60% of juveniles in court have some mental health problems and 20% of these (ie. 10% of all juveniles referred to court) have serious mental health problems. The MST program was to be delivered under the umbrella of the Community Alternatives organisation, funded via a federal grant to the St Louis Mental Health Board for targeted case management.

Results

A randomised study of the juvenile participants showed that MST was more effective than usual mental health services with improvements to acting out/externalised behaviours, internalised behaviours and affective mood, parental reports of behaviour, reductions in self reports of criminal behaviour.

There was a lower rate of recidivism in subsequent groups, with fewer arrests amongst the MST group than among the less serious offenders who were not referred to MST.

At least 75% of the young people were able to be at home, avoiding out of home placement - detention. (This data includes all referrals - irrespective of whether the MST started or was able to continue, eg. one juvenile was placed in detention for a separate crime prior to commencing, and a girl was placed in detention when her mother was arrested and the girl was unable to be placed in foster care).

As one of the major issues is substance abuse by the parents it is a key focus of the MST in St Louis. Mental illness among parents is also a major issue. As a result of the high levels of poverty and the need for staff to deal with social issues such as getting the gas paid and reinstated, the timeframe for the MST service is slightly longer - up to 6 months.

Mental Health - MST Intersections

Young people exhibit ADHD, compulsive disorders and depression. The program works as well with these groups as with other groups unless it is a severe level or form of mental illness. The young person may also be in parallel mental health treatment and this does not create any problems.

Most difficulties arise when the parent have mental illnesses, the parent function can be very low and what is seen as poor behaviour on the part of the young person can actually be effective survival by the young person.

- Mental health issues in the child
  - Young people exhibit ADHD, compulsive disorders and depression.
  - May be in parallel mental health treatment and this does not create any problems.

- Mental health issues in parents- can be severe
  - The parent function can be very low, poor behaviour by the young person can be effective survival by the young person.
  - Wider social networks are required – MST effective.

Juvenile Sex Offenders

Link with Victimisation and Trauma

The following information was provided to me in the UK and is derived from a major review of backgrounds and services for juvenile sex offenders. It is relevant context for the use of MST with this group.

Juvenile sex offenders are a high profile group of young offenders who are frequently demonised and harsh sentences are demanded by the community. However, an extensive study of juvenile sex offenders' history and treatments (undertaken in the UK) shows a very high correlation of histories of abuse amongst this group. 79.4% of juvenile sex offenders in the study reported having been sexually victimised. (This figure does not account for the very high level of under-reporting of sexual victimisation). Further studies on post-traumatic disorders emphasise the correlation between juvenile sex offending, victimisation and trauma.

Post traumatic stress disorder McMackin et al (2002) in studying 40 male sex offenders between the age of 12 and 17 identify that traumatic experiences and related emotions can act as triggers for young sexual abusers with 95% of their sample population having experienced a traumatic event that would be classified as a Criterion A traumatic event in PTSD, while 65% were judged to meet the criteria for PTSD by clinicians. In identifying offence triggers, intense fear was found in 37.5% of the sample, helplessness in 55% and horror in 20%. In 96% of these cases the offending behaviour was seen as relating directly to the individuals' trauma experiences. Of the sample in this study, 12.5% had been exposed to either physical or sexual abuse and 47.5% had been exposed to both, with a mean age of 4.6 years for onset of physical abuse and 7 years for sexual abuse.

Application of MST for Juvenile Sex Offenders

Sexual offending is an area of increasing concern as increased reporting is bringing more sex offenders into the system. The low rate of reporting sex offences makes it unclear whether the increase is a trend or a shift in the base rate. The damaging effects of sexual offending are such that the community expects harsh sentencing for this offence. In order to prevent the escalation of prison numbers as a result it is important to examine the efficacy of community based treatments, particularly for young people. In the USA youths under 18 years account for approximately 17% of all arrests for forcible rape and 18% of arrests for other sexual offences.

MST has demonstrated positive effects on key social-ecological factors associated with sexual offending and has demonstrated long term reductions in criminal activity and incarceration. The majority of treatments are individually based focussing on accountability, empathy, insight, conditioning to alter arousal, addressing cognitive distortions and anger management. However, the correlates with juvenile sexual offending include individual factors, family characteristics, peer relations and school factors. Treatment approaches need the flexibility to address all of these.

Two MST studies are reported, the first small study showed significantly fewer re-arrests for sexual crime in the MST group (12.5% vs. 75%), the mean frequency of arrests was lower (0.12 vs. 1.62), and frequency of re-arrests for non-sexual crimes was lower (0.62 vs. 2.25). The second study was larger and showed the MST participants had fewer behavioural problems, less criminal offending, improved peer relations, improved family relations, better school results and parents showed less symptomatology. MST youths spent an average of 75 fewer days in detention and in an 8 year follow up MST participants were less likely to be arrested for sexual offences (12% vs. 41%) and nonsexual offences (29% vs. 62%).

These results again show cost effectiveness for juvenile and adult systems. A trial of MST is in place for 160 juvenile sex offenders in Chicago.

MST Implementation in Western Australia - Issues

Why is it worth doing? Cost Effectiveness and Reduced Recidivism.

Research evidence that has been documented and verified through clinical trials in different locations at different times continues to show better results for young people who have participated in MST programs than any other intervention. Violence, delinquency and antisocial behaviour in adolescents consume a large proportion of the resources of child mental health, juvenile justice, special eduction and child welfare systems, with considerable cost to Treasury, intrusion on family integrity and youth autonomy. In addition serious and violent young offenders frequently have continued contact with the mental health and criminal justice system into adulthood.

The implementation of two Justice MST teams will demonstrate the effectiveness of this approach in the metropolitan area. Implementation in Western Australia would potentially be better informed and more responsive to local conditions if it was supported by a developmental research approach. This would require a senior research/consultant to guide the process and assist in creating a system that is Western Australian specific.

The uniqueness of the geography, population dispersal, Aboriginal history since colonisation, Aboriginal family and structures and multiple government agencies responsible for well being of young people may need a purpose designed implementation. Process. There is significant risk that dispersed responsibility via several departments will encourage assessment of the individual's needs against the organisations core business, and exclude too many young people.

This will exacerbate two existing problems:

- The prevalence of "kids who fall through the cracks" that is young people who are on many agency books but who are either not serious enough to warrant comprehensive response by any one agency or do not access services from any government agency.

- Under-servicing in regional and remote areas because no agency has enough clients or service capacity in any particular location outside of the major towns and the service that is provided is stretched thin by the distances that need to be covered.

In contrast a multi-agency service approach that was initiated in response to referrals by any of the agencies could enable services to be delivered State-wide with shared referral and service arrangements.

A proactive design research model is strongly advocated for the use of MST with Aboriginal families. Successes to date have been achieved partly by the inclusion of an Aboriginal consultant when working with Aboriginal families. The high proportion of Aboriginal juvenile offenders suggests that it is appropriate to significantly expand the capacity to deliver MST programs to Aboriginal families, however it is also suggested that this be undertaken in a "design research" framework to ensure continuous improvement and success with the unique WA juvenile population.

Conclusion - Why It Works

The evidence clearly supports an expectation that properly delivered and with continuous and monitoring and development the MST program can achieve better than 80% success in the short term. It has no rivals in terms of evidence of effectiveness and rate of take up in international jurisdictions, including 30 US states, Norway, England and New Zealand. There are examples of lesser levels of success from this program and it is emphasised that the success is achieved when it is rigorously implemented and monitored and careful attention is paid to staffing.

What is required – Robert Perry – Court Administrator

Robert Perry who was the Court Administrator for all of the early years of the development of the Missouri Delinquency Project had this advice for implementing the MST program:

1. Provide juvenile justice officers with knowledge about the initiative and train them - even briefly.
2. Have a champion for implementation.
3. Ensure system is capable of delivery everywhere - to ensure equitable provision.
4. Do not establish as pilot but with long term agenda.
5. Recognise it is a long term process and takes time to demonstrate full results (eg. includes siblings).
6. Consider partnering with a University and develop a support base of knowledge profile.
7. Maintain a range of juvenile justice services and ensure those not engaged in MST are valued and not sidelined.
8. Address practical economic and political issues.
9. Retain a flexible approach, eg. no parents doesn't mean don't use service.
10. March down the road of institutionalising MST with a long term view.