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Aftercare Services for Juvenile Parolees with Mental Disorders

**A Collaboration Between the Ohio Department of Youth Services (DYS) and
Columbus Children's Research Institute**

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FINAL REPORT

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Abstract

The purpose of this study was to examine aftercare services available to juvenile parolees after release from correctional facilities. Youth (162) assigned to a mental health caseload were interviewed and assessed within 60 days of release. A declining number were also interviewed at one (60), three (38), and six (24) months post release. About two thirds of youth met criteria for one or more disorder diagnoses prior to release. About 40% of the initial sample were rearrested within six months of release. About two thirds of those interviewed had received some sort of mental health services one month after release.

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EXECUTIVE SUMMARY

Purpose of the Present Study

Mental disorders among adolescents remanded to juvenile correctional facilities are common, disabling, and expensive. While access to mental health care within youth correctional facilities has improved in certain locales, the linkage of juvenile correctional facility care with community-based services upon release remains anecdotally problematic throughout the nation. This is a critical issue for youths with mental disorders released into the community, as inadequate or interrupted care may lead to abrupt cessation of medications or psychotherapy and thereby increase rates of recidivism. The present study examines the aftercare services juvenile parolees with mental disorders receive as they transition from correctional facilities to the community.

Our three objectives were as follows. First, we assessed rates of recidivism for juvenile parolees with mental disorders. Second, we examined the type and frequency of mental health care received in the community by youths on parole. Third, we investigated the relationship between parolees' recidivism and functional outcomes with their utilization of mental health care. Our ultimate goal is the improvement of treatment services for youths with mental disorders through research on aftercare for youths released from correctional facilities.

Methodology for the Present Study

We conducted a prospective cohort study to examine recidivism, adaptive functioning and mental health services for juvenile parolees from the mental health caseload who were released from juvenile correctional facilities. The sample came from the Ohio Department of Youth Services (DYS). Study inclusionary criteria for youths were as follows: (a) 12-19 years of age, (b) had a presumptive release date within the next 60 days, and (c) placement on the mental health caseload. One hundred eighty-seven eligible youths were approached for participation, and 162 (86%) agreed to participate and completed the baseline assessment. Our sample's mean age was 17.1 years. Ninety percent were male, and ten percent were female. Sixty-six percent were Caucasian, 27% were African-American, 2% were Hispanic American, 1% were Native American, and 3% were other (e.g., multiracial).

We sought to collect data from youths at four time points: one month pre-release, one month post-release, three months post-release, and six months post-release. A variety of standardized measures were completed, including the Voice Diagnostic Interview Schedule for Children-IV (psychopathology), the Columbia Impairment Scale (adaptive functioning), and the Service Assessment for Children & Adolescents (mental health service utilization). All statistical analyses were completed using SPSS for Windows 14.0 and SAS Version 9.1.3.

One hundred eighty-seven eligible youths were approached for participation, and 175 (94%) agreed to participate. One hundred sixty-two youths completed the initial pre-release telephone interview and Voice DISC-IV. Sixty youths completed the 1-month post-release interview. Thirty-eight youths completed the 3-month post-release interview. Twenty-four youths completed the 6-month post-release interview. The

sample met criteria for 0 disorders, 25.3% met criteria for 1 disorder, and 41.4% met criteria for more than 1 disorder. Separation Anxiety Disorder, Obsessive Compulsive Disorder, Major Depressive Disorder, and Oppositional Defiant Disorder were among the most common disorders.

In addition, 31 caregivers answered questions about lifetime presence of ADHD and ODD symptoms for these youths during the 1-month post-release interview. 64.6% of these caregivers reported 4 or more symptoms of Oppositional Defiant Disorder, 38.7% of these caregivers reported 6 or more symptoms of ADHD, Predominantly Inattentive Type, and 45.2% of these caregivers reported 6 or more symptoms of ADHD, Predominantly Hyperactive-Impulsive Type for their child.

Table 3 presents information collected from the youths' MAYSI-2 responses at admission to their most recent incarceration at DYS. 73.7% of youths were in the caution zone of at least one subscale, suggesting appropriate initial placement on the mental health caseload. An admission MAYSI-2 was available for 40 out of the 54 youths who did not meet criteria for a mental health disorder shortly before release according to the Voice DISC-IV. Twenty-eight out of these 40 youth were in at least one caution or warning zone of the MAYSI-2, suggesting that the majority of these youths were appropriately placed on the mental health caseload at entry into a DYS facility.

Aim 1: Description of re-arrest rates, functional outcomes, and mental health symptoms for six-month post release period

We collected information from DYS on 128 youths regarding whether or not they had been re-arrested or absent from parole during the six-month post release period. 40% of youths had been re-arrested or absent from parole during this interval.

Table 4 presents youth and caregiver mean scores for the Columbia Impairment Scale during the 1-month, 3-month, and 6-month interviews. Scores suggested a low to moderate degree of impairment. Also included in Table 4 are youth and caregiver mean scores for the internalizing and ADHD subscales of the Strengths & Difficulties questionnaire for each interview. At 1-month, based upon normative data provided by Bourdon, Goodman, Rae, Simpson, and Koretz (2005), 26% of caregivers reported at least moderate levels of youth internalizing symptoms and 42% of caregivers reported at least moderate levels of youth ADHD symptoms.

Aim 2: Description of the type and frequency of mental health services.

Tables 5 and 6 present youth and caregiver report on the type of mental health service received at each interval. Community mental health centers, home based therapists/counselors, and primary care providers were among the most common service providers. Of particular note, only 37 (62.7%) out of 60 youths reported receiving any mental health service in the community at the 1-month interview. For youths reporting receiving any service, a median number of 5 total visits for mental health issues occurred between pre-release and the 1 month interview.

Table 7 presents youth self-report of class of medication received at each interview. Each class of medication was used at comparable rates during the pre-release interview versus post-release interviews. Roughly 20% of youths reported missing at least one dose of psychiatric medication between release and the 1-month interview.

Aim 3: Investigating the relationship between mental health service utilization, re-arrest, and adaptive functioning

Because we wanted to see if mental health care prospectively predicted subsequent re-arrest/absence from parole, we selected three parameters of service utilization from the youth's one-month post-release interview. These three parameters were: (1) Did the youth receive any type of mental health service?; (2) Number of mental health visits; and (3) Was the youth compliant with his/her psychotropic medication regimen? Regarding the third parameter, youths were considered noncompliant only if they were reporting missing at least one dose of a prescribed psychotropic medication. Logistic regressions revealed that none of the three parameters predicted re-arrest/absence from parole (all $p > .05$). Similarly, when average Columbia Impairment Scale scores at 1-month were used as our dependent variable, none of the three service utilization parameters were predictive (all $p > .05$). Finally, given the substantial amount of missing service utilization data at 1 month, we conducted analyses with imputed data and still found that none of the three parameters of service utilization predicted re-arrest/absence from parole (all $p > .05$).

We subsequently conducted some exploratory logistic regressions using six predictor variables that have been previously found to predict recidivism: psychopathology at pre-release (i.e., Did the youth meet criteria for at least one VDISC diagnosis), age at first incarceration, total previous incarceration time, association with deviant peers at 1-month, ADHD symptoms at 1-month, and internalizing symptoms at 1-month. Only internalizing symptoms at 1-month were found to be predictive of re-arrest/absence from parole ($p < .05$).

Exploratory Aim: Identification of key barriers to youth's mental health service utilization

We found that 24.6%, 38.9%, and 27.3% of youths lacked health insurance coverage at 1, 3 and 6 months respectively. In addition, we conducted a non-parametric Friedman test to examine differences in the subscales from the Experience of Caregiving Inventory. The overall model was significant, $p < .01$. Pairwise comparisons indicated that concerns regarding stigma and difficulties with services were less common relative to the other sets of challenges (e.g., the youth's dependency on the family).

Discussion

Synopsis of Key Findings

Three key findings emerged from the present study. First, youths on the mental health caseload have substantial rates of psychiatric diagnoses shortly before release in the community. While a sizeable portion of youths no longer met criteria for a mental disorder, suggesting that mental health services may not be necessary for some parolees in the community or some parolees were minimizing symptoms, the majority of youths from the mental health caseload still met criteria for at least one disorder as they transitioned out of juvenile correctional facilities. In fact, we likely underestimated the rates of psychiatric diagnoses in this population, given that we did not include conduct disorder and substance use disorders as part of our computerized diagnostic interview. In summary, this high-risk population frequently needs mental health aftercare services during their parole.

Second, undertreatment of mental health problems appears quite common. While most youths reached for the 1-month post-release interview received some type of mental health service, just over one-third of these youths had received no mental health service during their first month in the community. Furthermore, 20% of youths reported missing

at least one dose of psychotropic medication during their first month post-release interview, indicating that medication noncompliance is a common issue for a substantial portion of youths. Finally, nearly 20% of our overall sample could not complete 1 and/or 3 month post-release interviews due to absence from parole or re-arrest, and we speculate that this group in particular was unlikely to have followed a treatment plan in the community.

Third, approximately two in five youths were re-arrested or absent from parole within only six months of being released. This rate appears slightly higher than the 36% six month recidivism rate for the overall Ohio juvenile correctional system for a time period before the present study was conducted. The frequency of mental health care did not predict re-arrest or recidivism, suggesting that community mental health care by itself may not be sufficient to promote optimal post-release functioning. However, youths with greater internalizing (e.g., anxiety and depression) symptoms at 1 month were at heightened risk for re-arrest during the six month post-release period. This result is consistent with Benda, Corwyn, and Toombs (2001), suggesting that youths reporting these symptoms may need greater assistance during the post-release period to prevent recidivism.

Limitations of the Present Study

Three limitations of our study are worth noting. First, data were collected from a single state in 2005 and 2006; therefore results may not generalize to other states or other time periods. Second, while data on multiple recidivism predictors (e.g., association with deviant peers) were collected, other variables (e.g., availability of mental health providers in certain locales, community mental health treatment's explicit inclusion as a parole

condition) might have been important predictors and should be incorporated in future studies.

Third, and most importantly, a considerable amount of data was missing for the post-release interviews. The investigative team utilized multiple strategies to maximize data collection, including (1) the collection of contact information regarding relatives who were likely to know the youth's whereabouts about release, (2) calling during a variety of daytime, evening, and weekend hours to increase the chances of reaching participants, and (3) the use of financial incentives for participation. Despite these considerable efforts, we had modest rates of post-release data collection, and others (e.g., Ko, Wasserman, McReynolds, and Katz, 2004) have similarly reported substantial difficulties with missing data when interviewing informants in the community for juvenile justice studies. Of course, the fact that youths were frequently re-arrested or absent from parole before particular interviews could be completed was also a major reason for our missing data. Missing data may have interfered with our ability to support the study's major hypothesis—mental health care in the community would reduce recidivism. However, our imputed data analyses imply that higher rates of data collection would likely not have allowed for the support of this major hypothesis.

Overall implications for policy, practice, and research

Juvenile parolees with mental health concerns require substantial assistance based upon (a) their high rates of psychiatric disorders prior to release, (b) their noteworthy rates of re-arrest within six months of being released, (c) their substantial lack of health insurance in the community, and (d) their frequent lack of receiving any mental health care in the community. Although mental health care, as assessed through post-release

interviews, did not reduce recidivism as originally predicted, this null finding should be interpreted with caution. In particular, we speculate that the nearly 20% of youths who could not complete a 1 and/or 3-month post-release interview due to absence from parole or re-arrest were unlikely to have followed a community treatment plan that might have reduced their rates of recidivism.

Future research using other states and other methodologies (e.g., claims data, face-to-face interviews to establish a more personal relationship with participants, collection of parole officer impressions regarding youths' utilization of mental health care) should be conducted to study the utilization-recidivism relationship. However, these alternative methodologies are not without their own limitations. For example, claims data typically features enrollees with one type of insurance coverage (e.g., Medicaid) but not enrollees with other types of insurance coverage (e.g., specific private insurance plan). Furthermore, future research should incorporate additional adolescent delinquency risk factors (e.g., parental monitoring) when examining this relationship to help specify the types of multifaceted interventions likely needed to reduce recidivism in this population. In particular, integrated case management that focuses on domains besides mental health care (e.g., education, job training) may be needed to prevent re-arrest for these youths.

Table 1: Participation Status for Various Stages of the Study

<u>Study Status</u>	<u>Frequency (%)</u>
Completed All four assessments (including 6-month interview)	24(14%)
3-Month interview completed; 6-month interview could not be completed because:	
Youth absent from parole/re-arrested prior to completion of interview	4 (2%)
Youth could not be reached	8 (5%)
Further participation declined	1(1%)
Other (e.g., exclusionary criteria were met)	2 (1%)
1-Month interview completed; 3-month interview could not be completed because:	
Youth absent from parole/re-arrested prior to completion of interview	13(7%)
Youth could not be reached	6(3%)
Further participation declined	1(1%)
Other (e.g., exclusionary criteria were met)	1(1%)
Pre-Release interview completed; 1-month interview could not be completed because:	
Youth absent from parole/re-arrested prior to completion of interview	20(11%)
Youth could not be reached	40(23%)
Further participation declined	17(10%)
Other (e.g., exclusionary criteria were met)	24(14%)
Voice DISC not completed during incarceration	10(6%)
Pre-Release interview started, but youth declined to finish interview:	3(2%)

Table 2: Prevalence of Mental Disorders according to the Voice DISC-IV

Name of Disorder	Number (%) meeting criteria	Number (%) not meeting criteria
Separation Anxiety Disorder	64(39.8 %)	97(60.2%)
Specific Phobia	28(17.3%)	134(82.7%)
Obsessive-Compulsive Disorder	26(16.0%)	136(84%)
Oppositional Defiant Disorder	23(14.2%)	139(85.8%)
Social Phobia	23(14.2%)	139(85.8%)
Selective Mutism	21(13.4%)	136(86.6%)
Agoraphobia	20(12.3%)	142(87.7%)
Major Depressive Disorder	19(11.7%)	143(88.3%)
Attention Deficit/Hyperactivity Disorder	12(8.1%)	136(91.9%)
Chronic Motor or Vocal Tic Disorder	11(6.8%)	151(93.2%)
Generalized Anxiety Disorder	9(5.6%)	153(94.4%)
Panic Disorder	9(5.6%)	153(94.4%)
Post Traumatic Stress Disorder	8(4.9%)	154(95.1%)
Hypomania	6(3.7%)	156(96.3%)
Transient Tic Disorder	4(2.5%)	158(97.5%)
Mania	2(1.2%)	160(98.8%)
Bulimia Nervosa	2(1.2%)	159(98.8%)

Enuresis (diurnal)	1(.6%)	161(99.4%)
Dysthymic Disorder	1(.6%)	161(99.4%)
Encopresis	0(0%)	162(100%)
Tourette's Disorder	0(0%)	162(100%)
Anorexia Nervosa	0(0%)	162(100%)
Enuresis (nocturnal)	0(0%)	162(100%)

Table 3: MAYSI-2 Scores at Most Recent Admission to Juvenile Correctional Facility

Subscale	Frequency (% caution zone)	Frequency (% warning zone)	Frequency (% safe zone)
Alcohol/Drug Use	35(30.7%)	15(13.2%)	64(56.1%)
Angry/Irritable	31(27.2%)	10(8.8%)	73(64%)
Depression/Anxious	37(32.5%)	10(8.8%)	67(58.7%)
Somatic Complaints	41(36%)	12(10.5%)	61(53.5%)
Suicide Ideation	13(11.4%)	18(15.8%)	83(72.8%)
Thought Disturbance	30(26.3%)	21(18.4%)	63(55.3%)

Table 4: Functional Outcomes (Columbia Impairment Scale) & Mental Health Symptoms (Strengths and Difficulties Questionnaire) in the Community^a

<u>Subscale</u>	Number of 1 month Respondents	Mean (SD) at 1 month	Number of 3 month Respondents	Mean (SD) at 3 months	Number of 6 month Respondents	Mean(SD) at 6 mo.
CIS-youth	60	7.8(8.2)	38	9.3(8.5)	24	10.0(7.5)
CIS-caregiver	31	13.4(10.0)	21	15.9(9.7)	15	17.9(9.4)
Internalizing-youth	60	1.8(2.2)	38	1.6(2.2)	24	2.1(2.3)
Internalizing-caregiver	31	2.1(2.1)	21	2.3(1.9)	15	2.8(2.1)
ADHD-youth	60	3.2(2.7)	38	3.0(2.7)	24	3.1(2.1)
ADHD-caregiver	31	4.6(2.8)	21	5.6(3.0)	15	4.5(3.0)

^a Scores for the Columbia Impairment Scale can range from 0-28, scores for the Internalizing scale of the Strengths and Difficulties Questionnaire can range from 0-10, and scores for the ADHD scale of the Strengths and Difficulties Questionnaire can range from 0-10. For all scales, higher scores indicated greater difficulties.

Table 5: Youth Self-Report of Mental Health Service Utilization

Percentage of Youths who Used Mental Health Services Between:

Type of Service	Pre-Release & 1-month Interviews (n=60)	1-month& 3-month Interviews (n=38)	3-month& 6-month Interviews(n=24)
Inpatient Services			
Hospital	0	0	0
Drug/Alcohol Treatment Center	0	0	0
Residential Treatment Center	5.0	2.6	0
Group Home	0	0	0
Foster Home	1.7	0	0
Emergency Shelter	0	0	0
Outpatient Services			
Community Mental Health Center	18.3	10.5	8.3
Psychologist/Psychiatrist/Social Worker	16.7	21.1	41.7
Partial Hospitalization/Day Treatment	5.0	0	4.3
Drug/Alcohol Clinic	10.0	2.6	0
Home Based Therapist/Counselor	21.7	15.8	20.8
Emergency Room	5.0	0	8.3
Pediatrician/Family Doctor	6.7	2.6	4.2
Clergy	1.7	0	0

Self-Help	23.3	15.8	0
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Table 6: Caregiver Report of Youth Mental Health Service Utilization

Percentage of Youths who Used Mental Health Services Between:

Type of Service	Pre-Release & 1-month Interviews (n=31)	1-month & 3-month Interviews (n=21)	3-month & 6-month Interviews (n =15)
Inpatient Services			
Hospital	0	0	0
Drug/Alcohol Treatment Center	3.2	0	0
Residential Treatment Center	0	0	0
Group Home	0	0	0
Foster Home	3.2	0	0
Emergency Shelter	0	0	0
Outpatient Services			
Community Mental Health Center	32.3	42.9	46.7
Psychologist/Psychiatrist/Social Worker	12.9	33.3	33.3
Partial Hospitalization/Day Treatment	9.7	0	0
Drug/Alcohol Clinic	3.2	9.5	0
Home-Based Therapist/Counselor	25.8	23.8	20.0
Emergency Room	6.5	0	0
Pediatrician/Family Doctor	12.9	14.3	6.7

Clergy	3.3	9.5	6.7
Self-Help	12.9	14.3	0

Table 7: Percentages of Youth self-report of Psychotropic Medication Usage

Medication Class	History of Taking class (n=166)	Taking Class at pre-release interview (n=166)	Taking Class at 1 month interview (n=60)	Taking class at 3 month interview (n=38)	Taking Class at 6 month interview (n=24)
Psychostimulants/ Stimulants	49.4	7.8	6.7	13.2	13.0
Mood Stabilizers/ Anticonvulsants	27.7	15.1	23.3	13.2	21.7
Antidepressants	43.6	21.1	20	10.5	13.0
Antipsychotic	34.9	15.7	15	10.5	17.4
Anti-anxiety/ Anxiolytics/ Benzodiazepines	2.4	1.2	0	0	0
Other	10.2	3.0	1.7	0	0
Strattera	4.8	5.4	8.3	0	4.3

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