

## Community Treatment Programs for Juveniles: A Best-Evidence Summary

*Lee A. Underwood, Kara Sandor von Dresner & Annie L. Phillips*

### Abstract

A significant challenge facing the juvenile justice system is the task of transitioning and reintegrating juveniles from youth corrections facilities back into the community. This challenge, in part, is related to determining whether the referred community programs are effective. This article summarizes the literature on the effectiveness of community programs for juveniles involved in the justice system, including defining characteristics of evidence-based programs and examining the relationship between youth characteristics and evidence-based practices. Model evidence-based programs are reviewed, providing a description of respective programs, treatment targets, and their outcomes. Limitations of evidence-based programs will be discussed and recommendations for the field will be summarized.

*Key words:* Community programs, juvenile justice, evidence-based programs, delinquents, treatment.

---

### Introduction

The juvenile justice system is overwhelmed with the increasing number of youth who are arrested each year. In 2003 about 2.3 million youth under the age of 18 were arrested and over 130,000 are placed in detention and juvenile correctional facilities (Cocozza, Trupin, & Teodosio, 2003). As a result, the number of youth who are released back into society is growing; according to the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Census of Juveniles in Residential Placement, approximately 100,000 youth are discharged from a juvenile correctional facility each year. This estimate is a modest one at best because when compared to adult offenders, juveniles actually spend less time in correctional facilities; therefore the actual percentage of juveniles returning to the community each year is much greater (Sickmund, 2000). Effective treatment programs are key in youth's successful reintegration back into their homes and communities. Gendreau and Goggin (1996) found that recidivism rates decreased by as much as 25 percent than those youth who did not participate in any institutional or community program. The most effective, however, are evidence based treatment programs as they can reduce recidivism from 25 percent to 80 percent (Gendreau, 1996 & The National Mental Health Association [NMHA], 2006). This poses a significant challenge to the juvenile justice system for it now has the task of diverting and reintegrating some incarcerated juveniles into some kind of treatment program. While evidence-based community programs are ideal, they are often underused for a variety of reasons. It is often difficult to determine what treatment programs are research-based (Hoagwood, Burns, Kiser, Ringeisen and Schoenwald, 2001). Once this is done, the characteristics of a program must be complimentary or tailored to juveniles and their presenting problems. This involves properly identifying the youth who are appropriate for program and linking with community resources.

Another challenge that prevents the implementation of model programs is the interchangeable terms that are used in identifying research-based programs and the various definitions these terms hold. Juvenile justice systems must establish a universal language. Frequently used terms when discussing post-release programs include evidence-based, best practice, research-based and innovative practice. It is critical to exam the similarities and the differences of these types of treatment so that juvenile justice officials can choose evidence-based programs that are complimentary with the specialized needs of each juvenile in the juvenile justice system. Using a common language also helps researchers to further examine the unique characteristics of evidence-based programs (Burns, Hoagwood and Mrazek, 1999 & Beale & Jones-Walker, 2004).

Researchers endorse the idea that evidence-based programs in community settings are more effective than those in residential or institutional settings; however, further examination on the effectiveness of these programs is warranted (Altschuler & Armstrong 2002; Burns, et al., 1999 & Steiner, Dunne, Ayres, Arnold, Benedek, Benson, Bernstein, Bernet, Bukstein, Kinlan, Leonard & McClennan, 1997; Underwood, Barretti, Storms & Safonte-Strumbolo, 2004; Wood, Trupin, Turner, & Vander Stoep, 1999).

This article summarizes existing knowledge about evidenced based programs so that researchers, clinicians, and juvenile justice program administrators can choose interventions that are proven to lower recidivism rates. Evidence-based definitional criteria and its characteristics, efficacy and effectiveness will be defined. The importance of implementing or developing evidence-based programs to cater to the unique issues that juveniles bring is highlighted in the relationship between youth characteristics and treatment programs. Model evidence-based community programs are identified with a description of each. Limitations of evidence-based programs will conclude this article.

### **What is Evidence-Based Practice?**

#### **Defining Evidenced-Based Practices**

There are a variety of definitions for evidence-based practices utilized throughout the fields of juvenile justice and mental health. The National Institute of Mental (2001) and Hoagwood (2003) define evidence-based as a body of knowledge, obtained through scientific method, on the prevalence, the incidence, the risk for mental disorders, and the impact of treatment and services on mental health related issues. In the juvenile justice field, the term “evidence-based” is defined as a body of knowledge, also obtained through scientific method, on the impact of specific practices on targeted outcomes for youth and their families (Hoagwood, et. al, 2001). McDonald (2003) conceptualized that evidence-based programs consists of three characteristics (defined outcomes, measurable outcomes, and practical realities or the rate of recidivism).

The Interdisciplinary Committee on Evidence-based Mental Health Care mandated definitional criteria for evidence-based practice (Weisz, 2001). The committee states that in order for treatment to be determined evidence-based, it must have at least two between group design studies representing the same age group and receiving the same treatment for the same target problem. The National Institute of Mental Health (NIMH) developed a list of research procedures that are consistent with evidence-based practices. These include:

1. Minimum of two control group studies or a large series of single-case design studies.
2. At least two researchers.
3. Utilization of a treatment manual.
4. Therapist training and guidelines.
5. Accurate clinical samples of youth.
6. Clinical significant tests of outcomes.
7. Reviewed functioning and symptom outcomes.
8. Long-term effects after release (Burns 1999).
9. Two or more studies that are superior to medication, placebo or an alternative treatment that is equivalent to an established treatment.

Clearly understanding the definitional criteria related to evidence-based practices allows practitioners to determine which interventions will be more effective in treating youth (Virginia Youth Commission, 2004).

## Determining Effectiveness

The terms effectiveness and efficacy are often confused. Effectiveness refers to the validity of the intervention when applied in clinical circumstances, whereas efficacy refers to the validity of the intervention under controlled research conditions (Lehman, Godman, Dixon, & Churchill, 2004). Hoagwood et. al., (2001) suggest that in order for a treatment protocol to be efficacious, two or more studies must show it to be superior to a control condition, one or more experiment must meet the criteria for a well designed treatment, or three single case studies must be conducted. Other indicators of effective programs share characteristics:

1. Reliance upon an empirically validated theory, which addresses the reduction of risk factors.
2. Trained providers with clinical supervisors, who maintain the integrity of the program design.
3. Training/program manuals that are available to all staff members.
4. Validated risk assessments to classify offenders and determine their criminogenic factors.
5. Use of cognitive behavior interventions.
6. Follow-up interviews with youth and their families, which are structured components of the program (Andrews, Bonta & Hoge, 1990; Gendreau & Goggin, 1995).

Evidence-based practices should focus on the outcome. Joplin, Bogue, Campbell, Carey, Clawson, Faust, Florio, Wasson, and Woodward (2004) stated that “interventions within corrections are considered effective when they reduce offender risk and subsequent recidivism” (p. 3). Evidence-based practice relies on the following principles:

1. Assessment of actuarial risks/needs.  
-An ongoing assessment of youths’ psychosocial and risk for delinquency needs should be conducted to determine the level of supervision and the types of services needed (Clements, 1996).
2. Enhancement of intrinsic motivation.  
-Providers should relate to offenders in order to elicit change (Miller & Rollnick, 2002). Use of motivational interviewing and engagement strategies are helpful in developing rapport and effective relationships.
3. Objective interventions.  
-Risk principle: Prioritize supervision and treatment resources for higher risk offenders.  
-Need principle: Target interventions to criminogenic needs.  
-Responsivity Principle: Be responsive to temperament, learning style, level of motivation, culture, and gender when assigning programs and interventions.  
  
-Dosage: Structure 40-70% of high-risk offenders’ time for at least

three to nine months.

-Treatment: Integrate treatment into the full sentence/sanction requirements (Taxman & Byrne, 2001).

4. Rehearsal of skill training.  
-Providers should include components of role-playing and skill rehearsals in program activities ( McGuire, 2001, 2002).
5. Utilization of positive reinforcement skills.  
-Youth tend to respond better and maintain learned behaviors when approached in a positive manner (Higgins & Silverman, 1999).
6. Initiation of consistent support in surrounding communities.  
-Research indicates that effective interventions utilize an offender's surrounding environment in an effort to reinforce new behaviors (Meyers. Miller, Smith & Tonnigan, 2002).
7. Assess practices, as well as processes.  
-Programs should maintain accurate and detailed information, and the performance staff should be assessed regularly (Milhalic & Irwin, 2003).
8. Provision of measurable feedback.  
-Providing feedback to offenders is essential to the process of enhancing motivation for change and improved outcomes. Providing feedback also provides offenders with accountability of their progress (Alvero et al, 2001).

### **Intervention Practices**

Crowded facilities, exceptionally high recidivism rates, and the rising costs of incarcerating juveniles are among the factors calling for community-based intervention programs that are supported by the literature (Altschuler, 1998). Common practices include innovative, promising, and best practices.

Innovative or "new idea" programs have never been systematically evaluated, and therefore their effectiveness is undetermined (Hoagwood, 2003). An example of an innovative practice is may include some community-based residential treatment programs. Underwood, Barretti, Storms, and Safonte-Strombolo (2004) suggest, "the problem lies in the fact that traditional-oriented residential treatment programs lack a research base to support its effectiveness." (p.12). Practitioners have little empirical research to help guide them in developing more effective practice guidelines for residential treatment programs.

Promising practices are generally thought to be in the early stages of formal evaluation because they have only met two out of four criteria for practices to be effective (Hoagwood, 2003). An example is the Los Angeles County Probation Department's Social Learning Model (SLM) home-based program for high risk and high need gang involved youth on probation (Underwood, 2005). The SLM provides a standardized approach to the method of delivery for treatment. The SLM is designed to positively impact thinking patterns, cognitions, social skills, violent behaviors, and youth and family engagement, all within the context of cultural competency. The six month program is designed to address the needs of males and females ages 14-18, and their families in all service areas. These services include home-based with an intensive family-centered approach. The model integrates principles of cultural competency, ensuring appropriate engagement and human relations strategies. Mutisystemic Therapy (MST) and Functional

Family Therapy (FFT) are the conceptual frameworks used to guide the practice parameters. The SLM is designed to have treatment providers and probation officers work closely together with gang-involved and violent high-risk youth in: 1) becoming more involved in school, improving moral reasoning, improving skills in handling difficult situations, and engaging in problem solving techniques; and 2) training treatment providers and probation officers in learning effective skills when working with families in further developing their engagement, alliance, and validation skills along with motivational enhancement techniques.

Best practices refer to effective programs. An example of a best practice is the Family Integrated Transitions Program (Trupin & Stewart, 2004). The Family Integrated Transitions (FIT) Program is an intensive treatment practice. The FIT program draws upon evidence-based operating principles from Multisystemic therapy, Motivational Enhancement therapy, Relapse Prevention, and Dialectical Behavior Therapy. An essential component to FIT is the integration of family in the treatment of the juvenile. A juvenile must be under the age of 17 ½ and be placed under supervision for at least four months after release in order to be eligible for FIT's services. This practice is initiated a couple of months before the juvenile's release from an institution, and services continue for an estimate of four to six months. Trupin and Stewart (2004) found that the recidivism rate of juveniles who participated in FIT dropped 27%, a highly significant decrease in the recidivism rate for this population.

### **The Relationship Between Youth Characteristics and Evidence-Based Practices**

Many researchers are interested in discovering key attributes of youth in order to determine what program characteristics are more relevant. Behaviors and histories of each youth are quite unique. For example, youth who have been traumatized will have different treatment needs than those who have not been traumatized. Juveniles with significant histories of substance abuse require unique therapeutic interventions that will differ from a juvenile living with a highly structured home. Most juveniles in the justice system will require specialized attention and programming while in community programs (Underwood, Mullan & Walter, 1997).

The next section provides a review of some key youth characteristics that exemplify the relationship between characteristic and evidence-based practices.

#### **Youth With Histories of Traumatization**

Juveniles vary considerably in their responses to traumatic events. Some youth may experience devastating, horrific events and have few effects, while others may experience minor events and have significant long-term reactions. It is important to understand that many "normal" experiences may be traumatic (e.g., an illness or death in the family) (Prescot, 1997 & Veysey, 2003). Certain types of experiences increase the likelihood of psychological damage, including being taken by surprise, trapped, and/or exposed to the point of exhaustion (e.g., sleep, hunger, hot or cold); also when certain experiences include physical violation or injury, exposure to extreme violence, and witnessing grotesque death (Veysey, 2003). The degree of psychological damage is indeed related to poor treatment outcomes for youth in both residential and post release rehabilitative programs. These youth tend to be more emotionally vulnerable in their communities and present histories of aggression (Veysey, 2003).

#### **Youth With Co-Occurring Disorders**

Co-occurring disorders occurs when at least one substance abuse disorder can be diagnosed simultaneously with another mental health disorder other than another substance abuse diagnosis. Each type must be determined independent of the other and must not be a cluster of symptoms resulting from the other disorder (Miller, Zweben, Diclemente, & Grychtarik, 1995). Juveniles with co-occurring disorders often have histories of profound mental health issues and therefore have used drugs or alcohol

as medications. Since these disorders severely affect their moods, thoughts, and behaviors, juveniles with co-occurring disorders may also be more impulsive and potentially more violent than youth. These behaviors are often unrecognized which deprives these youth from proper treatment because they have been mislabeled.

Youth with co-occurring disorders may be linked with differential longer-term treatment outcomes (Drake, Muesser, Clark and Wallach, 1996; Randall, Henggeler, Pickrel & Brondino, 1999). Juveniles who have a comorbid externalizing disorders as the coinciding diagnosis with substance abuse are predicted to drop out of high school (Kessler, Foster, Saunder, & Stang, 1995) and inpatient care (Abram & Teplin, 1991) whereas juveniles with co-occurring internalizing disorders are predicted to complete inpatient treatment (Kaminer and Frances, 1991). Different mental health diagnosis coupled with substance abuse disorders impacts youth differently than those with only a substance abuse disorder or a mental health disorder. Youth with co-occurring disorders are more likely to engage in higher rates of delinquent behavior, use more drugs and alcohol, and conform to antisocial peer pressure (Randall, et al., 1999; Kessler, et al., 1995).

### **Family and Environmental Difficulties**

The profiles of juveniles in community programs vividly illustrate a large variety of family and environmental risk factors. Family factors that have been consistently implicated in juvenile justice include, but are not limited to, poor parent-child relationships, neglect, coercive child-rearing (Patterson, Reid & Dishion, 1992), lack of warmth and affection, inconsistent parenting, violence, sexual abuse, disrupted attachments, and parental substance abuse (Henggeler, 1998).

Various studies have linked delinquent behavior and emotional distress with many different aspects of family functioning. Among the most consistently linked studies, there have been family characteristics suggesting familial antisocial behavior or values, including delinquent behavior as part of the family history, harsh parental discipline, and family conflict (Tolan & Lober, 1993). Several studies across a range of populations related delinquency and poorly controlled emotional regulation to a lack of parental monitoring, neglect, poor discipline methods, and conflict about discipline (Capaldi & Patterson, 1996; Farrington, 1989; Gorman-Smith, Tolan & Henry, 1998; Patterson et al., 1992). Similarly associated are low levels of parental warmth, acceptance and affection, low cohesion, high conflict and hostility, divorce, parental absence, and other losses (Farrington, 1994; Henggeler, Melton, & Smith, 1992; McCord, 1982).

### **Ethnic Minority Youth**

Ethnic minority youth, specifically African-American and Latina, are increasingly at risk for entering the juvenile justice system rather than treatment facilities (Bilchick, 1999; Elliot, 1994; Elliot, Tolan & Loeber, 1993). In 1996, youth of color comprised about one-third of the juvenile population yet accounted for about two-thirds of the incarcerated population (Hamparian & Leiber, 1997) and possibly more. Many studies fail to differentiate ethnicity from race and Latina's are often counted as white; this makes it impossible to know the accurate number for which youth of color are represented in the juvenile justice system (Poe- Yamagata & Jones, 2000).

Many factors may contribute to delinquent behavior by youth of color. Complicated social, medical, and psychological factors are among them (Bilchick, 1999; Canino & Spurlock, 1994). Youth of color are associated with the lack of legitimate job opportunities, increasing social isolation, poor schools, and weak community organizations. Thirty five percent live in not just poor neighborhoods, but "underclass" neighborhoods (Wilson, 1991) where crime rates are extremely high. Most youth of color in the juvenile justice system come from a young, undereducated, single family household headed by a

single mother. They are likely to be unemployed, truant from school, and to be on welfare (Issacs, 1992). These variables, as well as, others predict that youth of color have limited access to treatment networks and opportunities that would minimize the need for mental health services (Boyd-Franklin, 1991; Issacs, 1992; Osher, Steadman, & Barr, 2002). They also implicate that the adolescents' parents shared this limited availability of mental health services, thus often providing pathogenic home environments. Each subsequently constitutes risk factors for adolescent and young adulthood crime and violence (Group for the Advancement of Psychiatry, Committee on Preventative Psychiatry, 1999).

Substantial evidence suggests that youth of color who are involved in community programs should have their individualized needs addressed by integrating procedures that influence youth decision-making and critical thinking abilities (Boyd, Franklin, 1991; Issacs, 1992; Underwood and Rawles, 2002).

The next section provides a review of several model community programs. These programs have been systematically researched and meet the criteria needed to be classified as evidence-based.

### **Model Evidence-Based Programs**

The model evidence-based programs described in this section were selected on the basis of a thorough search of the literature (Jose & Sechrest, 1999; McCord, Widom, & Crowell, 2001 & Spencer & Jones Walker, 2004). The authors have selected community programs with at least some known use in juvenile justice or adolescent clinical settings and some evidence of reliability and other psychometric properties. The following section reviews of model evidence-based programs describe their respective change targets and outcomes.

#### **Multisystemic Therapy (MST)**

Multisystemic Therapy (MST) is considered an intensive family and community based treatment for youth who display antisocial behaviors, which puts them at risk for out-of-home placements. MST has been applied to youth with a variety of clinical problems which consists of: 1) chronic and violent juvenile offenders, 2) substance-abusing juvenile offenders, 3) adolescent sexual offenders, 4) youth in psychiatric crises (homicidal, suicidal, and psychotic), and 5) maltreating families (Randal, Heneggeler, Pickrel & Brondino, 1999). In treating these particular populations, the ultimate goals of MST programs are to reduce the rates of antisocial behavior, enhance the youth's functioning, and decrease the utilization of out-of-home placements (incarceration and residential treatment). MST's focal point is on the juvenile's surrounding environment (neighborhood, family, peers, school, etc.) and how it contributes to the juvenile's well-being. Service delivery occurs within the home environment and the community. Cortes (2004) states that many authors believe in the effectiveness of home-based family therapy due to the fact that it reduces the attrition rate of families who may not trust the mental health field or may not possess transportation. Home-based services may also benefit the juvenile and his/her family since the family is more at ease. This helps the family in developing better relationships with the therapist, while maintaining some type of control. Home-based services provide more accessible services for low income families (Henggeler, Mihalic, Rone, Thomas & Timmons-Mitchell, 1998).

MST has a body of research that supports its effectiveness with juveniles involved in post-release programs. Research has shown reductions up to 70% in long term rates of re-arrest, reductions up to 64% in out of home placements and improvements in family functioning (Randall, et al., 1999 & Mulvey, Arthur & Reppucci, 1993).

#### **Functional Family Therapy (FFT)**

Functional Family Therapy (FFT) is a family-based intervention, which is delivered in a clinical setting. FFT consists of four different phases: Impression, Motivation, Behavior Change, and Generalization phase (Alexander, Pugh & Parsons, 2000). These phases include assessments of the family, specific interventions utilized throughout the treatment, and the goals of the therapist. FFT's major goal is to enhance the family's communication with each other despite much of the negativity that may be displayed. Other goals include enhancing parenting and problem-solving skills. FFT addresses delinquent behavior, substance abuse, and mental health disorders (Conduct disorder, Oppositional Defiant disorder, and Disruptive Behavior disorder).

FFT provides services for youth between the ages of 6 and 18 years. Recently, components of multi-ethnicity and multicultural have also been incorporated into the program, which is essential to the change process of this population. The outcomes of FFT services have been positive. With less serious juvenile offenders, there has been a 50-75% reduction in recidivism rates. There has also been a 35% reduction in recidivism rates for more severe juvenile offenders (Alexander, Pugh & Parsons, 2000).

### **Multidimensional Treatment Foster Care (MTFC)**

Multidimensional Treatment Foster Care (MTFC) is an intensive parent training in an effort to enhance parents/guardians with more effective methods of parenting the juvenile when they return home. MTFC places emphasis on utilizing behavioral management methods with juvenile offenders in order to elicit change (Chamberlin & Mihalic, 1998).

MTFC provides services to juvenile delinquents who are also having difficulties with their families. The program lasts between 6 to 9 months, during which, practitioners focus on assisting juvenile delinquents with reducing criminal behavior, improving school attendance, establishing positive peer relationships, and improving familial relationships. The intensive parenting training continues for 12 months following the termination of services.

There were some notable long-term, positive outcomes found in the review of this program. Chamberlin & Mihalic (1998) state that 60% of juvenile offenders spent less time incarcerated during their 12 month follow-up. There were also fewer arrests with these juvenile offenders. Results indicate that these juveniles ran away from their placement three times less often than before receiving the MTFC treatment.

### **Wrap-Around Milwaukee**

The Wrap-Around Milwaukee program relies upon community services and natural supports for youth and families to achieve positive outcomes (Burns & Goldman, 1999). The wrap-around approach ensures that youth and families utilize a single individualized treatment plan that connects a youth's strengths and needs with specific services from within home, school and the community. The goal of Wrap Around Milwaukee is to reduce out of home placements. The Wrap-Around Milwaukee approach has been effective in reducing out-of-home placements as well as showing improvements in the social functioning of youth (Burns & Goldman, 1999).

Effectiveness studies, as measured by the Child and Adolescent Functional Assessment Scale (Hodges, 1995), have demonstrated promising trends. For a group of 300 delinquent youth enrolled in Wraparound Milwaukee, the average score of psychosocial impairment decreased from high levels at the time of enrollment to moderate levels at six months and one year after enrollment in the program. Goldman & Faw (1999) have also described positive effects.



### **Intensive Aftercare Program (IAP)**

The Intensive Aftercare Program (IAP) was designed to assist adolescents with their transition from incarceration back into the community (Altschuler & Armstrong, 1998). The IAP model consists of five main principles; preparation of juveniles for increased responsibility and freedom, facilitating interaction between the youth and the community, assisting both the offender and community support systems, developing new resources and supports, and monitoring whether the youth and community facilities can effectively work together.

The IAP model has been tested and evaluated in several states, including Colorado, Nevada, and Virginia. Both Caucasian and African-American juveniles were included in the sample of these studies. Due to the fact that this model considers the cultural components, the IAP may have a more positive outcome on the target population.

### **Mode Deactivation Therapy (MDT)**

Mode Deactivation Therapy (MDT) was developed in response to the difficulty in treating youth with high levels of co-morbidity, which resulted in ongoing resistance to current treatments modalities as well as being considered treatment failures in both the outpatient and residential settings. Apsche, Bass & Murphy (2004) have demonstrated that MDT is effective in reducing aggression and suicidal ideations within this population. Through the synthesizing of an applied CBT methodology as well as Linehan's work with Dialectical Behavior Therapy (DBT), MDT was developed for youth who displayed a reactive conduct disorder, personality disorders/ traits, and Post Traumatic Stress Disorder symptomology. Apsche and his colleagues have demonstrated the effectiveness of MDT in reducing aggression, specifically with youth who display the aforementioned diagnostic traits (Apsche, et al., 2004; Apsche & Ward 2004). Apsche & Siv (2005) further emphasize the need for an efficacious methodology by positing the development of personality disorder traits/features as a coping mechanism by these youth. This methodology encapsulates the needs of these youth who present with a complicated neglect, multi-axial diagnoses, as well as often being the victims of sexual, physical, and/ or emotional abuse.

Mode Deactivation Therapy also includes a series of mindfulness exercises that are specifically designed for these adolescents. Exercises incorporated within the client workbook designed to allow the youth to practice the technique which helps ensure trust, reduce anxiety and increase commitment to treatment as it helps develop mindfulness skills for the youth. The mindfulness skills result in development of the youths heightened awareness of their fears, triggers and beliefs which helps, them to use this new coping strategies in place of the aggressive behaviors.

Several descriptive studies indicate that MDT has been more effective than standardized CBT in the treatment of this population of youth (Apsche & Ward, 2004). Mode Deactivation Therapy has also been demonstrated as effective in a series of case studies (Apsche, Ward, Evile, 2002) and an empirical study which shows that it was more effective than standard CBT and social skills training (Apsche, Bass, Siv, 2005). Preliminary results of several recent case studies has shown MDT to be effective in reducing suicidal ideation and in reducing fire setting behaviors (Apsche & Siv, 2005, Apsche, Siv, Bass, 2005). The study of this methodology is important on several levels. The first level being the need to provide evidence based therapy for youth with deficits in multiple areas regarding their mental health issues. Kazdin and Weisz (2003) indicate how aggressive behaviors have an adverse effect not only on the adolescent but also in a variety of social settings such as academics, peer relations, and an increased contact with the juvenile justice system. Providing a methodology which allows increased progress with this difficult population as well as offering hope to both providers and clients is paramount for the benefit of both parties.

### **Big Brothers Big Sisters of America (BBBSA)**

Big Brothers Big Sisters of America (BBBSA) is a community-based organization. Services are provided by volunteers of the community, utilizing more of a mentoring relationship. First, all volunteers attend an orientation of the program. Second, volunteers are screened by a written application, a background check, an extensive interview, and a home assessment. Third, the youth is assessed. This process allows the caseworker to learn more about the youth and their parent. Matching the youth and the volunteer is an essential component to the program. Matches are made based on the youth's needs, the parent's preference, and the availability of the volunteer. Supervision is maintained throughout the program.

BBBSA provides services to youth, who are between the ages of 6 and 18 years. The majority of these children come from single parent homes. BBBSA services continue until the eligibility criteria are no longer met or the youth/volunteer makes the decision that they can no longer participate in the program.

After 18 months, the study found that 46% were less likely to initiate drug and alcohol use. One third of the youth were less likely to hit someone. Youth, who participated in BBBSA, presented a more positive attitude towards their academic behavior and performance. The youth also reported that they had more positive relationships with friends and family (McGill, Mihalic, Grotspeter, 1998).

The next section discusses the limitations of evidence-based practices and offers recommendations for policymakers. A caution about these selections: What is best for one setting—or in the hypothetical circumstances described—might not be best for other settings.

### **Limitations of Evidence-based Practices**

Researchers rely on rigorous designs and statistical procedures in developing evidence-based programs and interventions. However, there are some limitations to these practices. Researchers find it difficult to conduct a true random study on the outcome and effectiveness of these community based programs oftentimes use a quasi-experimental design in which the control group and experimental group are equivalent, but not randomly chosen. A well designed study that controls for external factors, has a low rate of participant attrition, accurate measurements, and appropriate analysis involves time and money of which most community based programs do not have.

Lack of adequate studies involving minorities raise important concerns when analyzing the effectiveness of evidence-based practices when the sample population is not representative of the actual population. Supporters of evidence-based community programs as treatment alternatives must take into account that some empirically validated interventions were normed on juveniles who may not have represented the heterogeneity of juveniles involved in the justice system. More studies are needed to examine the effectiveness that they may have on youth with special needs including youth of color, ethnic minorities, females, mentally retarded, developmentally delayed, medically fragile, violent adolescents, and those with mental health issues.

Many at-risk youth present with many complex and unique issues that make it difficult to develop or implement a treatment program. Each intervention will have to be examined to match and tailor it to the developmental stage of the targeted population. The Virginia Commission on Youth (2004) finds that evidence-based practices often fail because of the poor fit with their target audience. There must be a clearly defined rationale and procedure when assessing youth for the appropriateness of their participation in a program. This poses a problem because in order to identify the population that would potentially

benefit from treatment, youth need to be screened. Many community based treatment programs are understaffed and do not have the funds to implement such screening devices. Training new staff providing ongoing training for staff already involved is also costly, but necessary in order for juveniles are receiving adequate care.

When time, effort, and money well spent are not taken to ensure these measures are being conducted, chances are high that those juveniles will reenter back into the juvenile justice system.

### Summary

This article summarized the literature on the effectiveness of community programs for juveniles involved in the justice system. In examining the literature, this article discusses critical factors in determining the effectiveness of evidence-based practices. In order to provide effective, evidence-based practices, terms associated with evidence-based practices must be defined. This article referred to evidence-based practices as a “body of knowledge, obtained through carefully implemented scientific methods, about the prevalence, incidence, or risk for mental disorders or about the impact of treatments or services on mental health problems” (National Institute of Mental Health (NIMH), 2001).

Evidence-based practices must be tailored to the population that is being treated. These interventions must address certain issues, such as the juvenile’s environment, cultural aspects, and their development (physically and mentally).

In light of the advancements made in the area of evidence-based practices, we have argued that juveniles in community programs should receive the same level of services as those juveniles in mental health and substance use programs. Evidence-based practices require the integration of cognitive-behavioral theory, assessment, and treatment interventions. Furthermore, these characteristics for community programs are supported by the literature.

The emergence of evidence-based community programs has encouraged careful analyses on the development of evolving treatment strategies. Short and long-term outcome studies are needed to capture pertinent information for 18 to 36 months after discharge from community programs. The focus of these studies should not only provide measures of technical violations (re-arrests, etc.), but should also provide measures of positive outcomes, such as school attendance, substance use, peer association, and community involvement.

Future longitudinal studies are needed to determine if there are critical youth characteristics related to the most significant change targets. It is critical to focus on trauma, aggression and family violence and its mediating impact on juvenile delinquents. There is a need to further explore innovative programs that are directed towards ethnic minorities. These programs should focus on the role of acculturation and the level of community success and reintegration.

Policymakers must be aware of the impact of evidence-based programs. Funding and policy entities should be held responsible for their actions, supporting an atmosphere where service providers can provide evidence-based practices. Federal sources should highly encourage the use of evidence-based operating principles when considering acceptance of state and county Medicaid plans. Programs that subscribe to evidence-based practices should be held accountable for achieving expected outcomes. All evidence-based practices should be available to the community (Lehman, Goldman, Dixon, & Churchill, 2004).

### References

Abram, K., & Teplin, L. (1991). Co-occurring disorders among mentally ill jail detainees: Implications for public policy. *American Psychologist, 46* (10), 1036-1045.

- Alexander, J., Pugh, C. & Parsons, B. (2000). Functional family therapy: In D. Elliot (Series Ed), *Blueprints for Violence Prevention* (Vol 3). Golden, CO: Venture.
- Altschuler, D. (1998). Reintegrating juvenile offenders into the community: OJJDP's intensive community-based aftercare demonstration program.
- Altschuler, D., & Armstrong, T. (1995). *Managing aftercare services for delinquents*. In B. Glick & A.P. Goldstein (Eds.), *Managing Delinquency Programs That Work*. Laurel, MD: American Correctional Association, pp. 137-170.
- Altschuler, D., & Armstrong, T. (1998). Reintegrating high-risk juvenile offenders into communities: Experiences and prospects. *Corrections Management Quarterly*, 5, 72-88.
- Altschuler, D., & Armstrong, T. (2002). Juvenile corrections and continuity of care in a community context: The evidence and promising directions. *Federal Probation*, 66, 2, 72-78.
- Alvero, A., Bucklin, B., & Austin, J. (2001). An objective review of the effectiveness and essential characteristics of performance feedback in organizational settings. *Journal of Organizational Behavior Management*, 21 (1), 3-29.
- Andrews, D.A., Bonta, J., and Hoge, R.D. 1990. Classification for effective rehabilitation: Rediscover psychology. *Criminal Justice and Behavior* 17:19-52.
- Apsche, J.A. (2005). Beck's theory of modes. *International Journal of Behavioral Consultation and Therapy*, 2,1, in press.
- Apsche, J.A. (1999). *Thought Change Workbook*. Portsmouth, VA: Alternative Behavioral Services.
- Apsche, J.A., Evile, M.M., and Murphy, C.J. (2004). The thought change system: An empirically based cognitive behavior therapy for male juvenile sex offenders. A pilot study. *The Journal of Behavior Analysis Today*, 5, 1, 101-107.
- Apsche, J.A., & Ward Bailey, S.R. (2004a). Mode deactivation therapy: Cognitive behavioral therapy for young people with reactive conduct disorders or personality disorders or traits who sexually abuse. In M.C. Calder (Ed), *Children and Young People Who Sexually Abuse: New Theory Research and Practice Developments*, pp. 263-287. Lyme Regis, UK: Russell House Publishing.
- Apsche, J.A., & Ward Bailey, S.R. (2003). Mode deactivation therapy: A theoretical case analyses (Part I). *The Journal of Behavioral Analyst Today*, 4, 3, 342-353.
- Apsche, J.A., & Ward Bailey, S.R. (2004b). Mode deactivation therapy: A theoretical case analyses (Part II). *The Journal of Behavioral Analyst Today*, 5, 1, 395-434.
- Apsche, J.A., & Ward Bailey, S.R. (2004c). Mode deactivation therapy: A theoretical case analyses (Part III). *The Journal of Behavioral Analyst Today*, 5, 3, 314-332.
- Apsche, J.A., Bass, C.K., Jennings, C.J., Siv, A.M. An empirical comparison between

- two treatments for adolescent males with conduct and personality disorders: Cognitive Behavior Therapy and Mode Deactivation Therapy. *International Journal of Behavior Consultation and Therapy*. Winter 2005 1 (1). Pp 27-45.
- Apsche, J.A., Bass, C.K., Jennings, J.L., Murphy, C.J., Hunter, L.A., and SIV, A. An empirical study of behavior: A comparison of Mode Deactivation Therapy, Cognitive Behavior Therapy and Social Skills Training. *International Journal of Behavior Consultation and Therapy*. Spring 2005 1. (2), pp. 113-132.
- Apsche, J.A., Bass, C.K., Murphy, C.J. (2004). A comparison of two treatment studies: CBT and MDT with adolescent sex offenders. *Journal of Early and Intensive Behavioral Intervention*, 1, 2, (Winter)179-190.
- Armstrong, T. (2003). Achieving positive results with serious juvenile offenders in a reintegrative framework: Strategies essential for rehabilitative effectiveness with the intensive aftercare program (IAP) model. Retrieved on July 19, 2005, from [http://www.csus.edu/ssis/cdcp/OnatiPaperEuropeanVersionRev3\\_05.pdf](http://www.csus.edu/ssis/cdcp/OnatiPaperEuropeanVersionRev3_05.pdf).
- Beale Spencer, M., & Jones-Walker, C. (2004). Interventions and services offered to former juvenile offenders reentering their communities. *Youth Violence and Juvenile Justice*, 2, 1, 88-97.
- Bilchik, S. (1999). *Minorities in the juvenile justice system. 1999 National Report Series. Juvenile Justice Bulletin*. Department of Justice, Washington, D.C. Office of Juvenile Justice and Delinquency Prevention, 1-15.
- Botvin, G., Mihalic, S., & Grotmeter, J. (1998). Blueprints for violence prevention, book five: Life skills training. Boulder, CO: Center for Study and Prevention of Violence.
- Bourdin, C. (1999). Multisystemic treatment of criminality and violence in adolescents. *Journal of American Academy of Child and Adolescent Psychiatry*, 38 (3), 242-249.
- Boyd-Franklin, N. (1991). Culturally sensitive treatment of the inner-city African-American adolescent: A multi-systemic model. In W. Snyder, & T. Ooms (Eds.), *Empowering families, helping adolescents: Family-centered treatment of adolescents with alcohol, drug abuse and mental health problems*. Washington, DC: U.S. Department of Health and Human Services.
- Burns, B., Hoagwood, K., and Mrazek, P. (1999). *Effective Treatment for Mental Disorders in Children and Adolescents*. *Clinical Child and Family Psychology Review* 2 (4): 199-254. For a report on the proceedings of the NIMH Child and Adolescent Mental Health Services Research Planning Meeting. [Online]. Available: <http://www.nimh.nih.gov/childhp>. [June 2002].
- Burns, B.J., & Goldman, S.K. (1999). Promising practices in wraparound for children with serious emotional disturbance and their families. *Systems of care: Promising practices in children's mental health*, 1998 series, volume IV. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

- Canino, I., & Spurlock, J. (1994). *Culturally diverse children and adolescents*. New York: Guilford Press.
- Capaldi, D. (1992). Co-occurrence of conduct problems and depressive symptoms in early adolescent boys: A 2-year follow-up at grade eight. *Development and Psychopathology*, 4, 125-144.
- Capaldi, D., & Patterson, G. (1996). Can violent offenders be distinguished from frequent offenders? Prediction from childhood to adolescence. *Journal of Research in Crime and Delinquency*, 33, 206-231.
- Chamberlain, P., & Mihalic, S. (1998) Blueprints for violence prevention, book eight: Multidimensional treatment foster care. Boulder, CO: Center for the Study and Prevention of Violence.
- Clements, C. (1996). Offender classification: Two decades of progress. *Criminal Justice and Behavior*, 23, 121-143.
- Cocozza, J. (1997). Identifying the needs of juveniles with co-occurring disorders. *Corrections Today*, 147-149.
- Cocozza, J. J., Trupin, E., & Teodosio, L. (2003) *Diverting youth with mental health needs from the juvenile justice system: Critical issues and model approaches*. Presented at the GAINS TAPA center easy access net/teleconference.
- Cortes, L. (2004). Home-based family therapy: A misunderstanding of the role and a new challenge for therapists. *The Family Journal: Counseling and Therapy for Couples and Families*, 12(2), 184-188.
- Department of Justice, Office of Juvenile Justice and Delinquency Prevention. (1999). *Minorities in the juvenile justice system. 1999 National Report Series. Juvenile Justice Bulletin*. Washington, D.C.: Juvenile Justice Clearinghouse, 1-17.
- Drake, R., Mueser, K., Clark, R., & Wallach, M. (1999). The course, treatment and outcomes of substance disorder in persons with severe mental illness. *American Journal of Orthopsychiatry*, 66 (1), 42-51.
- Farrington, D. (1989). Early predictors of adolescent aggression and adult violence. *Violence and Victims*, 4, 79-100.
- Farrington, D. (1994). Childhood, adolescent, and adult features of violent males. *In: Aggressive behavior: current perspectives* (pp. 215-240). New York: Plenum Press.
- Fulkerson, J., Harrison, P., & Beebe, T. (1997). *Residential behavioral treatment facilities. 1996 Minnesota student survey*. Substance Abuse and Mental Health Services Administration. Rockville, MD, 1-33.
- Gendreau, P., & Goggin, C. (1995). The principles of effective intervention with offenders. In A. J. Harland (Ed.), *Choosing Correctional Options That Work: Defining the demand and evaluating the supply*. Thousand Oaks, CA: Sage.

- Goldman, S.K. & Faw, L. (1999). Three wraparound models as promising approaches in Burns, B.J. & Goldman, S.K. (Eds) (1999). Promising practices in wraparound for children with serious emotional disturbance and their families. *Systems of care: Promising practices in children's mental health, 1998 series, volume IV. Washington DS: Center for Effective Collaboration & Practice, American Institutes for Research*, (pgs 17-60).
- Gorman-Smith, D., Tolan, P., Loeber, R., & Henry, D. (1998). Relation of family problems to patterns of delinquent involvement among urban youth. *Journal of Abnormal Child Psychology*, 26(5), 319-333.
- Greenbaum, P., Foster-Johnson, L., & Petrilla, A. (1996). Co-occurring addictive and mental disorders among adolescents: *Prevalence Research and Future Directions*. American Orthopsychiatry Association.
- Greenberg, M., Kusche, C., & Mihalic, S. (1998). Blueprints for violence prevention, Book Ten: Promoting Alternative Thinking Strategies (PATHS). Boulder, CO: Center for the Study and Prevention of Violence.
- Group for the Advancement of Psychiatry, Committee on Preventive Psychiatry. (1999). Violent behavior in children and youth: preventive intervention from a psychiatric perspective. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38 (3), 235-241.
- Hamparian, D., & Leiber, M. (1997). Disproportionate confinement of minority juveniles in secure facilities: 1996 National Report. Champaign, IL: Community Research Associates.
- Henggeler, S., Melton, G., & Smith, L. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology*, 60, 953-961.
- Henggeler, S., Mihalic, S., Rone, L., Thomas, C., & Timmons-Mitchell, J. (1998). Blueprints for violence prevention, book six: Multisystemic therapy. Boulder, CO: Center for the Study and Prevention of Violence.
- Hoagwood, K., Burns, B., Kiser, L., Ringeisen, H., & Schoenwald (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52 (9), 1179-1189.
- Hodges, K. (1995). *CAFAS self-training manual and blank scoring forms*. Ypsilanti, MI: Eastern Michigan University Psychology Department.
- Isaacs, M. (1992). Assessing the mental health needs of children and adolescents of color in the juvenile justice system. Overcoming institutionalized perceptions and barriers. In J. Coccozza (Ed.), *Responding to the mental health needs of youth in the juvenile justice system* (pp. 141-163). Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System.
- Joplin, et al. (2004). Using an integrated model to implement evidence-based practices in corrections. *International Community Corrections Association and American Correctional Association*, 1-28.

- Josi, D.A., & Sechrest, D.K. (1999). A pragmatic approach to parole aftercare: Evaluation of community reintegration program for high-risk youthful offenders. *Justice Quarterly*, 16 (5), 1-80.
- Kaminer, Y., & Frances R. (1991). Inpatient treatment of adolescents with psychiatric and substance abuse disorders. *Hospital and Community Psychiatry*, 42, 894-896.
- Kessler, R., Foster, C., Saunder, W., & Stang, P. (1995). Social consequences of psychiatric disorders. *American Journal of Psychiatry*, 152, 1026-1032.
- Lehman, A., Goldman, H., Dixon, L., & Churchill, R. (2004). Evidence-based mental Health treatments and services: Examples to inform public policy. Retrieved on July 19, 2005, <http://www.milbank.org/reports/2004lehman/2004lehman.html>.
- McCord, J. (1982). A longitudinal study of the link between broken homes and criminality. In: *Abnormal offenders delinquency and the criminal justice system*. London: Wiley.
- McCord, J., Widom, C., & Crowell, N. (2001). *Juvenile Crime, Juvenile Justice*. Washington, DC: National Academy Press.
- McDonald, C. (2003). Forward via the past? Evidence-based practice as strategy in social work, *The drawing board: An Australian review of public affairs*, 3 (3), 123-142.
- McGill, D., Mihalic, S., & Grotper, J. (1998). Blueprints for violence prevention, book two: Big brothers big sisters of America. Boulder, CO: Center for the Study and Prevention of Violence.
- McGuire, J. (2001). What works in correctional intervention? Evidence and practical implications. Pp. 25-43 in *Offender rehabilitation in practice: Implementing and evaluating effective programs*, edited by D. F. Gary Bernfeld, Alan Leschied. New York, NY: John Wiley & Sons, LTD.
- McGuire, J. (2002). Evidence-based programming today. Paper presented at international community corrections association conference, Boston, MA, November, 2002.
- Meyers, R., Miller, W., Smith, J., & Tonnigan, S. (2002). A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. *Journal of Consulting and Clinical Psychology*, 70 (5), 1182-1185.
- Mihalic, S. & Irwin, K. (2003). Blueprints for violence prevention: From research to real world settings-factors influencing the successful replication of model programs. Boulder, CO: Center for the Study & Prevention of Violence.
- Miller, W. & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. New York, NY: Guilford Press.
- Mulvey, E., Arthur, M., & Reppucci, N. (1993). The prevention and treatment of juvenile delinquency: A review of the research. *Clinical Psychology Review*, 13, 133-167.
- National Institute of Mental Health. (2001). *Blueprint for change: Research on child and adolescent mental health*. Report of the National Advisory Mental Health



Council's Workgroup on Child and Adolescent Mental Health Intervention.

- National Mental Health Association. (2006). *Treatment works for youth in the juvenile justice system*. [www.nmha.org/children/justjuv/treatment.cfm](http://www.nmha.org/children/justjuv/treatment.cfm)
- Olds, D., Hill, P., Mihalic, S., & O'Brien, R. (1998). Blueprints for violence prevention, book seven: Prenatal and infancy home visitation by nurses. Boulder, CO: Center for the Study and Prevention of Violence.
- Osher, F., Steadman, H., & Barr, H. (2002). A best practice approach to community re-entry from jails for inmates with co-occurring disorders: The APIC model. *The National GAINS Center*. Delmar, New York.
- Palmer, T. (1995). Programmatic and non-programmatic aspects of successful intervention: New directions for research. *Crime & Delinquency*, 41 (1), 100-131.
- Patterson, G., Reid, J., & Dishion, T. (1992). *Antisocial boys: A social interactional approach* (Vol. 4). Eugene, OR: Castalia.
- Pentz, M., Mihalic, S., & Grotzger, J. (1998). Blueprints for violence prevention, book one: The midwestern prevention project. Boulder, CO: Center for the Study and Prevention of Violence.
- Poe- Yamagata, E., Jones, M. (2000). *And justice for some*. Building Blocks for Youth.
- Prescot, L. (1997). *Adolescent girls with co-occurring disorders in the juvenile justice system*. Delmar, NY: The National GAINS Center.
- Randall, J., Henggeler, S., Pickrel, S., & Brondino, M. (1999). Psychiatric comorbidity and the 16-month trajectory of substance-abusing and substance-dependent juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 100-107.
- Sickmund, M. 2000. *Census of Juveniles in Residential Placement Databook*. Fact Sheet. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. FS-200008.
- Spencer, M., & Jones-Walker, C. (2004). Interventions and services offered to former juvenile offenders reentering their communities: An analysis of program effectiveness. *Youth Violence and Juvenile Justice*, 2, 88-97.
- Steiner, J., Dunne, J., Ayres, W., Arnold, V., Benedek, R., Benson, S., et al. (1997). Practice parameters for the assessment and treatment of children and adolescents with conduct disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 122-140.
- Taxman, F. & Byrne, J. (2001). Fixing broken windows probation together. *Perspectives, Spring*, 23-29.
- Thompson, L., Riggs, P., Mikulich, S., & Crowley, T. (1996). Contribution of ADHD symptoms to substance problems and delinquency in conduct-disordered adolescents, *Journal of Abnormal Child Psychology*, 24, 325-347.

- Tolan, P., & Loeber, R. (1993). Antisocial behavior. In: *Handbook of clinical research and clinical practice with adolescents* (pp. 307-331). New York: Wiley.
- Underwood, L.A. (2005). Los Angeles County Probation Social Learning Model for High Risk and High Need Youth in Community Programs. Unpublished Document.
- Underwood, L.A., Barretti, L., Storms, T.L., Safonte-Strumbolo, N. (2004). A review of clinical characteristics and residential treatments for adolescent males with mental health disorders: A promising program\_A review of clinical characteristics and residential treatments for adolescent males with mental health disorders: A promising program Journal of Trauma, Violence and Abuse, 5, 3, 199-242.
- Underwood, L., Mullan, W., & Walter, C. (1997). We built them and they came: New insights for managing Ohio's aggressive juvenile offenders with mental illness. *Corrections Management Quarterly*, 1(4), 19-27.
- Underwood, L., & Rawles, P. (2002). Screening and assessing African-American youth involved in the juvenile justice system: Practical Considerations, *Juvenile Correctional Mental Health Report*, 2 (4), 49-50, 56-62.
- Veysey, B. (2003). Adolescent girls with mental health disorders involved with the juvenile justice system. National Center for Mental Health and Juvenile Justice. Delmar, New York.
- Virginia Youth Commission (2004). Evidence-based treatments. Retrieved on July 19, 2005, from <http://coy.state.va.us/Modalities/evidence.htm>.
- Waldron, H., Slesnick, N., Peterson, T., & Turner, C. (2001). Treatment outcomes for adolescent substance abuse at 4-and 7-month assessments, *Journal of Consulting and Clinical Psychology*, 69 (5), 802-818.
- Weinberg, N., Rahdert, E., Colliver, J., & Glantz, M. (1998). Adolescent substance abuse: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 252-261.
- Weisz, J.R. (2001). Lab-clinic differences and what we can do about them: Linking research and practice to enhance our public impact. *Newsletter of the Division of Clinical Child Psychology*.
- Wood, P., Trupin, A., Vander Stoep, A. (1999). The community transition of incarcerated mentally ill youth: An outcome study. Washington State Department of Social and Health Services. Seattle, WA.
- Wilson, W. (1991). Studying inner-city social dislocation. *American Sociological Review*, 56, 1-14.

#### Author Note

Lee A. Underwood, Psy.D. Licensed Clinical Psychologist, Regent University and the National Center for Mental Health and Juvenile Justice (NCMHJJ).

Dr. Lee A. Underwood serves as an Assistant Professor with Regent University School of Psychology and Counseling and is a Senior Consultant for the National Center for Mental Health and Juvenile Justice, an affiliate of Policy Research Associates (PRA).

Kara Sandor von Dresner, MA, CGS is a Psy.D. student in the Clinical Psychology at Argosy University/Washington DC. She also serves as a Program Consultant for USA Consulting Group.

Annie L. Phillips, MA is a graduate of Regent University School of Psychology and Counseling and is a doctoral student in the Counseling Psychology at Walden University.

**Author Contact Information:**

**Dr. Lee A. Underwood**  
**Regent University,**  
**1000 University Drive**  
**Virginia Beach, VA 23464**  
**Email: leunde@regent.edu.**

---

**ADVERTISING IN THE  
INTERNATIONAL JOURNAL OF BEHAVIORAL AND CONSULTATION THERAPY**

**The prices for advertising in one issue are as follows:**

**1/4 Page: \$50.00   1/2 Page: \$100.00 vertical or horizontal   Full Page: \$200.00**

**If you wish to run the same ad in multiple issues for the year, you are eligible for the following discount:**

**1/4 Pg.: \$40 - per issue**  
**1/2 Pg.: \$75 - per issue -vertical or horizontal**  
**Full Page: \$150.00-per issue**