

# Juvenile Corrections and Continuity of Care in a Community Context— The Evidence and Promising Directions

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**OVER THE LAST** several years, the criminal justice system has awoken to the fact that the record number of inmates who have been imprisoned are now emerging from correctional facilities (Travis and Petersilia, 2001). This phenomenon has prompted a surge of interest in what recently has been termed “reentry.” In the juvenile justice system, reentry concerns have been the primary focus of a federally-funded initiative that began in 1988. At that time, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) initiated a research and development effort in what is commonly referred to in juvenile corrections as “aftercare” (Altschuler and Armstrong, 1994; Altschuler and Armstrong, 2001). Whether it is called reentry or aftercare, this topic provokes concern over how successful the reintegrative process can be for offenders and their ability to function, as well as the impact on their families, victims, the community at large, public safety, and even the community corrections system itself (e.g., parole, post-release supervision, contracted services). From a “what works” perspective, the questions to be addressed in this article are: 1) how might reentry and aftercare best be conceptualized and defined? 2) what is the current state of evidence regarding its workability? and 3) how should corrections research and practice on this topic proceed? Additionally, overlapping issues and relevant research drawn from research on confined and released youthful and adult offenders will be discussed.

Never far removed from discussions of “what works” is the issue of sustaining in the community those gains made by offenders while in correctional confinement. This way of posing the problem emphasizes both what

services are provided in facilities to prepare offenders for reentry and how skills and competencies acquired while confined are reinforced and monitored in the community. More appropriate terms that convey this broader meaning of reentry are “reintegration” and “continuity of care.” The terms “aftercare,” “reentry” and even “relapse prevention” are often defined and understood as referring primarily to what does or does not happen when offenders return to the community. Sometimes a more expansive definition is used to include what happens during the period of so-called “pre-release,” when discharge planning is supposed to occur. By contrast, “reintegration” includes several very distinctive dimensions, which, taken together, pinpoint rather precisely what must be accomplished for a continuity of care approach to be implemented. Only full implementation of a reintegrative approach will make it possible to evaluate the impact such a framework can have on both re-offending and community adjustment. The terms “reintegration” and “continuity of care” are used interchangeably in the discussion that follows.

In this framework of reintegration and continuity of care, the OJJDP-funded project developed the Intensive Aftercare Program (IAP) model. The specific aim of intensive aftercare, as distinct from standard or routine aftercare, is to help identified “high-risk” juvenile offenders make the transition from correctional facilities gradually back into the community in a more calibrated and highly structured fashion, with the hope of lowering the high rate of failure and relapse usually experienced by this group. IAP is explicitly designed to address two widely acknowledged

deficiencies of institutional corrections. These are that 1) institutional confinement does not adequately prepare youth for return to the community where at least part of their problem has its origins, and 2) lessons and skills learned in confinement are not systematically monitored, much less reinforced, on the “outside.” Lack of communication, coordination, collaboration and consistency between correctional facilities and parole or probation agencies, community-based socializing institutions, and other step-down programs (residential and nonresidential) have long plagued the development of truly reintegrative corrections.

The initial research and development work and the subsequent formulation of the IAP model highlighted the value of conceptualizing reintegration as comprised of three distinct but overlapping phases: 1) institutional services and programming tied directly to pre-release planning and lending themselves to application and reinforcement in the community; 2) structured transition experiences before and after community reentry, involving both facility and community-based staff; and 3) longer-term normalization in the community, where non-correctional agencies and community support systems become ascendant.

The challenge posed by reintegration is not new to juvenile corrections, particularly as related to the drug treatment, mental health, education and employment needs of juvenile offenders. Many researchers and practitioners have long believed that the concept of continuity of care holds great potential in reversing the persistent lack of success in achieving effective transitions (see, for example, Altschuler, 1994; Altschuler and Armstrong, 1994; Catalano et al., 1989; Center for Sub-

stance Abuse Treatment, 1998). Whether measured by recidivism, relapse or both, the failures experienced by juvenile corrections are frequently attributed, at least in part, to discontinuity. Discontinuity can take numerous forms, a reality not always recognized by those responsible for addressing the problem. An additional complication is that responsibility for, and jurisdiction over, offenders is often split between agencies and even between divisions within one agency that have fundamentally different perspectives, philosophies, missions, and priorities regarding what to do with offenders and how to do it (Altschuler and Armstrong, 1995).

Frederick (1999) has conceptualized continuity of care and how to put it into operation as consisting of five essential dimensions. The dimensions are: 1) continuity of control, 2) continuity in the range of services, 3) continuity in service and program content, 4) continuity of social environment, and 5) continuity of attachment. The IAP model and Frederick's conceptualization share assumptions on the importance of establishing consistency, coordination and collaboration between the two very different worlds of institutional corrections and community corrections.

Underlying both the IAP model and the five continuity of care dimensions is the assumption that any positive change experienced by young people while in confinement is likely to be of little long-lasting value if it is not relevant to their pressing daily concerns upon reentry to the community. This assumption is testable through program evaluation that systematically compares the impact of institutional corrections with and without continuity of care. Unfortunately, few such evaluations have been conducted to date, and among those that have, many have been plagued by flawed implementation (Altschuler, Armstrong and MacKenzie, 1999; National Research Council, 2001). Flawed implementation is a substantial limitation, because, from an evidence-based and research-driven perspective, it is only when continuity of care is reflected in practice (i.e., the integrity and fidelity of program implementation) that it becomes possible to determine whether and in what ways continuity of care contributes to success. To the extent that continuity of care is not well conceptualized or is unsuccessfully implemented, there can be no true test of its potential value and impact. Even if continuity of care is found beneficial, it will have little practical meaning if it cannot be implemented.

## Research Design and Implementation Weaknesses

What is known about reintegration and how does this knowledge base establish a sufficient basis to justify continued implementation and testing? In a recently issued report, The National Research Council (2001) stated that to date the research conducted specifically on juvenile aftercare programs is far from conclusive, with some evaluations finding moderate benefits and other studies showing less positive findings. In a study prepared for the National Institute of Justice by the University of Maryland (Sherman et al., 1997), juvenile aftercare was regarded as among those strategies showing promise because at least some of the published research indicated reduced recidivism. What might explain these mixed findings?

As noted in MacKenzie (1999), National Research Council (2001), and Altschuler and Armstrong (1999), some of the reasons are methodological, some are conceptual, and some are programmatic. In terms of methodology, the small number of subjects in particular studies provides little basis to detect statistically significant differences between the aftercare and non-aftercare groups. Other studies make comparisons between non-comparable groups of participants and nonparticipants, do not measure outcomes other than recidivism, and only collect officially reported record data while entirely omitting self-report data. Still other studies fail to measure whether the experimental (aftercare) group received more of the specified aftercare services than the control group.

Implementation is another area in which some aftercare programs have been weak. Poorly designed programs, badly implemented ones, and those experiencing difficulties in providing treatment services have not produced positive results. Reintegration and continuity of care require: 1) treatment in facilities that prepare offenders for reentry into the specific communities to which they will return, 2) making the necessary arrangements and linkages with people, groups and agencies in the community that relate to known risk and protective factors, and 3) ensuring the delivery of required services and supervision (Altschuler and Armstrong 1999; Altschuler and Armstrong 2001; Frederick 1999). Accordingly, appropriate treatment while confined and concerted efforts to maintain and reinforce treatment after reentry into the community are both heavily emphasized in continuity of care approaches.

Thoughtfully designed and well-implemented reintegration is far removed from the customary experience of offenders. Design and implementation problems are unfortunately more the rule than the exception. But the challenge of successful implementation should not be confused with a testing of the impact of reintegration when it is put in operation with documented fidelity and treatment integrity. Reforming both institutional corrections and traditional community-based aftercare is unquestionably a huge undertaking—a reason why the change strategy used in jurisdictions experimenting with the Intensive Aftercare Program (IAP) approach over the past decade has been highly selective and strategic in the selection of involved facilities, communities, and staff (Altschuler and Armstrong, 2001). Even then, implementation has been highly demanding (Wiebush et al., 2000). IAP is a truly reintegrative alternative to 1) typical confinement and 2) reentry into the community under traditional aftercare supervision.

## Research Findings on What Works

Reintegration in general and the IAP model in particular draw heavily upon two bodies of research. First, there is research on the confinement experience and its impact on subsequent success and failure in the community. Lipsey (1992) found that treatment in public facilities, custodial institutions, and within the overall juvenile justice system was less effective than treatment provided by agencies outside the juvenile justice system. Others have argued that aspects of the confinement experience itself increase the chances of failure upon release (Altschuler, 1994; Byrne and Kelly, 1989; Hagan, 1991; National Research Council, 1993; National Research Council, 2001; Shannon et al., 1988). Still others have shown that length of confinement has no impact on recidivism (Beck and Shipley, 1987; Cohen and Canela-Cacho, 1994; National Research Council, 1993).

It should further be noted that while confinement prevents offenders from committing crimes in the community *while* incarcerated, it may also deter other individuals from committing crime at all. Confinement is also used at times for accountability, punishment and just deserts purposes having nothing to do directly with deterrence and risk reduction (MacKenzie, 1997). Confinement is clearly used for several very different

reasons, crime reduction being only one. Moreover, while crime reduction achieved during an offender's confinement is one aspect of recidivism, it is potentially quite another matter when the focus is on an offender's recidivism when back in the community. Strictly from a crime reduction perspective, however, research indicates the benefits of incorporating into the confinement experience the delivery of those services and activities that maximize the chances of successful community reintegration. Yet, institutional reform, as part of a broader reintegration paradigm, represents only the first leg of the correctional mission.

The second body of research addresses the second leg, which includes treatment services and community intervention accompanying the post-release supervision and monitoring. Community intervention refers to what occurs 1) in neighborhoods, 2) with families, friends, and acquaintances, and 3) with various socializing institutions (e.g., schools, faith-based organizations, neighborhood groups, recreational programs and clubs, employers). Emphasis is placed upon the direct involvement of both a juvenile offender's social network and the applicable socializing institutions in the community (Altschuler, 1984). Correctional oversight and supervision must extend well beyond the formal role played by aftercare staff. According to this definition, there is much more to a community intervention than merely establishing a correctional program *in* a community setting. Furthermore, it is possible to initiate a community intervention strategy even when the correctional program is not located directly in the specific community to which the juvenile will eventually return. This can be accomplished, for example, by having family counseling sessions at a correctional facility and by having community treatment programs begin their service provision during a juvenile's confinement.

The added value of rehabilitative measures being intermeshed with surveillance and control techniques has found widespread support in the literature on promising interventions with both juvenile and adult offenders. Various intermediate sanctions, such as intensive supervision for adult offenders, have been utilized since the 1960s. The deployment of this strategy has been studied extensively. For example, Byrne and Pattavina (1992) reviewed the basic findings about recidivism and cost-effectiveness from 18 evaluations of intermediate sanction programs for adult offenders as

of 1989. This review found that the majority of the evaluations did not show intensive supervision significantly reducing the rate of offender recidivism. Speculating on the lack of effectiveness, Byrne and Pattavina suggested that failure could be traced to the fact that day-to-day emphasis of the programs was more on offender surveillance and control (e.g., drug and alcohol testing, electronic monitoring, curfew checks, strict revocation policies) and less on treatment, services and community interventions related to substance abuse, employment, and family problems. A number of prominent researchers have concluded, after reviewing Byrne and Pattavina's review, as well as numerous other studies showing that intensive supervision does not generally reduce recidivism (see, for example, Banks, et al., 1977; Byrne and Kelly, 1989; Byrne, Lurigio and Baird, 1989; Neithercutt and Gottfredson, 1973; Petersilia, 1987; Petersilia and Turner, 1990; Petersilia, Turner and Deschenes, 1992), that strategies for treatment and rehabilitation must be present to effectively change offender behavior long term (see, for example, Andrews et al., 1990; Cullen and Gendreau, 1989; MacKenzie, 1999).

Many questions still remain unanswered, however. On the issue of what specific type of programs work best for whom, some researchers have focused on the extent and nature of risk and needs as being critical. For example, Lipsey and Derzon (1998), as well as Hawkins et al. (1998), have shown that risk and protective factors associated with serious and violent juvenile (SVJ) offenders include much more than criminal history characteristics (e.g., early age of onset, number of prior referrals to juvenile services, number of prior commitments to juvenile facilities) alone. Factors related to delinquency history *combined with* particular problem or need factors—so-called criminogenic (Andrews and Bonta, 1994) or instability factors (Krisberg et al., 1989)—cumulatively place a juvenile into a "high risk" category. *It is not the presence of one factor but the potent combination of several that seems to make the difference.* Among the several risk/need factors that are commonly included in the potent combination are those involving family functioning, participation in school and/or work, nature of peer group, and substance abuse. Precisely these factors are among those that community interventions must be explicitly designed to address.

Risk, as a concept in the development of policy and practice in corrections, is frequently misunderstood. For example, some

believe that a designated "serious" offense or a violent offense is a sufficient indicator on its own to flag a "high risk for reoffending" individual. As noted above, however, it is not just criminal history or severity alone that establishes high risk. Rather, it is criminal history along with the presence of criminogenic needs. This is more than "splitting hairs," as demonstrated by the fact that when low-risk offenders are subjected to high levels of supervision, the research suggests that they tend to do worse than if handled less intensively (Andrews, 1978; Baird, 1983; Clear, 1988; Erwin and Bennett, 1987; Markley and Eisenberg, 1986).

One reason lower-risk offenders have been found to do worse on intensive supervision is that they are more likely to be cited for technical violations, which by definition in many of the intensive programs is a measure of program failure. This is especially alarming given the lack of evidence indicating that technical violations are predictors of future offending (see, for example, Lurigio and Petersilia, 1992; Petersilia and Turner, 1991; Turner and Petersilia, 1992). Another reason is the tendency of some individuals, particularly adolescents, to react negatively to the pressures created by highly intrusive supervision. For both of these reasons, research indicates that intensive supervision is frequently accompanied by an increase in technical violations, revocations and re-incarcerations (Byrne, Lurigio and Baird, 1989). In short, the poor performance of some reintegration programs may be due to misclassified offenders being enrolled in intensive programs or lesser-risk offenders participating and not due to highly structured reintegrative correctional approaches being inherently ineffective. The issue of properly targeting offenders for the more intensive type of reintegrative programs, such as IAP, requires much more attention and study.

The importance of continuity of care that begins early during confinement, not just shortly prior to reentry, and continues upon return to the community is another programming area where additional research is clearly needed. What type and dosage of treatment and services would be the optimal mix to use with offenders during confinement and after reentry? Meta-analysis conducted by Lipsey and Wilson (1998) points to certain types of treatment showing considerable promise in lowering recidivism when compared to control groups. Most notable among interventions for *institutionalized* juveniles that have

produced the greatest reductions in recidivism were facilities providing interpersonal skill training (Glick and Goldstein, 1987; Shivrattan, 1988; Spence and Marzillier, 1981), teaching family homes (Kirigin et al., 1982; Wolf, et al., 1974), cognitive behavioral approaches (Guerra and Slaby, 1990; Schlichter and Horan, 1981), and multimodal approaches (Kawaguchi, 1975; Moore, 1978; Seckel and Turner, 1985; Thambidurai, 1980).

Lipsey and Wilson's analysis of interventions used with *noninstitutionalized* juveniles suggested that interpersonal skill training (Chandler, 1973; Delinquency Research Group, 1986), behavioral contracting (Barton et al., 1985; Gordon et al., 1987; Jesness et al., 1975; Kantowitz, 1980; Schwitzgebel and Kolb, 1964), and individualized counseling that is cognitive-behavioral oriented (Bean, 1988; Borduin et al., 1990; Kemp and Lee, 1975; Lee and Haynes, 1978; Lee and Haynes, 1978a; Lee and Olejnik, 1981; Moore, 1987; Moore and Levine, 1974; Piercy and Lee, 1976) were best at reducing recidivism rates. As shown, there is considerable convergence between the types of treatment best at reducing recidivism for both institutional and noninstitutional settings.

While not definitive, the overlap of effective treatment types between the institutional and noninstitutional programs certainly suggests the *potential for stronger and more lasting recidivism reduction if effective institutional programs were followed up with quality (noninstitutional) aftercare programs* (Altschuler, Armstrong and MacKenzie, 1999). The overlap of treatment types also suggests that, from a treatment modality and programmatic standpoint, a strong argument exists for integrating aftercare programs and their staff into planning and treatment activities occurring in the institutional setting. The goal would be to establish an ongoing commitment to continuity and reinforcement across the institutional and noninstitutional boundary. The research question most begging to be answered, however, is whether the types of treatment found most effective in either institutional or noninstitutional programs could be even *more effective and enduring* when linked in an overarching reintegration framework. Progress can only occur through research that answers this question, because it directly addresses the value of transition and aftercare over and above what has been gained during confinement.

It should be emphasized that the evaluated programs included in the Lipsey and Wilson meta-analysis represent only those program-

matic efforts meeting certain methodological standards. Consequently, the programs have likely been designed and implemented under relatively optimal circumstances characterized by better-than-average treatment integrity. In fact, among the noninstitutional programs, the more successful ones were those that involved the researcher in the design, planning and delivery of the treatment. These more successful programs can thus be contrasted with many operating programs in which the researcher is only involved in the evaluation. Thus, an important qualification is that the *quality and integrity of program implementation, as well as the competence and quality of the staff, are necessary ingredients in effective programming*. This should serve as a caution in thinking that *any* program claiming to provide the identified treatments can expect success.

### Next Steps—Challenges and Prospects

Continuity of care and reintegration directly challenge the structure and practice of traditional juvenile corrections. A major commitment and openness to change will be required if a number of existing impediments are to be overcome. These challenges include bridging the chasm that often divides the worlds of institutional and community corrections, reforming current institutional and aftercare practices that ignore the broader reintegration concerns discussed above, and forging partnerships between correctional agencies and those responsible in the public and private sectors for mental health, child welfare, substance abuse, education and employment.

That the research record has been mixed and that many questions remain is neither startling nor unexpected. As shown, there have been notable and demonstrable successes, along with failure and disappointment. Lessons can clearly be learned both in success and failure. It is critical that those implementing such programs directly confront the challenge of divergent perspectives and contradictory priorities assigned to the various components of the juvenile justice "system." In particular, they will need to engage and resolve differences in outlook and philosophy between corrections and other child-serving agencies and groups regarding 1) the role of punishment versus treatment; 2) which agency has authority to make various decisions on what will happen and what to do (and a related question—who takes the

blame, heat or credit?); 3) which agency has to pay and how much; 4) who will have to do most of the work and can it be accomplished with current staffing and personnel; and 5) which agency believes that it rightfully is or is not in a position to handle the type of adolescent likely to participate. These challenges and barriers are currently being addressed in a variety of efforts across America. There is no credible reason why such experimentation should stop.

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