Tuesday, March 22, 2016

Assessment and Treatment of Young Offenders

Chapter 12

Juvenile Delinquency Act (1908) - The JDA applied to youths between age 7 and 16. The JDA was affective until 1984.

Young Offenders act (1984)- Youths had to be atlas 12 years old and up to 18 years old to be processed through the justice system. Those under 12 would be dealt with through child and family services. YOA allowed youths to be diverted. Diversion is a decision to not prosecute young offender but rather to have him undergo an educational or community service program. The YOA attempted to make youths more accountable for their behaviour, while supporting rehabilitation through treatment programs and providing alternatives to jail for less serious crimes. Minimum age of responsibility was moved from 7 to 12.

Youth Criminal Justice Act (April, 1 2003) - Three main objectives. 1) Prevent youth crime 2) Provide meaningful consequences and encourage responsibility of behaviour 3) Provide rehabilitation and reintegration of youth into the community. There is a duty by the police to consider community outlets and less serious alternatives than custody for youths. These alternatives are called **Extrajudicial Measures** and include giving a warning or making a referral for treatment (with consent of youth).

Implications of YCJA

- Judges are able to provide a reprimand (Lecture or warning to youth)
-Intensive support and supervision order
-Attendance order (Youth must attend a specific program)
-Deferred custody and supervision (Youth can serve their sentence in the community)
-Intensive rehabilitate custody an supervision order
-Under the YCJA transfer to adult institution is eliminated. Instead, youth court determines guilt and if offender is found guilty then the judge can impose an adult sentence if it is appropriate with youths as young as 14.

Youth Crime Rate

-Probation remained the most common sentence provided to youth in youth court in 2010/ 2011.
-Over 50% of youths found guilty in court were given probation, either as a stand alone sentence or in combination with another sentence.
-The proportion of youth cases being sentenced to custody fell from 29% in 2001 to 16% in 2010.
-Under the YCJA a two year maximum sentence can be given to youths.

Assessment of Young Offenders: Under 12

Internalizing Problems: Emotional difficulties such as anxiety, depression and obsessions.

Externalizing Problems: Behavioural difficulties such as delinquency, fighting, bullying, lying and destructive behaviour. Externalizing problems are more difficult to treat and more likely have long term persistence. Males are more likely to have externalizing problems with a 10:1 ratio

Three frequent diagnoses occur with young offenders. These are Attention deficit hyperactivity disorder, Oppositional Defiant Disorder, and Conduct Disorder

ADHD: a disorder in youth characterized by a persistent pattern of inattention and hyperactivity or impulsivity.

ODD: a disorder in youth characterized by a persistent pattern of negative, hostile and defiant behaviours. Approximately 40% of kids who develop ODD develop CD. ODD is not diagnosed if person is over 18 years old

Conduct Disorder: A disorder characterized by a persistent pattern of behaviour in which a youth violated the rights of others or age appropriate social norms and rules. Approximately 50% of children meeting criteria for Conduct disorder develop antisocial Personality disorder. CD is not diagnosed if person is over 18 years old.

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Assessing the Adolescent

-Young offenders are assed so that resources can be used effectively and the risk to the community is reduced.

-Risk Assessment instruments collect information about a set of factors, both static and dynamic. Generally the notion is that the more relevant risk factors that are present, the more likely it is that the youth will reoffend.

- Identifying risk factors for adolescents is difficult because in a lot of cases many of them don't have years behind them that can be examined.

-Childhood and adolescent behaviour may be more influenced by context than enduring character.
- It is Difficult to separate developmental issues from persistent personality an character for the prediction of future offending.

Rates of Behaviour disorder in Youth

- It is estimated that 5 - 15% of children display severe behavioural problems. In an ontario research it was reported that approximately 18% of children between age 4 and 16 had some form of a behavioural disorder.

- Researchers have also found that behavioural disorders commonly co-occur within each other. 20-50% of children with AD/HD also have symptoms consistent with CD or ODD.

Trajectories of Young Offenders

- Two common developmental pathways to youthful antisocial behaviour have been suggested: Childhood onset vs adolescent onset.

- Age of onset is a critical factor in the trajectory to adult offending.
- A number of researchers have found that early onset of antisocial behaviour is related to more serious and persistent antisocial behaviour later in life.

-Childhood onset is not as frequent of an occurrence as opposed to adolescent onset. Only 3-5% of the population show childhood onset.

Biological Theories of Antisocial Behaviour

- The frontal lobe is responsible for planing and inhibiting of behaviour. Henry and Mofitt Have found that conduct disorder youth have less frontal lobe inhibition of behaviour.

- Physiologically conduct disorder youth have been found to have slower heart rates than youth who do not engage in antisocial behaviour.

- Children who have an antisocial biological father are more likely to engage in antisocial behaviour, even when raised apart from the biological father.

Cognitive Theories of Antisocial Behaviour

- Cognitive disordered youth display cognitive deficits and distortions. These youth attend to fewer cues and misattribute hostile intent to ambiguous situations.

- Conduct disordered youth demonstrate limited problem solving skills, producing few solutions to problems. These solutions are usually aggressive in nature.

- There has been a distinguishing between two forms of aggression; reactive and proactive. Reactive aggression is an emotionally aggressive response at a perceived threat or frustration. Proactive aggression is aggression directed at achieving a goal or receiving positive reinforcement.

- Reactive aggressors tend to have earlier onset of problems than proactive aggressors.

Social Theories of Antisocial Behaviour

Social Learning Theory: Suggest that children learn their behaviour from observing others.

- As children are developing numerous models are available to imitate, including parent, siblings, peers, and media figures. Studies found that children who are highly aggressive and engage in antisocial behaviour often have witnessed parents, siblings or grandparents engage in aggression and antisocial behaviour.

- Watching extremely violent televisions and movies increases the likelihood of acting aggressively. In addition playing aggressive video games

Risk Factors: Individual vs Social Risks

Individual Risk Factors;

- A variety of genetic an biological factors have been linked to behavioural problems.

- A parents own history of ADHD or behavioural difficulties are known risk factors for their offspring, especially sons.

- Risk factors for violence at age 14 was increased by a diagnosis of ADHD, lack of engagement in school, low grades and peer delinquency.

- Woman's use of drugs and alcohol can place the fetus at risk for later behavioural problems. Also diet and exposure to high levels of lead are risk factors.

Familial Risk Factors;

- Children of Parents who are neglectful or children who do not attach securely to their parents are at risk for later behavioural problems.

- Inconsistent and overly strict parents who apply harsh disciplines pose a risk to the child.
- Parents who drink heavily are less likely to respond appropriately to their children behaviour thus increasing the likelihood of future negative behaviour.
- Boys are more prone to respond to abuse by abusing their spouse in later years.
-Physical abuse during adolescence increases the risk for behavioural problems and mental health difficulties.

School and Social Risk Factors

- Younger children who play with aggressive peers at an early age are at risk for externalizing behaviour.

- Being part of a gang was positively related to engaging in delinquent behaviour and using drugs/ Alcohol frequently. Parental supervision and coping skills were negatively related to gang membership.

- Gang youth are more likely to reoffend than non-gang youth.

Protective Factors

-The child who has multiple risk factors but who can overcome them and prevail them has been termed **resilient.**

- Resilient children may have protective factors that allow them to persevere in the face of adversity.

- Protective factors include; Genetic variables, personality disposition, supportive family environments, and community support.

- Protective factors can be grouped into three categories, 1) individual 2)familial 3) social/external factors.

Individual Protective Factors

- These include exceptional social skills, child competencies, confident perceptions, values, attitudes and beliefs within the child

-Protective factors from reoffending included being older when first arrested, offending less overall, having fewer psychopathological problems.

Familial Protective Factors

- Positive aspects of the child's parent and home environment.
- A good parent-child relationship is a protective factor for the child who is growing up in an underprivileged community

Social/External Protective Factors

- Associating with pro-social children is a protective factor again antisocial behaviour.

Prevention, intervention and Treatment of Young Offenders

-Prevention, intervention and treatment can be conceptualized as happening at 3 levels; Primary, secondary and tertiary.

- **Primary intervention strategies:** Strategies that are implemented prior to any violence occurring, with the goal of decreasing the likelihood that violence will occur later on.

- **Secondary Intervention Strategies:** Strategies that attempt to reduce the frequency of violence.

- **Tertiary Intervention Strategies:** Strategies that attempt to prevent violence from reoccurring.

Primary intervention Strategies

-The goal or primary intervention is to identify groups of children that have numerous risk factors for engaging in antisocial behaviours later on.

-Belief is that if the needs of these children are addressed early on before violence occurs then the likelihood that they will go on to be a young offender is reduced.

- These strategies occur at the broad level such as in the family, school or community.
- Examples of primary intervention strategies are

Family Oriented Strategies Family based intervention efforts can be generally classified either as parent focused of family supportive.

Parent Focused interventions: Interventions directed at assisting parents to recognize warning signs for later youth violence and training parents to effectively manage any behavioural problems that arise.

Family-Supportive Interventions: Interventions that connect at risk families to various support services (counselling, medical assistance).

School Oriented Strategies

-It is not uncommon to recommend a social skills program to children showing some signs of interpersonal and behavioural difficulties. Social skills training may include; teaching methods for conflict resolution, adjusting social perceptions, managing anger and developing empathy.

Community Wide Strategies

Goal is to provide structured community actives for children and increasing community cohesion. Studies have found a strong connection between bullying as a child and later offending after the age of 12. Thus reducing the likelihood of bullying may be a beneficial component to community based programs in order to reduce the likelihood of later offending.

Secondary Intervention Strategies

- Secondary intervention strategies are directed at young offenders who have either had contact with the police or the criminal justice system or demonstrated behavioural problems at school.

- The goal of these strategies is to provide social and clinical services so that young offenders do not go on to commit serious violence.

- Common secondary intervention strategies include diversion programs, alternative/ vocational education, family therapy and skills training.

-Diversion programs divert youth offenders from the criminal justice system into community based treatment or school based treatment programs.

-Another form of secondary intervention is Multi-Systemic Therapy (MST). MST examines a child across the context or “systems” which they live in; Family, peers, school, neighbourhood and community. MST was found to be no more effective than typical services in ontario.

-When comparing families with paternal involvement vs those with no paternal involvement, externalizing and internalizing behaviours were reduced for both groups. however a significantly greater reduction in these behaviours was seen for families with paternal involvement.

Tertiary Intervention Strategies

-These interventions are aimed at youth who have engaged in criminal acts and who may have already been processed through formal court proceedings.

-The goal of tertiary intervention is to minimize the impact of existing risk factors and foster the development of protective factor, which may reduce the likelihood that the at-risk adolescent will engage in future reoffending.

- Tertiary intervention strategies include in-patient treatment (institutionalization, residential treatment)

-Meta analysis report that shorter institutionalization and greater involvement within community are more effective for violent young offenders.