View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by UND Scholarly Commons (University of North Dakota)

University of North Dakota
UND Scholarly Commons

Occupational Therapy Capstones

Department of Occupational Therapy

2014

Reducing Recidivism for Youth through an Integrated Residential and Community-Based Program

Alexandra Berdal
University of North Dakota

Megan Meyer
University of North Dakota

Nicolet Sadlowski
University of North Dakota

Follow this and additional works at: https://commons.und.edu/ot-grad

Part of the Occupational Therapy Commons

Recommended Citation

Berdal, Alexandra; Meyer, Megan; and Sadlowski, Nicolet, "Reducing Recidivism for Youth through an Integrated Residential and Community-Based Program" (2014). *Occupational Therapy Capstones*. 21.
https://commons.und.edu/ot-grad/21

This Scholarly Project is brought to you for free and open access by the Department of Occupational Therapy at UND Scholarly Commons. It has been accepted for inclusion in Occupational Therapy Capstones by an authorized administrator of UND Scholarly Commons. For more information, please contact zeineb.yousif@library.und.edu.

REDUCING RECIDIVISM FOR YOUTH THROUGH AN INTEGRATED RESIDENTIAL AND COMMUNITY-BASED PROGRAM

by

Alexandra Berdal, MOTS; Megan Meyer, MOTS; Nicolet Sadlowsky, MOTS
Master of Occupational Therapy, University of North Dakota, 2014

Advisor: Sarah K. Nielsen, Ph.D., OTR/L

A Scholarly Project

Submitted to the Occupational Therapy Department

of the

University of North Dakota

In partial fulfillment of the requirements

for the degree of

Master of Occupational Therapy

Grand Forks, North Dakota
May 17, 2014

Copyright 2013 Alexandra Berdal, Megan Meyer, Nicolet Sadlowsky, & Sarah K. Nielsen

APPROVAL

This Scholarly Project Paper, submitted by Alexandra Berdal, Megan Meyer, and Nicolet Sadlowsky in partial fulfillment of the requirement for the Degree of Master of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

____
Signature of Faculty Advisor

____
Date

PERMISSION

Title	Reducing Recidivism for Youth through an Integrated Residential and Community-Based Program.
Department	Occupational Therapy
Degree	Master of Occupational Therapy

In presenting this Scholarly Project/Independent Study in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, I/we agree that the Department of Occupational Therapy shall make it freely available for inspection. I/we further agree that permission for extensive copying for scholarly purposes may be granted by the professor who supervised our work or, in his/her absence, by the Chairperson of the Department. It is understood that any copying or publication or other use of this Scholarly Project/Independent Study or part thereof for financial gain shall not be allowed without my/our written permission. It is also understood that due recognition shall be given to me/us and the University of North Dakota in any scholarly use which may be made of any material in our Scholarly Project/Independent Study Report.

Signature________________________ Date ____________
Alexandra Berdal

Signature ________________________ Date ____________
Megan Meyer

Signature________________________ Date_____________
Nicolet Sadlowsky

TABLE OF CONTENTS

LIST OF TABLES vi

ACKNOWLEDGMENTS vii

ABSTRACT viii

CHAPTER I. INTRODUCTION 1

Goal of Product 4

Key Terminology 5

Organization of Remaining Chapters 7

CHAPTER II. LITERATURE REVIEW 8

Person Environment Occupation Model 8

Person Concept 9

Environment Concept 14

Occupation Concept 21

Role of Occupational Therapy in Mental Health 24

Interventions for Community Reintegration 26

Summary of Literature Review 44

CHAPTER III. METHODS 46

CHAPTER IV. PRODUCT 54

CHAPTER V. DISCUSSION, SUMMARY, AND CONCLUSIONS 59

Purpose 59

Strengths of Product 60

Limitations of Product 60

Recommendations for the Future..60

REFERENCES 64

APPENDIX..74

LIST OF TABLES

Table Page

1. Systematic Analysis of Occupational Performance 50

ACKNOWLEDGEMENTS

The authors wish to thank our advisor, Sarah Nielsen, for providing us with all the guidance and support as well as donating many, many hours to the completion of our project. We are truly grateful for her experience and knowledge within the practice of mental health occupational therapy with youth and adolescents. The authors also wish to thank our families as they have provided us with continuous support throughout our paths of becoming occupational therapists. Lastly, we wish to thank each and every member of the UND Occupational Therapy Class of 2014. It has been a long journey and we could not have made it to the end without each one of these individuals.

-Alexandra Berdal, MOTS, Megan Meyer, MOTS, & Nicolet Sadlowsky, MOTS

ABSTRACT

Purpose

Reportedly, 95% of youth in the juvenile justice system have had prior involvement with the juvenile justice system, suggesting that intervention does not adequately address the needs of these youth (Sedlack & Bruce, 2010; OJJDP, 2003). The purpose of this project was to address the problem of recidivism with an emphasis on preparing for transition from residential placements to community engagement.

Methods

An extensive literature review was conducted in order to understand the occupational performance deficits that youth in the juvenile justice system face in transitioning to their community. The information obtained from the literature review was then analyzed using the Person Environment Occupation model (Law et al., 1996). Areas of need for youth were identified through completion of the systematic analysis and include: (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation, which are all important aspects of occupational performance within the youth's community. In addition, the following key principles emerged from the systematic analysis: (a) self-determination, (b) engagement in meaningful occupations, (c) care through an interdisciplinary team, and (d) mentorship.

Results

Based on the methodology described above, we developed *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* for youth who are transitioning back to their community. Interventions were created to improve the youth's occupational performance to integrate into the community after discharge from the residential treatment center. This program is intended for use while youth are in the residential treatment facility and as a guide for transition to the community with a community interdisciplinary. Within each area of occupation, phases build upon one another in order to facilitate successful performance in all areas of occupation once youth are in the community.

Conclusion

Several barriers may limit the implementation of this program, such as limited funding and resources, dedication from the residential treatment facility staff, the youth's family, and members of the youth's community interdisciplinary team, and the effectiveness and validity of the program have not yet been researched. Several areas of strength include the program being based on literature and grounded in theory for development of the program, the program addresses a need for this population, and is able to be modified and adapted to fit the needs of the youth.

CHAPTER I

INTRODUCTION

The United States Office of Juvenile Justice and Delinquency Prevention (OJJDP) (2003), an office of the United States Department of Justice, conducted a survey in order to assess the characteristics and backgrounds of youth in the juvenile justice system. In 2003, there were 101,040 youth placed in various residential facilities due to an encounter with the justice system (Sedlak & Bruce, 2010; OJJDP, 2003). *The Survey of Youth in Residential Placement* (OJJDP, 2003) was used to collect information in regards to the number of convictions that youth had in the juvenile justice system. Eighty-five percent of these youth had prior convictions, with 10 percent having been in prior custody, probation, or parole, and only 5 percent stating no prior involvement in the juvenile justice system (Sedlak & Bruce, 2010; OJJDP, 2003). With 95 percent of youth in the juvenile justice system having had prior involvement with the juvenile justice system, there is a need to address the skills and abilities required for youth to successfully reintegrate into their communities in hope of preventing recidivism. The costs associated with juvenile justice system will continue to increase with the high rate of recidivism for the youth. *The Survey of Youth in Residential Placement* (Snyder & Sickmund, 2006; OJJDP, 2003) found that many of the youth within the juvenile justice system have had more than one committed stay with 62% claiming that they had at least one prior commitment. Due to the large number of youth that re-enter the juvenile justice system, Snyder and Sickmund (2006) and OJJDP (2003) state that there is a need for extensive

supervision as well as continued services in order to achieve successful community reintegration.

In regards to residential placement on a local level, The North Dakota Department of Human Services (2013) identified two levels of residential treatment centers for youth with behavioral, emotional, or mental health difficulties. North Dakota has six facilities that are considered psychiatric residential treatment facilities and ten residential child care facilities or group child care facilities. North Dakota has the ability to provide residential care to 372 youth at one time between the sixteen facilities (Lee, 2013). The average length of stay for a youth at these facilities ranges from 3 months up to 10 months (North Dakota Department of Human Services, 2013). At the residential treatment centers, the youth are in a secure setting and are under the care of the staff 24-hours a day. While at the facility, the youth engage in numerous therapeutic activities and groups, attend educational services either on site or within the community, interact with peers, and complete job tasks as applicable to the facility (North Dakota Department of Human Services, 2013).

Once the youth have completed their residential care placement, youth must transition back to their community. For the transition back into the community, or community reintegration, youth need to have services pre and post discharge from residential facilities to be successful (Altschuler & Brash, 2004). The skills needed to be successful in community reintegration include the occupational areas of work, leisure, education, the instrumental daily activity of health management and maintenance, and social participation with family and peers (Bream, 2013; Eggers, Munoz, Sciulli, & Hickerson Crist, 2006; Gibson, D'Amico, Jaffe, & Arbesman, 2011; Knis-Matthews,

Richards, Marquez, & Mevawala, 2005; Lopez, 2013; McCamey, 2010; Unruh, Gau, & Waintrup, 2009; Zhang, Roberts, & Callanan, 2006). Without education and skill building in these areas, youth have difficulty with community reintegration. If each of these aspects is considered in the youth's residential care services, they are likely to promote successful community reintegration.

Youth who are in residential treatment centers receive services while they are residents at the facility, but most often, these services do not incorporate the family in the process. The services are provided to the youth by social workers and counselors. Social workers and counselors work with the youth on skills during discussion based activities rather than providing them with the opportunity to put their skills to use in the natural environment. This leads to the problem in which the youth are not aware of how to use the skills they have learned during their residential placement when put into real-life situations, which tends to get them back into trouble, leading to recidivism. The recidivism rate and the challenges that the youth have suggest the need for occupational therapy to be included in the treatment of the youth when transitioning into their natural context, returning to their occupational roles and participating in occupations as they occur on a daily basis.

The Person Environment Occupation model (PEO model) (Law et al., 1996) was chosen to guide this project as it clearly defines the dynamic, transactional relationship between a person, the various environments they function in, and the occupations in which they perform and participate in. At-risk youth and those youth who are in residential treatment centers looking to transition back into their home community have deficits in the occupational areas of education, leisure, social participation with family

and peers, work, and the instrumental daily activity of health management and maintenance (Bream, 2013; Eggers, Munoz, Sciulli, & Hickerson Crist, 2006; Gibson, D'Amico, Jaffe, & Arbesman, 2011; Knis-Matthews, Richards, Marquez, & Mevawala, 2005; Lopez, 2013; McCamey, 2010; Unruh, Gau, & Waintrup, 2009; Zhang, Roberts, & Callanan, 2006). These individuals' occupational deficits are also influenced by the environment in which the occupations are performed. Often, the environment is not supportive for the individual to return to their occupational performance after they have been placed in a residential treatment center (Altschuler & Brash, 2004; Griffith et al., 2009; Nickerson, Colby, Brooks, Rickert, & Salamone, 2007; Youngblade et al., 2007). The goal of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* is to increase the success of the youth during their transition back into their natural environment following placement in a residential treatment center by aligning aspects of the person, environment, and occupation to make them more congruent.

Based on the occupational needs of the youth transitioning from residential treatment to their home community *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* has been developed. *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* includes one part to be implemented into the residential center and the other to act as aftercare for the youth in their natural setting with the guidance of the community interdisciplinary team. The goal of this program is to increase the youth's success in community reintegration and to decrease the rate of recidivism into residential treatment level of care. Factors that may influence the

application of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* include: (a) funding, (b) resources, (c) support of the residential treatment centers and North Dakota Department of Human Services, and (d) support of the communities in which the youth return to after discharge from the residential treatment center.

Key Terminology

The following terms and concepts are used throughout the literature review and *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*. Therefore, we have defined the following terms for clarification.

Youth: Individuals between the ages of 14 and 19 years old.

Residential Treatment Center: Within North Dakota, there are two different levels of residential treatment centers, a Psychiatric Residential Treatment Facility and a Residential Child Care Facility.

A Psychiatric Residential Treatment Facility can be defined as:

> a facility or a distinct part of a facility that provides to children and adolescents, a total, 24 hour, therapeutic environment integrating group living, educational, interdisciplinary clinical assessment and a individualized treatment plan that meets the needs of the child and family. The services are available to children in need of and able to respond to active psychotherapeutic intervention and who cannot be effectively treated in their own family, in another home, or in a less restrictive setting (Price, 2005, para. 5).

In comparison, a Residential Child Care Facility is defined as:

> the provision of substitute parental child care for those children who are in need of care for which the child's parent, guardian, or custodian is unable, neglects, or refuses to provide, and includes the provision of food, shelter, security and safety, guidance, and comfort on a twenty-four-hour basis, to one or more children under twenty-one years of age to safeguard the child's growth and development and to minimize and counteract hazards to the child's emotional health inherent in the separation from the child's family. This may be provided in a family foster home, group home, or residential child care facility (Price, 2005, para. 6).

Community Reintegration: The process of transitioning back into the community from residential facilities that includes pre-release, as well as post-release services (Altschuler & Brash, 2004).

Interdisciplinary Team: In the residential setting, the interdisciplinary team coordinates the services within the facility and collaborates with members of the community-based interdisciplinary team for continuation of services. The community-based interdisciplinary team collaborates with the youth to aid in use of skills gained in residential setting to the community environment. The interdisciplinary team consists of those individuals within the community who will be providing support to the youth in order to have continued success following discharge from the residential facility. The interdisciplinary team will include the youth, the youth's family, the youth's case manager, an occupational therapist, a community-based mentor, and a school representative.

Mentor: An individual that guides the youth's transition into the community by providing support in emotional and behavioral functioning, psychological and physical

health, academic success, employment and career pursuits, as well as evasion of risk-taking behaviors (Avery, 2011).

Chapter II presents the results of a comprehensive literature review that provides the evidence and need for a program that aids in the youth's transition to the community. Chapter III will present with the methodology and activities used to develop the program. *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* is described in Chapter IV and is available in its entirety in the Appendix. Finally, Chapter V is a summary of the program that was developed that includes recommendations and limitations of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*.

CHAPTER II

LITERATURE REVIEW

Youth is a multifaceted and complex stage of development in a person's life. This stage in life is influenced by a variety of aspects. These aspects can include personal characteristics, environmental influences, and occupational choices. The inter-relationship between these factors can contribute to the likelihood of youth coming in contact with the juvenile justice system. Throughout this chapter we describe at-risk youth through the lens of person, environment, and occupation.

Person Environment Occupation Model

The Person-Environment-Occupation model (PEO model) was chosen to guide the development of this literature review and this scholarly project. The goal of the literature review is to provide a basic understanding of youth within the juvenile justice system and the steps taken for community reintegration. The PEO model addresses the transactions and interactions between the person, the occupation, the environment the occupation takes place in, and performance in the meaningful occupations (Cole & Tufano, 2008). Within this model, the person consists of "physiological, psychological, neurobehavioral, cognitive, and spiritual factors" (p. 128), the environment can be "physical, natural, cultural, societal, and social interactive factors and social and economic systems" (Cole & Tufano, 2008, p. 128), occupations are the activities a person completes for their daily lives, and the performance aspect is the "act of doing the occupation" (Cole & Tufano, 2008, p. 128).

The PEO model provides support in the development of understanding youth and the interactions of the three key aspects: person, environment, and occupation (Cole & Tufano, 2008). First, this model places focus on the person. The person is made up of demographics, mental health and physical well-being, and developmental risk factors that a youth is dealing with during this transitional period in life. The second aspect is the model's focus on the environment. The model looks at environmental factors that contribute to a youth's performance. The environments that can either promote or hinder a youth's occupational performance include the home, community, school, and the placement environment. The third aspect of the PEO model is occupation. Occupations support the roles in the individual's daily life. Occupational examples include substance use, schooling and education, leisure, personal care, social participation, and work and vocations. Youth often have trouble identifying their roles and the occupations that correlate with them in order to have successful and independent lives. These difficulties can correspond with the interactions that may occur between the youth and the juvenile justice system. The purpose of using the PEO model to structure the literature review is to create a foundational understanding of factors that can intercept into a youth's life and ability to live an independent, successful, and meaningful life.

Person

As much as it is important to assess the reason the youth was convicted to the juvenile justice system, it is just as important to understand what makes up the person. The profile of youth or young adults within the juvenile justice system varies based on a magnitude of factors. These factors can include, but are not limited to where they live, the culture they grew up in, their age, color of their skin, and their mental status. The

person will be further described by the following characteristics: (a) demographics, (b) mental health, (c) trauma, and (d) developmental risk factors.

Demographics

The majority of youth released from a committed facility are male with some studies reporting incidences as high as 50-88% (Synder, 2004; Goodkind, Shook, Kim, Pohlig, & Herring, 2013). Youth over 16 years of age accounted for 63% of the population in the justice system (Synder, 2004). Within the juvenile justice system, 78% of males, with ages ranging from 13-17, identify their race as white (Puzzanchera, Sladky, & Kang, 2013). Comparatively, 77% of females with the same age range identified their race as white. Both male and female youth that identify as African American each make up 21% of their respective groups.

When comparing male and female youth, male youth, regardless of race accounted for 52% of the population in the juvenile justice system in 2012 for youth ranging in from 13-17 years of age (Puzzachera et al., 2013). Youth males that identify their race as non-Hispanic white or non-Hispanic African American have a higher percent of interactions with the juvenile system. However, male or female youth that identified their race as white were almost four times the amount of youth that identified as African American (Puzzachera et al., 2013).

Mental Health

It is important to understand mental health factors of youth in the juvenile justice system as it plays an critical role in appropriate placement. It has been found that as high as 65-75% of all youth within the juvenile justice system, regardless of intervention/setting, have been diagnosed with a minimum of one mental health diagnosis

(Shufelt & Cocozza, 2006; Synder, 2004). Up to 60% of those youth with a mental health diagnosis had three or more diagnoses. The most common diagnoses were mood disorders, anxiety disorders, disruptive disorders, and substance related diagnoses (Shufelt & Cocozza, 2006).

Females have significantly higher rates of mental health symptoms than males (Grande et al., 2012; Shufelt & Cocozza, 2006). Comparatively, 80% of all girls within the juvenile justice system had a mental health diagnoses; whereas only 67% of the male population had a mental health diagnosis (Shufelt & Cocozza, 2006). Females appear to have higher rates of diagnoses that are associated with internalization, mood, and anxiety. The diagnoses of disruptive disorder and substance related disorders displayed more comparable rates between males and females (Shufelt & Cocozza, 2006).

Of those entering the juvenile justice system, Goodkind et al. (2013) found that within their sample of youth in the welfare system, 32% of the youth had interactions with mental health services prior to their involvement with the juvenile justice system. Of those youth entering the juvenile justice system, 65-75% of them have mental health diagnoses (Shufelt & Cocozza, 2006; Synder, 2004). Those who had a history of mental health problems were more likely to be admitted to drug court (Barnes, Miller, & Miller, 2009). This demonstrates that mental health is common factor of youth within the juvenile justice system, making assessment of mental health symptoms an important piece.

Trauma

The experience of trauma has shown a link between decreased ability to create strong relationships and delayed biopsychosocial development (Ford, Chapman, Connor,

& Cruise, 2012). It has been found that 25-75% of youth have had a traumatic experience at one time in their life. Ford et al. (2012) suggested that the experience of trauma may potentially lead to delinquent behaviors, such as aggression, lack of impulse control, lack of arousal control, and inability to self-regulate. The experience of trauma has also been seen with youth who have difficulty with building peer supportive relationships and trusting adults. For many youth that have been in traumatizing relationships, the adult has displayed helpful and caring approaches with ulterior motives; this creates a barrier between professionals that display a caring approach as it may remind them of a previous traumatic relationship (Ford et al., 2012).

Similarly, Harr, Horn-Johnson, Williams, Jones, & Riley (2013) reviewed 457 charts from a youth residential treatment center, where only 18 of them having not experienced any reported trauma. This indicates that the majority of youth entering a residential facility have experienced trauma of some sort. The researchers found that those who experienced a higher frequency of trauma had more internalized responses, such as attempted suicide. There was not a difference within external problems, such as delinquency. Based on the results, the authors suggest that it is a necessity to provide treatment for youth that addresses experienced trauma, as well as addressing family issues and functioning in natural contexts within treatment sessions. The authors also suggest the need for formation of positive adult relationships to foster trust, respect, and empathy in order to help prevent readmission and further difficulties for youth (Harr et al., 2013).

Developmental Risk Factors

The time of youth is associated with normal physical and internal changes that humans go through. These changes include puberty, relationships with peers, development of morals, and cognitive functioning, all of which can play a factor in a youth's delinquent behavior trends (Bonham, 2006). It has been found that the earlier in life a youth has interactions with the juvenile justice system; the more likely they are to present with long-term criminal behaviors.

A youth's brain development can play a factor on a youth's delinquent behavior. Youth who have been maltreated at young ages demonstrate behavioral and physical characteristics that are commonly associated with delinquency, including antisocial behaviors and brain damage (Bonham, 2006). Within a sample of youth in the welfare system, 10% of the youth have spent time within a juvenile justice facility (Goodkind et al., 2013). Of youth within out of home placements, approximately 36% had a chance of being involved in the juvenile justice system. The age at which youth interact with the welfare system also plays a factor in involvement with the juvenile justice system. Those whose welfare cases were closed prior to the age of 13 displayed three-times lower rate of interactions with the juvenile justice system (Goodkind et al., 2013).

When working with youth who experience mental health disorders in addition to physical, emotional, or sexual abuse, or substance use, it is important to look at the effects that interactions with law enforcement and incarceration can have on their development during their youth years. Psychosocial maturity is one aspect that is looked at in terms of its development for those who are incarcerated throughout their youth years versus its development when the youth is placed in a residential setting during that time.

Psychosocial maturity includes responsibility, temperance, and perspective (Dmitrieva, Monahan, Cauffman, & Steinberg, 2012). Little research has been conducted that assesses the effects of interactions with the juvenile justice system. Dmitrieva et al. (2012) conducted a research study with the intent to look specifically at the differences of psychosocial maturity development of those who were incarcerated versus those who have been placed in a residential setting over a seven-year period. Dmitrieva et al. (2012) found that with a greater amount of time spent in a secure facility, the youth demonstrated slower growth and development in psychosocial maturity. The slowed growth was focusing on the responsibility and temperance pieces, but not the perspective aspect of psychosocial maturity. When the youth had spent time in a residential setting, there was no significant difference in their ability to develop their psychosocial maturity, except in responsibility (Dmitrieva et al., 2012).

Environment

Adequate and proper care for youth within the juvenile justice system could not be complete without addressing the environment that they live in. Home, community, and school environments are important to consider as a youth leaves a residential facility to return to their natural environment. Each environment is influential in how successful a youth can be during the reintegration process.

Home Environment

Family characteristics including broken homes, abuse, and financial difficulties were commonly addressed within the existing literature. Current literature also states that family involvement and safe post-discharge environments promote treatment success (Griffith et al., 2009; Nickerson, Colby, Brooks, Rickert, & Salamone, 2007). Griffith et

al. (2009) state that youth receive skilled treatment in residential facilities, but the issues that existed in the family environment prior to treatment have not changed when youth return to their natural environment, which can propose a challenge to post-discharge success. Familial issues include youth not living with biological parents, substance abuse, improper discipline, abandonment, neglect, unemployment, and isolation (Griffith et al., 2009; Nickerson, et al., 2007). Considering these family characteristics, aspects that support treatment success include family involvement throughout treatment as well as having a safe, positive post-discharge environment (Blau et al., 2010; Fette & Estes, 2009; Knis-Matthews, Richard, Marquez, & Mevawala, 2005; Trupin, Kerns, Walker, DeRobertis, & Stewart, 2011). When families and factors of the natural environment are not part of treatment for the youth, they enter back into negative environments without the emotional or social supports that they need to be successful (Griffith et al., 2009).

A home environment with a family routine is a source of well-being, structure, and support, as well as a way to measure youth functioning (Koome, Hocking, & Sutton, 2012). Youngblade et al. (2007) suggest that the modeling of positive and negative behaviors by parents at home influences youth development, while Knis-Matthews et al. (2005) found that many issues for youth start at home. Meanwhile, many parents of youth who have a mental illness, report they were unable to carry on with home maintenance skills like cleaning, and laundry and of 51 families, 77% reported increased irritability in the home (Fette & Estes, 2009).

Community Environment

Although family is an important part of youth growth and success, addressing multiple environments such as community and school in addition to the home

environment fosters youth development (Fette & Estes, 2009; Knis-Matthews et al., 2008; Youngblade et al., 2007). One of the themes presented in the literature is the importance to have at-risk youth be involved in the community and to have supports to promote positive behaviors, otherwise youth often become involved in negative activities such as drugs and gang activity (Blau et al., 2010; Brunner, 2012). Brunner (2012) engaged with a community that facilitated engagement in safe, positive occupations for at-risk youth through after school activities with the hope to keep youth away from violence and gang activity.

Numerous factors within a youth's environment can influence participation or susceptibility to participation in these unhealthy occupations. Buu et al. (2009) conducted a study in order to examine the risks that a youth's family and neighborhood have on substance use in youth and the psychiatric symptomatology that presents throughout the youth's years. The authors found that the neighborhood characteristics had a greater influence on the outcome of the youth's substance usage and psychiatric symptomology than family characteristics did. With stable neighborhoods, youth were less likely to present with alcohol-use disorder symptoms, but had more major depressive disorder symptoms. Youth were less likely to develop marijuana-use disorder symptoms if the neighborhood became more affluent. As the neighborhood became less affluent, the youth presented with fewer major depressive disorder symptoms (Buu et al., 2009). Wooditch, Lawton, and Taxman (2013) also conducted research, studying the correlation between environmental factors and illicit drug use. The authors found that individuals at highest risk for illicit drug use are those who have a larger criminal history, associated with more drug users, or inhabit neighborhoods that are considered drug markets

(Wooditch et al., 2013). Environmental factors such as neighborhood characteristics influence youth in using drugs or illegal substances (Buu et al., 2009; Wooditch et al., 2013).

Youngblade et al. (2007) found that safe neighborhoods promoted good behavior, social capabilities, and health for youth, while unsafe neighborhoods were tied to more negative, outward behaviors. Returning to the post-discharge community also means returning to their peer groups which is a point of concern (Altschuler & Brash, 2004; Casey et al., 2010). Peers often were influential in negative behaviors and choices made by youth, and they expressed worry about returning to community environments because of these factors (Altschuler & Brash, 2004; Casey et al., 2010).

Community involvement and supports are a factor in youth success and are influential in assisting them to develop new occupations and engage in positive activities such as volunteering at local animal shelters (Fette & Estes, 2009; Knis-Matthews et al. 2008; Youngblade et al., 2007). Fette and Estes (2009) stated that parents found it difficult to participate in the community with their youth who have mental illnesses due to the lack of support. Youngblade et al. (2007) found that the more connected a neighborhood was, the more likely it was for youth to be successful and involved. On the other hand, if a neighborhood or community was not deemed connected, youth would display more negative behaviors (Youngblade et al., 2007).

School Environment

Long-term outcomes show that youth who received residential services have difficulties with re-entering high school and seeking higher education (Casey et al., 2010). The school environment is a place of difficulty for many youth in the juvenile

justice system as most schools have a zero tolerance policy, meaning most of the youth are not welcomed back into a typical school environment (Altschuler & Brash, 2004). Parents believed that there needed to be more programs and education within the schools to promote the well-being of youth with mental illness (Fette & Estes, 2009). Examples include supportive learning environments, enforced consequences of bullying, parent supports, as well as education for teachers, counselors, and school personnel (Fette & Estes, 2009). Family characteristics such as aggression and parent aggravation impact a youth's academic success and results in negative academic behavior (Youngblade et al., 2007). In addition, school safety had a positive influence on social competence and lessened externalizing behavior (Youngblade et al., 2007).

Additionally, parents felt that teachers needed to promote self-determination more often within the school environment (Carter, Lane, Pierson, & Glaeser, 2006). Dunn and Thrall (2012) state that one way self-determination can be promoted in school is to facilitate youth to be self-directed learners. If youth are given opportunities to be self-determined in all environments including school, they can learn skills such as advocacy, problem solving, self-regulation, empowerment, and self-awareness that can positively influence the direction of their futures in areas of employment and community living (Dunn & Thrall, 2012). A barrier to self-determination in school is that teachers and other professionals in classrooms are unsure how to incorporate it into their curriculum (Dunn & Thrall, 2012).

Placement Environment

There are two different types of residential facilities that youth in the juvenile justice system are potentially placed in the state of North Dakota. The settings are

Psychiatric Residential Treatment Facility (PRTF) and a Residential Child Care Facility (RCCF). A PRTF can be defined as:

> a facility or a distinct part of a facility that provides to children and adolescents, a total, 24 hour, therapeutic environment integrating group living, educational, interdisciplinary clinical assessment and a individualized treatment plan that meets the needs of the child and family. The services are available to children in need of and able to respond to active psychotherapeutic intervention and who cannot be effectively treated in their own family, in another home, or in a less restrictive setting (Price, 2005, para. 5).

In comparison, an RCCF is defined as:

> the provision of substitute parental child care for those children who are in need of care for which the child's parent, guardian, or custodian is unable, neglects, or refuses to provide, and includes the provision of food, shelter, security and safety, guidance, and comfort on a twenty-four-hour basis, to one or more children under twenty-one years of age to safeguard the child's growth and development and to minimize and counteract hazards to the child's emotional health inherent in the separation from the child's family. This may be provided in a family foster home, group home, or residential child care facility (Price, 2005, para. 6).

When looking at the decision of a secure incarceration setting versus a residential rehabilitative setting for the juvenile offenders, the perspectives of the society have a tendency to be unclear. Piquero and Steinberg (2010) conducted a telephone survey within four states, Washington, Pennsylvania, Louisiana, and Illinois, with the purpose of identifying the public's preference for sentencing of these offenders. The response was,

the respondents were willing to pay 20% more in taxes for rehabilitative services than increased incarceration time for offenders, as well as a preference for rehabilitation services rather than strictly incarceration in a secure setting (Piquero & Steinberg, 2010). These results of Piquero and Steinberg's (2010) study show that the public are willing to support rehabilitation services for these offenders.

Regardless of the placement type, inclusion of the family and youth in discharge planning from the beginning of treatment helps the youth transition successfully into their natural environment (Nickerson et al., 2007). McCurdy and McIntyre (2004) acknowledge that residential treatment facilities are useful for the most troubled youth; however, the youth need to be prepared for their post-discharge environment with parental involvement. Incorporating an environment and discharge-based intervention brings youth closer to being part of their regular communities (McCurdy & McIntyre, 2004). Due to the complexity of youth's environments, Blau et al. (2010) stressed the importance of residential staff members and community-based treatment staff needed to have a collaborative and consistent relationship to promote success for youth transitioning back into the community.

Knis-Matthews et al. (2005) and Nickerson et al. (2007) discuss how many of the youth within a residential program single out family matters as their first treatment priority, which increased the collaboration and communication with families. In addition, Fette and Estes (2009) and Gogel, Cavaleri, Gardin, and Wisdom (2011) also stressed the importance of the therapist-family relationship in the success of intervention for youth with mental health needs. In the program development of Knis-Matthews et al. (2005), a family night was held in which the youth had to plan and host an event for their families

to attend. Through this, residents were able to use self-direction, decision making, and esteem building techniques to achieve therapy and personal goals (Knis-Matthews et al., 2005). Youngblade et al. (2007) indicate that family involvement and connectedness promotes social competence, self-esteem, positive academic participation, as well as less internalizing and externalizing behavior among youth. Considering the importance of the parental role, parental training was incorporated into treatment to help youth get the support they needed to be successful. McCurdy and McIntyre (2007) incorporated Behavioral Parent Training to help parents successfully form relationships and discipline their youth. Trupin et al., (2011) also had parenting skills training when using Family Integrated Transitions to help youth return to their natural environments. Overall, the literature suggests that parental involvement is important to address and plays a role in youth success post-discharge.

Occupation

Youth participate in many occupations on a daily basis. Such occupations include formal education by going to school, activities of daily living including getting dressed, grooming, hygiene tasks, feeding and eating, going to work, social participation with peers and family, leisure exploration and participation, play exploration and participation, and rest and sleep. While these occupations seem to be healthy and meaningful, there is a possibility of the activities and tasks that fit within these occupations are unhealthy to the youth participating in them. Unhealthy occupations can include using alcohol or drugs, stealing, committing crimes, sexual activity, and reckless driving. Farnworth (2000) conducted a study in order to evaluate the time usage and engagement in occupations of juvenile youth who were currently on probation at the time of the research study.

Occupational categories in which youth engaged in during the research study included passive leisure, personal care, household, active leisure, education, labor force, legal related, and social leisure (Farnworth, 2000).

Substance Use

According to the Monitoring the Future (MTF) report, in 2012, 6.5% of 8th graders reported using marijuana in the past month (National Institute on Drug Abuse, 2012). In addition, 17% of 10th graders and 22.9% of 12th graders reported using marijuana in the previous month (National Institute on Drug Abuse, 2012). Illicit drug use is not the only form of drugs being used; use and abuse of prescription and over the counter drugs are also on the rise for youth. The National Institute of Drug Abuse's MTF report (2012), indicates marijuana, synthetic marijuana, Adderall, Vicodin, cough medicine, tranquilizers, hallucinogens, sedatives, salvia, OxyCotin, MDMA (Ecstasy), inhalants, cocaine, and Ritalin make up the list of illicit drugs and pharmaceuticals used in the past year by high school seniors. Although alcohol is on recent decline in usage by youth in 2012, 28.1% of seniors, 14.5% of sophomores, and 3.6% of 8th graders reported, getting drunk within the past month (National Institute on Drug Abuse, 2012). In 2000, 56% of youth males and 40% of youth females who were involved in the juvenile justice system for criminal offending tested positive for drug use (Chassin, 2008).

Education and Schooling

A youth has many hours that are spent each day within the school setting. On top of the possible mental health diagnosis, up to 25% of juvenile delinquents have been diagnosed with learning disabilities (Altschuler & Brash, 2004). Within the school system, a common concern for youth, whether they are involved in the juvenile justice

system or not, is truancy. Truancy can be defined as "any unexcused absence by a student under the age of 16 to include three (3) consecutive days within a semester; or six (6) one-half unexcused days within a semester (elementary school); or twenty-one (21) class hours, as defined by each local education authority (LEA)" (Heidt, n.d., p.1). Zhang, Katsiyannis, Barrett, and Willson (2007) conducted a research study in order to track interactions of youth who were truant and their later interactions with the juvenile system and law enforcement. The difference in being initially referred for truancy versus other concerns was part of the research study that was also analyzed. The sample for the study included 12,468 youth in the juvenile justice system, in which 1,725 were first referred for truancy. Zhang et al. (2007) found that youth initially referred to the juvenile justice system for truancy are less likely to commit more serious crimes later, but the anticipated timing for a second offense has no statistically significant difference for non-truant offenders. If the offender does end up becoming incarcerated for a serious crime later, they are more likely to serve shorter commitment sentences (Zhang et al., 2007). When 37 juveniles on probation were asked to document their involvement in occupation for one week, 6.3% of the reported time was spent in educational occupations (Farnworth, 2000).

Vocation and Work

The American Occupational Therapy Association ([AOTA], 2008b) adopted Mosey's (1996) definition of work as "activities needed for engaging in remunerative employment or volunteer activities (p. 632)." Being involved in the juvenile justice system influences the ability for the individual to find meaningful and successful work and employment. Having a criminal record or having public juvenile records can exclude

the youth from jobs or influence the search for employment. With the study of time usage for probationary juveniles by Farnworth (2000), 3.3% of time for the 37 participants for a week was reported as being in labor usage.

Role of Occupational Therapy in Mental Health

Occupational therapists have been working with individual deficits with occupational functioning due to mental health issues since the 18th century beginning with the use of moral treatment, which stated that individuals with mental illness were to be treated with kindness and given the opportunity to be engaged in activity (Gordon, 2009). Early occupational therapists used craft groups to engage individuals in activity in order to decrease mental illness symptoms and increase function. In the 20th century, events such as World War I left many soldiers with physical and psychosocial impairments, leading the profession to have a mind and body approach. After World War II, the profession of occupational therapy boomed and activities of daily living were incorporated into therapy. Throughout the years, occupational therapy has used occupations to facilitate treatment success in individuals with mental illness (Gordon, 2009). As society has given more attention to mental illness, occupational therapy has been a member of the therapy team for individuals of all ages, including youth (Bream, 2013). Due to the demand for mental health services, today occupational therapy has been a valuable member of the interdisciplinary team by assisting with symptom management and recovery (Bream, 2013).

According to American Occupational Therapy Association's (2008b) Occupational Therapy Domain and Practice, the role of the occupational therapist within the mental health population is similar to that of any other population that occupational

therapists work with. Occupational therapists work "to support the individuals' health and participation in life through engagement in occupations" (AOTA, 2008b, p. 626). Occupational therapists are able to work in many settings such as inpatient hospitals, juvenile correctional settings, homes, community based settings, schools, and transitional living settings (Bream, 2013). Mental health conditions include major depressive disorder, generalized anxiety disorder, bipolar disorder, schizophrenia, obsessive-compulsive disorder, conduct disorder, oppositional defiant disorder, attention deficit hyperactive disorder, social phobias, and narcissistic personality disorder, along with numerous others. Within this area of occupational therapy practice, there are theories, models of practice, and frames of reference that guide the therapeutic process for these individuals who are struggling with a mental health condition (Bream, 2013).

Occupational therapists believe in client-centered practice focused on the therapeutic relationship which is developed through the use of therapeutic use of self (Taylor, 2008; AOTA, 2008b). American Occupational Therapy Association (2008b) defines therapeutic use of self as "an occupational therapy practitioner's planned use of his or her personality, insights, perceptions, and judgment as part of the therapeutic process" (p. 653). Occupational therapists are able to provide a therapeutic relationship to the youth and able to assist the individual in functioning independently once outside the residential treatment center within their meaningful occupations successfully.

The remainder of this literature review focuses on programs that address community reintegration from the occupational therapy literature as well as interdisciplinary programs that address aspects of community reintegration. The reason for including interdisciplinary research is that limited research that has been conducted

within the occupational therapy profession on community reintegration. From the occupational therapy literature, programs for both youth and adults are examined, addressing the importance that occupational engagement has on the outcome of the program. From interdisciplinary research, included in this literature review are programs to address substance abuse, either prevention or no longer using, programs to that prevent recidivism for criminals, and programs for community reintegration for youth in residential treatment centers that do not include occupational therapy in them. Through these programs, there is highlighted importance of aftercare programming which is addressed at the end of this literature review.

Interventions for Community Reintegration

Community reintegration provides challenges for youth and adults as they make the transition from residential treatment or a secure environment back into the community, their natural environment. As an occupational therapist works with these clients, their therapy goals include occupational performance in the areas of activities of daily living, instrumental activities of daily living, employment skills, leisure, social participation, and health and wellness (Bream, 2013). In the following sections, occupational therapy programs and interventions for youth and occupational therapy programs and interventions for adults are discussed. The overall goal within these programs is successful community reintegration for the individuals.

Occupational Therapy and Youth Community Reintegration

Occupational therapists are involved in the youth's transition and community reintegration from the residential facility back to the natural environment in order for the youth to complete and engage in meaningful occupations. The American Occupational

Therapy Association (2008a) describes strategies often used by occupational therapists including supported employment, social skill development, and the development of daily living routines, health promotion, and leisure pursuits. Examples of how occupational therapists support transitions are by preparing the youth and their support system of role changes and routine development, education of youth needs, supportive education and employment, activity analysis, and supporting self-determination for successful social and community integration. In addition, occupational therapists are able to collaborate with the entire transition team in order to promote successful integration, self-advocacy skills, as well as provide resources (American Occupational Therapy Association, 2008a).

Knis-Matthews et al. (2005) implemented an occupational therapy program as a part of a twelve-week fieldwork within a residential care facility in New Jersey. The program was guided by the Model of Human Occupation. The goal of this facility was to have the residents return home successfully with their families in a supportive environment and decrease the need for further hospitalization of the youth. Through assessment, the residents were asked to rate statements relating to occupational functioning in everyday life and then explain their perspectives on the statement. From this information, strengths and areas of growth were identified and goals for therapy were created. Therapy priorities included family issues of reuniting with family members, decreasing self-esteem, decreasing ability to function independently, difficulty in decision-making, and health and wellness. Therapeutic interventions implemented within this program included group discussions, one-on-one meetings, community outings, and a family night at the facility organized by the residents to address successful

communication, self-direction and independence, and self-esteem building. Positive experiences were reported at the end of the twelve-week program by the residents, family members of the residents, the occupational therapy students, and staff members from the residential facility (Knis-Matthews et al., 2005). The work completed by these authors highlights the importance of an occupational therapy program for youth with mental health concerns who are in a residential facility placement. The youth were able to set personal and meaningful goals, engage in occupations, build skills for successful independence after placement in the facility, and involvement in the community.

Adapting to different environments, participating in a purposeful occupation, and gaining a sense of meaning behind personal existence are values of the Perseverance, Accountability, Resiliency, Fellowship, Opportunity, Respect, and Empowerment (PAR FORE) program that is being implemented at the University of Utah and Kean University (Lopez, 2013). Under the guidance of the occupational therapy program at the two universities, undergraduate and graduate students are mentors to at-risk youth in gaining skills through the game of golf. PAR FORE's mission is "a mentor program that utilizes therapeutic principles inherent in the sport of golf to foster positive personal, social, and physical growth and development" (Lopez, 2013, para. 1). The game of golf provides many opportunities to youth such as opportunities to interact socially and build relationships with others; as well as, proper golf etiquette to follow that is comparable to societal norms regarding engagement in the community. Occupational therapists provide the structured activities and help the youth set goals to promote engagement in occupations that promote purpose and meaning while engaging in a sport. Additionally, the mentors work with the youth on building life skills that are essential for success as an

adult, such as preparation for educational skills, anti-bullying, self-esteem building, anger management and emotional regulation, time management, or other skills fundamental to adult success and the acquisition of healthy occupations (Lopez, 2013).

Bazyk and Arbesman (2013) created an occupational therapy guideline for youths with mental health difficulties based upon a three tier guide. Tier one is titled Universal Mental Health Promotion and Prevention Services and is tailored to youth with and without mental health or behavioral deficits. Services provided in tier one promotes mental health services such as: social and emotional learning, positive supports, leisure activities, prevention, as well as social skills. Tier two is labeled Targeted Mental Health Service and is made for youth who are at-risk for engaging in deviant behaviors or developing mental health difficulties. Interventions for tier two included social skills, health promotion, play, leisure, and recreation, as well as parent education. Tier three, Intensive Mental Health Services is made for youth you have mental health, emotional, or behavioral disorders that hinder participation in meaningful areas of occupation. Tier three interventions are to be done in a system of care approach with youth empowerment and promotion of subjective well-being. Additionally, tier three utilizes cognitive-behavioral therapy to help address feelings and behaviors. Tier three youth should also have social skills, play, leisure, and recreation, as well as parent education. Each tier is intended to help youth participate successfully in their meaningful occupations within their environment (Bazyk & Arbesman, 2013).

As occupational therapists play a role in assisting with community reintegration for youth, there are a few key aspects to be included in the programming. Areas of occupation that should be addressed within these programs include leisure, instrumental

activities of daily living, education, work, and social participation (Knis-Matthews et al., 2005; AOTA, 2008a; Lopez, 2013). In order to increase the youth's ability to independently engage in these areas of occupation, the occupational therapist utilizes the youth's skills in order to increase their confidence and independence (Knis-Matthews et al., 2005). Allowing the youth to play a role in their treatment planning, such as collaboratively setting therapy goals and guiding their therapy interventions allows for increased meaning in their therapy process which leads to greater outcomes in the process (AOTA, 2008a; Knis-Matthews et al., 2005). Shea and Wu (2013) suggest that it may be beneficial to use the Adolescent/Adult Sensory Profile (Brown & Dunn, 2002) to better understand how youth in the justice system interact with their environment. From this information, occupational therapists can help youth re-enter in an environment that promotes success (Shea & Wu, 2013). The occupational therapy scope of practice fits within the needs of those youth who are participating in community reintegration and should be involved within the treatment programming for the youth.

Occupational Therapy and Adult Community Reintegration

With limited occupational therapy literature on youth community reintegration, the search for literature on community reintegration with occupational therapy was expanded to include adults. Eggers, Munoz, Sciulli, and Hickerson Crist (2006) implemented an occupational therapy program based on components of behaviorism and cognitive behavioral aspects into a county jail for adult offenders for successful community reintegration and employment placement after incarceration. The program addressed wellness, family and support structure, skills for living, and education and employment. Each participant set their own goals that fit within these areas for

successful community reintegration. Upon release from the county jail, the adult continues to meet with a reintegration specialist, where the occupational therapy goals are carried over and put into the adult's natural context. In the 11 months following the implementation of this occupational therapy program at the county jail, 67.8% of those enrolled in the program have been released back into the community, with only one participant having returned to jail in the first 11 months of the program. Successful employment had been gained by 57% of those released to the community within the first 11 months, while 9% were actively searching for jobs. Of those released back into the community, 34% had been dropped from the community reintegration program because of non-compliance to the program guidelines. The results of this study are that the program aided in reducing recidivism and increased job placement for adults after incarceration (Eggers et al., 2006). As Eggers et al. (2006) found, an occupational therapy program involving meaningful goals and addressing areas of independent living skills, including education, employment, and social skills, and health and wellness helps to reduce recidivism and improve community reintegration of individuals after incarceration.

There is limited occupational therapy research regarding any age population with mental illnesses and community integration or normative life roles. Gibson, D'Amico, Jaffe, and Arbesman (2011) completed a systematic review of research studies to identify common themes. From 52 articles that met the inclusion criteria, the researchers identified seven common themes in interventions for community integration and normal life roles: "social participation (including social skills training); IADLs (including life skills training and physical activity); work and education; neurocognitive training;

intensity and duration of intervention; client-centered interventions; and context and environment of interventions" (Gibson, et al., 2011, p. 249-250). Either longer duration, increased intensity, or a mixture of the two, proved to have higher results than interventions that were shorter in length and less intense. Interventions that were client-centered and met the particular needs of the patient were deemed most effective. Regarding the intervention context and environment, the studies that the researchers assessed showed mixed results between natural environment and a clinical setting (Gibson et al., 2011).

The literature on community reintegration programs including occupational therapy have aided in understanding important aspects that need to be included. Based on the previous studies, being client-centered and allowing the person to choose their individual goals promotes successful reintegration (Eggers et al., 2006; Gibson et al., 2011). Other aspects within the programs that demonstrated effectiveness in reducing recidivism of adults in reintegration programming addressed work and educational opportunities, social skills, and promoting a healthy lifestyle (Eggers et al., 2006; Gibson et al., 2011).

Interdisciplinary Intervention for Community Reintegration

When reintegrating back to the community, many professionals are involved in the care and transition of the adult or youth. These professionals can include, but are not limited to, a parole officer, social worker, case manager, transition specialist, a member from vocational rehabilitation, and a behavioral therapist. The goal for these individuals from an interdisciplinary approach is similar to that of an occupational therapist's viewpoint, in which successful community reintegration involves healthy behaviors, non-

criminal behaviors, and reduced recidivism of the individuals. In the following sections, interdisciplinary programs for reducing recidivism and substance use treatment are discussed. These programs have been chosen as substance use is highly prevalent and interferes with successful community reintegration, as does continued criminal behaviors. Additionally, interdisciplinary programs for community reintegration from residential treatment centers are discussed in this section.

Programs for Substance Use. Taylor and Mudford (2012) implemented a behavior modification program for positive behaviors within a drug and alcohol rehabilitation therapeutic community with youth females. Behavior modification includes positive reinforcement, extinguishing behaviors, and negative reinforcement. One form of positive reinforcement is a token reward system. Taylor and Mudford (2012) found that the positive behaviors included job readiness following breakfast, cleanliness of their bedroom, and how the females spoke and interacted with peers. Additionally, the token system showed improvements in positive talk and behavior, dorm cleanliness and promptness, and job function within the female youth (Taylor & Mudford, 2012). Within a residential treatment facility, behavior modification can be implemented in order to promote positive behaviors or to decrease negative behaviors. With youth presenting with positive behaviors within the residential facility, the goal is to have carryover of the positive behaviors into the community and upon discharge from the residential facility.

Dembo et al. (2011) stated that it is important to intervene with truant youth in order to lessen the likelihood that they will engage in other negative behaviors such as drug use or crime. The National Institute on Drug Abuse funded the brief intervention

project which incorporated elements of rational-emotive therapy, problem-solving therapy, discussion on substance use and the youth's willingness to change, identification of risk situations, goal setting to reduce drug use, as well as parent involvement and education over three sessions (Dembo et al., 2011). Results of the study showed that at the 12-month follow-up, youth had near significant effect on decreasing delinquent behaviors (Dembo et al., 2011).

For youth, whether they are considered at-risk or not, alcohol and substance use prevention programming is essential. With this population, addressing prevention of substance use and alcohol use is important for those who may not have begun using prior to placement, but are at a risk for using upon discharge from the treatment program. Longshore, Ellickson, McCaffrey, and St. Clair (2007) looked at the effectiveness of a school-based prevention program, Project ALERT. This middle school-based program uses components of the health belief model, social learning theory, and behavioral change. Project ALERT provides the youth with information about the consequences of substance use, identify the barriers and pressures to substance use, and building the youth's skills and confidence in order to say no to peer pressure. This is achieved through interactive discussions, small group activities, and practice of techniques through role-modeling with peers. The ALERT Plus program is a follow-up for those youth who participated in Project ALERT in middle school. ALERT Plus takes into consideration the changes that occur developmentally from middle school to high school, such as dating, gaining of a driver's license, awareness of the marketing of the products, and stronger friendship bonds all which lead to a greater chance of participating in substance use. When Longshore et al. (2007) looked at the effectiveness of ALERT Plus in

comparison to Project ALERT and a control group, providing the youth with exposure to ALERT Plus following Project ALERT was more effective then only Project ALERT during middle school. Those who had completed ALERT Plus were less likely to report substance and alcohol drug use than those in the control group and those who participated in Project ALERT only (Longshore et al., 2007).

Through an evidence-based review of literature on substance abuse programming, Stoffel and Moyers (2004) found that brief intervention, cognitive behavioral therapy, motivational strategies, and 12-step programs are beneficial to the treatment of individuals with substance use disorders. Stoffel and Moyers (2004) believe that in order to be successfully disengaged from substance and alcohol use, the individual needs to be engaged in occupations and roles that are disassociated from their prior using patterns. Each of the four approaches to the substance use programming can provide the individual with the opportunity to become engaged in healthy occupations and roles. Brief intervention includes short sessions with the individual in order to figure out the occupational problem and for the therapist to find the inner motivation the individual needs to take action on the problem, use of alcohol or substances. Cognitive behavioral therapy attends to the cognitive aspects of the individual’s behavioral choices, using alcohol or substances, with the goal of changing what the individual thinks and does during a high-risk substance use situation. Coping strategies are addressed within the cognitive behavioral therapy approach. Motivational interviewing, decisional balance exercises, FRAMES which stands for feedback, responsibility, advice, menu, empathy, and self-efficacy, and motivational enhancement therapy are all motivational strategies that are shown to be effective with individuals who have substance use disorders. With

the motivational strategies, the goal is to assess the individual's readiness for change and to enhance the individual's motivation to change their behavior. 12-step programs are those of Alcoholics Anonymous and Narcotics Anonymous. These programs look to support the individual through their process of recovery, as well as sustained recovery (Stoffel & Moyers, 2004).

From the professional literature on alcohol and substance use prevention, there are a few concepts that are seen throughout. Much of the focus with prevention and abstinence from using, whether the individual has never been a user before or if they are a chronic user, it is important to address the individual's readiness to change and if they have the motivation to change their behavior (Dembo et al., 2011; Stoffel & Moyers, 2004). With the readiness to change and the motivation, the behavioral change that occurs is essential and can be addressed through different approaches, such as behavior modification (Taylor & Mudford, 2012), through cognitive behavioral therapy (Stoffel & Moyers, 2004), and with the use of brief intervention strategies (Dembo et al., 2011; Stoffel & Moyers, 2004). Within the different strategies, education on the importance of refraining from using alcohol and substances is essential in the prevention process (Longshore et al., 2007). The overall goal of these programs is to change the behavior, which can be looked at from an occupational therapist viewpoint as changing the occupations in which the individual engages in, role changes, and changes in their patterned use of time from using substances and alcohol to productive, healthy occupations.

Programs for Criminals. McCamey (2010) studied ways to reduce recidivism in youth sexual offenders. The treatment provided was based on cognitive behavioral

principles, addressing ways thoughts and feelings influence the chosen actions or behaviors. Community reintegration was the most important aspect of treatment in terms of reducing recidivism. Within community reintegration, topics included social skills training, independent living skills, vocational training, and relationship building. Before community reintegration occurs, community activity participation is highlighted as being beneficial to helping the youth successfully reintegrate into their community (McCamey, 2010).

Zhang, Roberts, and Callanan (2006) implemented the Preventing Parolee Crime Program (PPCP), a community-based rehabilitation program, which provided the participants with job training and placement services on top of drug abuse treatment, independent living and housing, and education through math and literacy training. The PPCP worked in collaboration with two community-based employment programs, Jobs Plus and Offenders Employment Continuum. Both programs worked with the parolees in gaining full-time employment. For math and literacy training with the goal of improving educational skills by two grade levels, the PPCP utilized the Computer Literacy Learning Center (CLLC) network. The CLLC was a self-paced program in which the parolees could enroll or leave the program at their discretion. Substance abuse treatment was provided by one of two programs, Substance Abuse Treatment and Recovery (STAR) and The Parolee Services Network (PSN). For each parolee, there were treatment goals set addressing each of these areas, employment, substance abuse, and education. Of those who completed the PPCP by reaching their treatment and rehabilitation goals, there was 8% less recidivism rates than those parolees who did not participate in PPCP or did not complete the program by not reaching their treatment goals (Zhang et al., 2006). The

PPCP is a program based upon cognitive behavioral theory and elements of learning through behaviorism.

In an effort to reduce the recidivism rates of formerly incarcerated juveniles, Project SUPPORT was developed (Unruh, Gau, & Waintrup, 2009). Project SUPPORT, as described by Unruh et al. (2009) has a goal to increase participant's engagement in employment and/or school enrollment, and reduce rates of recidivism. In order to achieve these goals, the project includes treatment in the facility, activities preceding and following release, and continuous support from the community. Project SUPPORT utilizes a transition specialist, a vocational rehabilitation counselor, a treatment manager, a parole officer, and facility and community education staff in order to provide assistance to the youth trying to meet their treatment goals. Through the service delivery model, interventions provided within Project SUPPORT include enhancing self-determination skills, educational opportunities, social skills building, and coordination of wrap around services (Unruh et al., 2009).

When working with criminals who are anticipating transitioning out of the secure justice system into the community, the professional literature highlights important considerations for the transition process. McCamey (2010), Zhang et al. (2006), and Unruh et al. (2009) each discussed different programs for criminals and parolees, but the main components were similar. Each of these programs included improving independent living skills, educational opportunities, vocational rehabilitation, and continued support services once their sentencing in the secure environment was complete (McCamey, 2010; Zhang et al., 2006; Unruh et al., 2009). Allowing the individual to be involved in treatment goal setting was also highlighted as an important factor for reducing recidivism

in these programs, as this provided them with a sense of control and provided meaning to the treatment process (Zhang et al., 2006; Unruh et al., 2009). These are the main factors that are essential to provide the individual with the best opportunity to successful reintegrate into the community after serving a sentence within the secure justice system.

Programs at Residential Treatment Centers. When reintegrating into the community following placement within a secure residential center, Harder, Knorth, and Kalverboer (2011) found that the most difficult aspects include financial issues, family and parent relationships, living arrangements, substance use and/or abuse, and education. As Harder et al. (2011) looked at the perceptions of youth who have reintegrated back into the community, 37% stated they felt the process of planning for departure from the residential center was poorly organized or happened suddenly. Once these youth did depart from the facility, the two most commonly reported problems were associated with education and work followed by living situations and the financial issues. The youth report receiving support for these difficulties from multiple different individuals; these individuals may include either a guardian, professional support, or their parole officer. The behaviors in which these youth portrayed one year after their discharge could classify half of them as mild offenders and half of them as serious offenders, including substance use, alcohol use, property destruction, minor offenses, and aggressive or violent offenses (Harder et al., 2011). This study highlights the understanding that youth continue to experience difficulties when they transition into the community and require continued support and treatment services within the natural context.

For youth in residential treatment center programs, the family and parent relationship was highlighted by Nickerson, Salamone, Brooks, and Colby (2004) as being

an important piece of having an effective discharge from the residential treatment setting. If the family and support systems are a part of the treatment plan, there is an increased likelihood of skill transfer from the residential treatment facility to the youth's natural home environment. When building up to the youth's discharge from the facility, it is suggested the youth takes part in over-night passes to their natural environment up to a multiple day stay at their natural environment (Nickerson et al., 2004). Another aspect highlighted by Nickerson et al. (2004) for treatment during residential placement was that of building on the strengths of the youth rather than focusing on the areas of growth or weaknesses. If residential treatment provided the youth with meaningful work and service learning, the youth would be able to provide benefits to others and see the results of their work. With the youth's skill set, involving them in activities within the community that highlights their strengths and allows them to build on them is also beneficial (Nickerson et al., 2004). Occupational therapists were not specifically included with the treatment program and strength building, but it does fit into the scope of occupational therapy practice. Occupational therapists are able to grade activities and tasks so that the youth is able to complete the task with their skills and provide an optimal level of challenge to continue building on the skill set.

Holden et al. (2010) echo the importance of including family in their residential treatment program entitled Children and Residential Experiences (CARE). The CARE program is based on the Theory of Change model. Within the CARE program is the importance of building relationships and competence in skills, knowledge, and the youth's attitude for everyday life, and promoting normal development (Holden et al., 2010). Family involvement through treatment is also an important part of the CARE

program. Through the CARE program's exposure to concepts, principles, modeling, role-playing of skills, and strategies, it is expected that the youth will experience increased well-being, experiences, and perceptions as outcomes. These outcomes include experiencing success in challenging tasks, trust, increased self-worth, meaningful relationships, improved self-concept and self-esteem, and social or emotional adjustment. The CARE Program uses daily activities to provide the opportunity for learning and growth (Holden et al., 2010).

When youth are transitioning from a residential treatment center back to their natural environment, the professional literature helps to guide the transition process with aspects to be included for effect treatment. One of the most important aspects is inclusion of family within the treatment process, including the planning stages and interventions to achieve goals (Nickerson et al., 2004; Holden et al., 2010). Continued support after transitioning from the residential facility is also important as there is evidence that the youth experience difficulties with independent living one year after discharge (Harder et al., 2011). Through involvement in the community and taking responsibility for their actions and behaviors, the youth has a greater chance at successful reintegration (Harder et al., 2011; Holden et al, 2010; Nickerson et al., 2004). Literature from Harder et al. (2011), Holden et al. (2010), and Nickerson et al. (2004) supports occupational therapy intervention because the emphasis is on occupational performance, as well as client factors and activity demands that support occupational performance.

Aftercare Programming

Community reintegration also involves continued aftercare programming. Components of aftercare services can include "intensive in-home counseling, relapse

prevention, specialized foster care/residential care support, academic tutoring, job skills training/placement, and housing referral services" (Ryan et al., 2001, p. 332). Professionals that may be involved in aftercare programming can include occupational therapists, social workers, case managers, and probation officers. Wells, Minor, Angel, and Stearman (2006) conducted a study looking at aftercare programs for juvenile offenders. They believe aftercare programming should focus on preparing youth for increased responsibilities and independence, increased involvement in community interactions, integrating the youth with the family and school, creating and building new supports for the youth and continued evaluation of the youth's functioning and interactions within the community (Wells et al., 2006). Though this research study does not include occupational therapy as an involved healthcare professional, occupational therapists are able to provide youth with the performance skills needed to achieve their independence within the community.

Additional literature has been found regarding community-based treatments in reducing recidivism rates of paroles (Zhang et al., 2006). The PPCP program focus on four domains within the person's natural community environment: (a) future and current employment opportunities, (b) education regarding the use of substances and the recovery process, (c) the obtainment and maintenance of a place to live, (d) and literacy skills in both writing and math. The delivery of these skills within the natural environment promotes transference of learning to promote continued success and reduce rates of recidivism. Although this program is a community-based treatment, community-based treatment settings are an example of a potential place to conduct aftercare services following preparation for reintegration at a residential facility.

The effectiveness of treatment for youth is greatly dependent on their personal motivation and desire to gain skills necessary for community reintegration. Huscroft-D'Angelo, Trout, Epstein, Duppong-Hurley, and Thompson (2012) conducted a study to assess youth's perceptions regarding how prepared they felt for discharge and the importance of aftercare services. Their hopes in conducting the study were to identify gender differences between the two variables (perceived levels of preparedness for discharge and need for aftercare services). Non-significant differences were found between genders. Cross-gender, lower perceived levels of preparedness were associated with those youth that were returning to independent living. Also, the importance of aftercare services was identified by both males and females. The male youth suggested the mean length of aftercare be one month, whereas, the female youth believed that six months would be adequate for aftercare. The youth stated that they would be willing to designate one to two hours per week for aftercare services. Overall, the researchers found that aftercare services cannot be put into one-size fits all approach (Huscroft-D'Angelo et al., 2012).

The benefits of aftercare services in maintaining continued support during the transition and the months first back into their natural context has been supported through research (Eggers et al., 2006; Huscroft-D'Angelo et al., 2012; McCamey, 2010; Nickerson et al., 2007; Taylor & Mudford, 2012; Unruh et al., 2009; Wells et al., 2006; Zhang et al., 2006). Occupational therapy can play an important part in preparing juveniles for community reintegration by providing services that assist them with identifying new supports, gaining skills to interact with the community, and working with family and community.

Summary

An occupation-based community reintegration program that reflects the critical components described in the literature emerged. Eggers et al. (2006) and Gibson et al. (2011) brought forth the importance of client-centered programming with the individual being involved in all aspects of their treatment process. Areas of occupation to be included in the program include instrumental activities of daily living, education, work, social participation, and leisure (Bream, 2013; Eggers et al., 2006; Gibson et al., 2011; Knis-Matthews et al., 2005; Lopez, 2013; McCamey, 2010; Unruh et al., 2009; Zhang et al., 2006). In order for the individual to engage in these areas of occupation, skills that will be addressed include social skills (AOTA, 2008a; Bazyk & Arbesman, 2013; Knis-Matthews et al., 2005; Longshore et al., 2007: McCamey, 2010; Unruh et al., 2009), coping skills (Longshore et al., 2007; Stoffel & Moyers, 2004), self-determination and assertiveness (Carter et al., 2006; Dunn & Thrall, 2012; Holden et al., 2010), self-esteem building (Holden et al., 2010; Knis-Matthews et al., 2005; Lopez, 2013; Nickerson et al., 2004; Stoffel & Moyers, 2004; Unruh et al., 2009), and time management (Lopez, 2013). Family will be involved throughout the whole treatment process (Bazyk & Arbesman, 2013; Blau et al., 2010; Griffith et al., 2009; Holden et al., 2009; Knis-Matthews et al., 2005; Nickerson et al., 2007; Nickerson et al., 2004; Trupin et al., 2011). Once the individual meets appropriate criteria for discharge from the residential facility, it is proven to be effective for the individual if aftercare services are provided and that youth want the continued support within their natural environment (Bazyk & Arbesman, 2013; Eggers et al., 2006; Huscroft-D'Angelo et al., 2012; McCamey, 2010; Nickerson et al.,

2007; Taylor & Mudford, 2012; Unruh et al., 2009; Wells et al., 2006; Zhang et al., 2006).

CHAPTER III

METHODOLOGY

When we began brainstorming for our scholarly project ideas, we knew we wanted to develop programming for youth with emotional and behavioral difficulties who have received or are currently receiving intervention through residential treatment centers. Youth gain many of the skills and knowledge that are required to be successful within the community; however, they do not get the opportunity to engage in self-determination by using those skills in true occupation in both the residential and community settings. Youth experience difficulties in the transition process due to multiple factors including family relationships, peer relationships, educational and vocational experiences, and healthy leisure pursuits (Harder, Knorth, & Kalverboer, 2011; Knis-Matthews, Richards, Marquez, & Mevawala, 2005). From these difficulties, it has been further identified that the youth need aftercare programming by care team members, as well as the youth reporting that they want continued supportive services within their natural environment (Eggers, Munoz, Sciulli, & Hickerson Crist, 2006; Huscroft-D'Angelo, Trout, Epstein, Duppong-Hurley, & Thompson, 2012; McCamey, 2010; Nickerson, Colby, Brooks, Rickert, & Salamone, 2007; Unruh, Gau, & Waintrup, 2009; Wells, Minor, Angel, & Stearman, 2006).

Once the problems were identified, a review of the literature was completed. Professional literature articles were obtained through a search of the CINAHL database, PubMed, PsycINFO, OT Search, and Academic Search Premier using the search terms

"residential care," "at-risk adolescents," "substance abuse," "community re-entry," "transition to community," "mental health and adolescents," "residential treatment and adolescents," "adolescent mental health and family," "juvenile justice," "community reintegration," "adolescent transition," and "aftercare programming." Fact sheets from the American Occupational Therapy Association website that related to transitioning and youth mental health were also reviewed to ensure that evidenced based and current information was obtained to complete this project.

Information obtained from the review of literature was organized using the Person Environment Occupation (PEO) model (Law et al., 1996). This model was chosen to organize the literature and guide the program development due to the unique way the model addresses the individual aspects of the person, the environment, and the occupations, and then incorporates how each of these aspects influence the individual's occupational performance (Cole & Tufano, 2008). Findings from the literature review were organized into the categories of person, environment, and occupation. In the PEO model, person aspects include demographic information, mental health issues, experiences of trauma, and developmental risk factors. The environment component of the literature review describes the contexts in which youth engage in different occupations including the home, community, school, and the treatment placement context. The occupation component includes information regarding the activities that youth engage in on a regular basis. These occupations include substance use and abuse, education and schooling, and vocation and work.

Once the information was obtained and organized, areas and patterns of deficits for these youth came to the surface. Through a systematic analysis of the occupational

performance issues, as shown in Table 1, areas of need were identified using the PEO model. Initially, the person, environment, and occupational demands, were assessed individually. Next, the transactions between the person and the occupation, the occupation and the environment, and the person and the environment were assessed. From this systematic analysis and the literature, aspects of intervention were identified to improve the occupational performance of community social participation for youth transitioning from residential to community settings.

There was limited research based on the intervention aspects of occupational therapy within residential treatment centers. This lead to having aspects of interventions that have been used when working with at-risk youth, criminals, and those with substance abuse issues included. These intervention components were researched and identified through the literature review process. Those findings were then incorporated into the program development in both the residential and community settings.

The program was developed using a backwards design approach (Fink, 2013). We began by addressing what we anticipated as the overall outcomes of providing services to these at-risk youth within residential treatment centers through their transition into their natural context. With those outcomes, we identified the objectives, activities, and outcomes for the community-based services with the occupational therapist playing a consultation role with the interdisciplinary treatment team. The community-based interdisciplinary team includes the youth, the youth's family, a mentor, their case manager, an occupational therapist, and a school representative. Resources were provided for the interdisciplinary team in order to increase their guidance and assistance for the youth as they continue performing in occupations within their community. From

there, we identified the objectives, activities, and outcomes for the program within the residential treatment center by an occupational therapist. The activities were put together within a manual following Cole's Seven Steps (Cole, 2005) for the group sessions and other aspects of the manual coming together based on phases and aspects that are important for occupational performance.

Table 1

Systematic analysis of occupational performance of community social participation

<table>
<tr><td colspan="3">Occupational Performance Issue

Community Social Participation for Individuals Transitioning from Residential to Community Settings: The occupational performance issue is community social participation secondary to difficulty with self-regulation, social skills, communication, and relationship building.</td></tr>
<tr><td colspan="3">Assessment of Main Components</td></tr>
<tr><td><u>Person</u></td><td><u>Environment</u></td><td><u>Occupational Demands</u></td></tr>
<tr><td>Demographics
• Males account for up 50-88% of those within the juvenile justice system (Snyder, 2004; Goodkind, Shook, Kim, Pohlig, & Herring, 2013)
• Cultural identity of White, non-Hispanic accounts for almost four times the amount of those who identified as African American (Puzzachera, Sladky, & Kang, 2013)
Mental Health Conditions
• 60-75% of youth in juvenile justice system have a mental health diagnosis (Shufelt & Cocozza, 2006; Snyder, 2004)
• Females have a significantly higher rate of mental health diagnosis (Grande et al, 2012; Shufelt & Cocozza, 2006)
Trauma
• 25-75% youth have experienced at least one traumatic event in their life (Ford, Chapman, Connor, & Cruise, 2012)
• Traumatic experiences have been linked to</td><td>Home
• Youth’s parental and familial issues include substance abuse, improper discipline, abandonment, neglect, unemployment, and isolation (Griffith et al., 2009; Nickerson et al., 2007)
• Youth are often not living with their biological parents (Griffith et al., 2009; Nickerson et al., 2007)
Community
• Neighborhood characteristics have a greater influence on the outcome of youth substance use and psychiatric symptomology than family characteristics (Buu et al., 2009)
• Safe and connected neighborhoods promote good behavior, social capabilities, and health (Youngblade et al., 2007)
• Peers are influential of negative behaviors and choices of youth</td><td>Analysis of community social participation
• Self-regulation of emotions
• Appropriate social skills
• Ability to express emotions appropriately
• Building and retaining of interpersonal relationships
• Ability to be involved in organizational activities
• Abstinence of illegal drug and alcohol use
• Avoidance of criminal behaviors
• Following social norms of the community and society
• Ability to express verbally and nonverbally
• Ability to read others’ verbal and nonverbal communication</td></tr>
</table>

decreased biopsychosocial development (Ford et al., 2012) • Youth have difficulty building peer relationships and trusting adults (Ford et al., 2012) **Developmental Risk Factors** • Youth in an out of home placement are at an increased risk of involvement with the juvenile justice system (Goodkind et al., 2013). • Youth is a period of hormonal and physical changes (Bonham, 2006) • Secure confinement effects a youth's normal maturation and development (Dmitrieva, Monahan, Cauffman, & Steinberg, 2012) **Substance Use** • 56% of youth males and 40% of youth females within the juvenile justice system tested positive for drug use (Chassin, 2008) **Education** • Up to 25% of juvenile delinquents have learning disabilities (Altschuler & Brash, 2004) • Truancy behaviors are a common problem with youth in the juvenile justice system (Zhang, Katsiyannis, Barrett, & Willson, 2007) **Work and Vocation** • Delinquent history affects job opportunities for youth and young adults (Farnworth, 2000)	(Altschuler & Brash, 2004; Casey et al., 2010) **School** • Youth often do not complete high school or pursue higher education options (Casey et al., 2010) • Due to zero tolerance policies, youth in the juvenile justice system have difficulty re-entering school (Altschuler & Brash, 2004) **Placement** • Youth single out family as being their first priority (Knis-Matthews et al., 2005; Nickerson et al., 2007)	

Assessment of PEO Transactions		
Person – Occupation	**Occupation – Environment**	**Person – Environment**
• Low self-determination limiting occupational performance in education and vocational tasks • Learning disabilities inhibiting successful education • Routines support occupational engagement • Anxiety in social participation and interpersonal relationships • Restricted interests and occupational participation may negatively influence community social participation	• Neighborhood influence on substance use • Limited community resources available to aid in successful community reintegration • At risk behaviors influenced by unsupportive home and community environments • Zero tolerance policy leading to educational deficits • Peer relations influence engagement in occupation	• At-risk behaviors are influenced by negative home environment, including physical, emotional, or sexual abuse • Environment influences externalizing behaviors of the adolescent • Home environment influences personal values and beliefs • Familial environment influences rate of becoming involved in the justice system • Difficulties adhering to social norms within community, school, and home environment
Intervention/Strategies to Improve Occupational Performance		

• Interventions will be occupation-based addressing different areas of occupation. These areas of occupation include instrumental activities of daily living (IADLs), education, work, social participation with family and peers, and leisure (Bream, 2013; Eggers et al., 2006; Gibson, D'Amico, Jaffe, & Arbesman, 2011; Knis-Matthews et al., 2005; Lopez, 2013; McCamey, 2010; Unruh et al., 2009; Zhang et al., 2006).
• Engagement in occupations will be increased through skill building.
    • Social Skills (AOTA, 2008a; Bazyk & Arbesman, 2013; Knis-Matthews et al., 2005; Longshore, Ellickson, McCaffrey, & St. Clair, 2007: McCamey, 2010; Unruh et al., 2009)
    • Coping Skills (Longshore et al., 2007; Stoffel & Moyers, 2004)
    • Self-determination and Assertiveness (Carter et al., 2006; Dunn & Thrall, 2012; Holden et al., 2010)
    • Self-Esteem Building (Holden et al., 2010; Knis-Matthews et al., 2005; Lopez, 2013; Nickerson et al., 2004; Stoffel & Moyers, 2004; Unruh et al., 2009)
    • Time Management (Lopez, 2013)		

- Vocational Skills

- The building and maintenance of a mentoring relationship will be utilized during the transition process from the residential treatment center to the youth's natural environment (Bazyk & Arbesman, 2013; Eggers et al., 2006; Huscroft-D'Angelo et al., 2012; Lopez, 2013; McCamey, 2010; Nickerson et al., 2007; Taylor & Mudford, 2012; Unruh et al., 2009; Wells et al., 2006; Zhang et al., 2006).
- Community involvement for at-risk youth to promote positive behaviors and avoid negative activities such as drugs and gang activity (Blau et al., 2010; Brunner, 2012).
- Family will be involved through the whole treatment process (Bazyk & Arbesman, 2013; Blau et al., 2010; Griffith et al., 2009; Holden et al., 2009; Knis-Matthews et al., 2005; Nickerson et al., 2007; Nickerson et al., 2004; Trupin, Kerns, Walker, DeRobertis, & Stewart, 2011). Family involvement throughout treatment as well as having a safe, positive post-discharge environment supports treatment success (Blau et al., 2010; Fette & Estes, 2009; Knis-Matthews et al., 2005; Trupin et al., 2011). Family routine is a source of well-being, structure and support (Koome, Hocking, & Sutton, 2012). Family involvement promotes social competence, self-esteem, positive academic participation, as well as decreased internalizing and externalizing behaviors (Youngblade et al., 2007).
- Parents want programs that promote the well-being of youth with mental illness (Fette & Estes, 2009).
- Parent training and education helps parents build positive relationships with their youth and promote a better transition into their natural environment (McCurdy & McIntyre, 2007; Trupin et al., 2011)
- Collaboration and consistency between residential treatment staff and community-based treatment staff promotes successful transition back into the community (Blau et al., 2010)
- Aftercare services provide continued support from a systems approach for the transition process and to reduce recidivism (Eggers et al., 2006; Huscroft-D'Angelo et al., 2012; McCamey, 2010; Nickerson et al., 2007; Taylor & Mudford, 2012; Unruh et al., 2009; Wells et al., 2006; Zhang et al., 2006)

Note. Adapted from "Systematic analysis of occupational performance of dating," by S. Strong & K. R. Gruhl (2011), Person-Environment-Occupation model. In C. Brown & V. C. Stoffel (Eds.), *Occupational therapy in mental health: A vision for participation* (31-46). Philadelphia: F. A. Davis Company.

CHAPTER IV

PRODUCT

The United States Office of Juvenile Justice and Delinquency Prevention (OJJDP) (2003), an office of the United States Department of Justice, conducted a survey in order to assess the characteristics and backgrounds of youth in the juvenile justice system. In 2003, there were 101,040 youth that were placed in various residential facilities due to an encounter with the justice system (Sedlak & Bruce, 2010; OJJDP, 2003). Eighty-five percent of these youth had prior convictions with 10 percent having been in prior custody, probation, or parole, and only 5 percent reporting no prior involvement in the juvenile justice system (Sedlak & Bruce, 2010; OJJDP, 2003). With 95 percent of youth having more than one encounter with the juvenile justice system, there is a need to address the skills and abilities required for youth to successfully reintegrate into their communities in hope of preventing recidivism. The costs associated with juvenile justice system will continue to increase with the high rate of recidivism for the youth. *The Survey of Youth in Residential Placement* (Snyder & Sickmund, 2006; OJJDP, 2003) found that many of the youth within the juvenile justice system have had more than one committed stay, with 62% claiming that they had at least one prior commitment. Due to the large number of youth that re-enter the juvenile justice system, Snyder and Sickmund (2006) and OJJDP (2003) state that there is a need for extensive supervision as well as continued services in order to achieve successful community reintegration.

An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare is based on the understanding that once the youth has completed their residential care placement, the youth must transition back to their community. For the transition back into the community, or community reintegration, youth need to have services pre and post discharge from residential facilities to be successful (Altschuler & Brash, 2004). The skills needed to be successful in community reintegration include the occupational areas of education, leisure, social participation with family and peers, work, and the instrumental daily activity of health management and maintenance (Bream, 2013; Eggers, Munoz, Sciulli, & Hickerson Crist, 2006; Gibson, D'Amico, Jaffe, & Arbesman, 2011; Knis-Matthews, Richards, Marquez, & Mevawala, 2005; Lopez, 2013; McCamey, 2010; Unruh, Gau, & Waintrup, 2009; Zhang, Roberts, & Callanan, 2006). Without education and skill building in these areas, youth have difficulty with community reintegration. However, in order for successful community reintegration to occur, the needs of the youth must be understood.

Youth who are in residential treatment centers receive services while they are residents at the facility, but most often, these services do not incorporate the family in the process. The services are provided to the youth by social workers and counselors. Social workers and counselors work with the youth on skills during discussion based activities rather than providing them with the opportunity to put their skills to use in the natural environment. This leads to the problem in which the youth are not aware of how to use the skills they have learned during their residential placement when put into real-life situations. This often leads the youth to return to previous habits and many times, recidivism. The recidivism rate and the challenges of the youth suggest the need for

occupational therapy to be included in the treatment of the youth when transitioning into their natural context, returning to their occupational roles and participating in occupations as they occur on a daily basis.

A literature review was conducted and information on the population was obtained. The information obtained from the review of literature was organized using the Person Environment Occupation (PEO) model (Law et al., 1996). This model was chosen to organize the literature and guide the program development due to the unique way the model addresses the individual aspects of the person, the environment, and the occupations, and then incorporates how each of these aspects influence the individual's occupational performance through a transactive approach (Cole & Tufano, 2008). Findings from the literature review were organized into the categories of person, environment, and occupation. In the PEO model, person aspects include demographic information, mental health issues, experiences of trauma, and developmental risk factors. The environment component of the literature review describes the contexts in which the youth engages in different occupations including the home, community, school, and the treatment placement context. The occupation component includes information regarding the activities that the youth engages in on a regular basis. These occupations include substance use and abuse, education and schooling, as well as vocation and work. Through the use of the Person Environment Occupational model, a systematic analysis of the occupational performance issues was conducted. Areas of need were identified and interventions were created to improve occupational performance specific to community reintegration.

Based upon the methodology described above, a two part program for community reintegration was developed for youth in residential treatment centers, *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*. The occupation-based residential treatment portion of *An Occupation-Based Community Re-Integration Program* consists of five aspects: (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation. While in the residential treatment facility, the youth and occupational therapist will meet twice a week for eight weeks formally. There is a facilitation guide for each of the occupation-based groups, developed using Cole's Seven Steps (Cole, 2005) for group facilitation with supplies and handouts provided. In addition to these formal meetings, the youth will meet individually with the occupational therapist and community-based mentor three different times throughout the eight weeks of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services*. The occupation-based groups should occur following this order: (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation. In addition to the formal meetings, the youth will be engaging in occupations within the residential treatment facility on a daily basis and will be able to reflect on their progress through *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services*.

The second part of *An Occupation-Based Community Re-Integration Program* is the community-based aftercare services. Within this section of *An Occupation-Based Community Re-Integration Program*, the interdisciplinary team roles and responsibilities are defined regarding how to support the youth in their occupational performance and

functioning. The interdisciplinary team defines a schedule for the youth to follow within the community and defines a meeting schedule for the interdisciplinary team as the youth remains in the community. There are resources provided for the interdisciplinary team in regards to each area of occupation, (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation. The full product is presented in its entirety in the Appendix.

CHAPTER V

SUMMARY

Purpose

The focus of this project was on reducing recidivism for youth within the juvenile justice system. This program specifically targets youth in residential centers who are transitioning back into their community. Through the use of the Person Environment Occupation model (Law et al., 1996), a systematic analysis of the occupational performance issues was conducted. Areas of need for youth were identified through completion of the systematic analysis which guided the creation of interventions to improve the youth's occupational performance, specific to community social participation. Based upon the systematic analysis and identification of evidence-based intervention themes, *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* was developed. This program addresses the areas of need intended for use while the youth is in the residential treatment facility and as a guide for the community-based interdisciplinary team to utilize while the youth is functioning in the community. Between both programs, the areas of occupation addressed include: (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation. Within each area of occupation, phases build upon one another within the residential facility in order to facilitate successful performance in the area of occupation with the continuation of engagement in each area of occupation once in the community.

Strengths

An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare was developed for youth within the juvenile justice system to reduce recidivism through residential treatment care and aftercare in the community. This program has many strengths. *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* is a two part program which provides the youth with the occupational experiences within the residential facility and continued support and aftercare services to increase the success in occupational performance in the community. The development of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* is grounded in evidence and is based on the Person Environment Occupation model (Law et al., 1996) which is a strength of the program. Another strength of this program is that it builds upon the skills the youth are learning in a residential facility and puts the skills into occupational engagement and performance. Being able to modify and adapt the program to the needs of the individual youth to increase their success in occupational performance areas is also a strength of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*.

Limitations

An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare developed for youth within the juvenile justice system to reduce recidivism through residential treatment care and aftercare in the community also has several limitations. The first limitation is that the research grounded

in the domain of occupational therapy is limited. A barrier to implementation of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* is the aspect of funding. There is limited funding and resources available for the implementation of programs within residential treatment centers and for the dedication of the community-based interdisciplinary team to the care and success of the youth. Methods for funding to be explored include grant options and reimbursement opportunities. A third barrier to the implementation and success is that is it not guaranteed that residential treatment centers, Department of Human Services from different states, and the communities of the youth will support the implementation and follow through of this program. Another barrier is that the implementation of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* has not yet been researched; therefore, the effectiveness and validity of the program are yet to be determined. Follow-up with program leaders and members of the community-based interdisciplinary team and an analysis of participant outcomes will help determine the effectiveness and validity of the program.

Recommendations

As previously mentioned, the effectiveness and validity of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* has not been determined. Once the program has been initially implemented, the overall usefulness of this program will be measured. At the completion of the program, the rate of recidivism should be measured in order to evaluate the community reintegration success rate. Feedback from the youth, their family members, staff from the residential treatment center, and members of the interdisciplinary team will also

be used to address usefulness of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*.

With this being the first edition of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*, there is room for improvement and additions. Once *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* is implemented and research on occupational therapy programs within residential treatment center increases, additional deficits in occupational performance for this population may emerge. With these additional deficits in occupational performance, *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* can be modified and expanded to address the deficits as the literature advances. *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* also has the potential to be altered and expanded to meet the needs of additional populations involved in the justice system.

An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare can also be used to further the research on youth within the juvenile justice system, pertaining to their occupational needs. In the future, the effectiveness and validity of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* may be researched through scholarly collaboration. *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* has the potential to be published, presented, marketed, and distributed to residential treatment facilities

within North Dakota and other states who are working with the population of youth in the juvenile justice system.

References

Altschuler, D. M., & Brash, R. (2004). Adolescent and teenage offenders confronting the challenges and opportunities of reentry. *Youth Violence and Juvenile Justice*, *2*(1), 72-87. doi: 10.1177/1541204003260048

American Occupational Therapy Association. (2008a). *Transitions for children and youth: How occupational therapy can help*. Bethesda, MD: Author. Retrieved from: http://www.aota.org/~/media/Corporate/Files/AboutOT/Professionals/WhatIsOT/CY/Fact-Sheets/Transitions.ashx

American Occupational Therapy Association. (2008b).Occupational therapy practice framework: Domain and process (2nd ed.). *American Journal of Occupational Therapy*, *62*(6), 625–683. doi: 10.5014/ajot.62.6.625

Avery, R. J. (2011). The potential contribution of mentor programs to relational permanency for youth aging out of foster care. *Child Welfare*, *90*(3), 9-26.

Barnes, J., Miller, H., & Miller, J. (2009). Identifying leading characteristics associated with juvenile drug court admission and success: A research note. *Youth Violence and Juvenile Justice, 7*(4), 350-360. doi: 10.1177/1541204009334630

Bazyk, S., & Arbesman, M. (2013). *Occupational therapy practice guidelines for mental health promotion, prevention, and intervention for children and youth*. Bethesda, MD: American Occupational Therapy Association.

Blau, G. B., Caldwell, B., Fisher, S. K., Kuppinger, A., & Levison-Johnson, J. (2010). The building bridges initiative: Residential and community-based providers, families, and youth coming together to improve outcomes. *Child Welfare*, *89*(2), 21-38.

Bonham, E. (2006). Adolescent mental health and the juvenile justice system. *Pediatric Nursing, 32*(6), 591-595.

Bream, S. (2013). The history of occupational therapy in adolescent mental health practice. *OT Practice Magazine*, *18*(5), CE1-CE8.

Brown, C., & Dunn, W. (2002). *Adolescent/adult sensory profile user's manual.* San Antonio, TX: Psychological Corporation.

Brunner, J. (2012). Time well spent: Empowering communities to help at-risk youth engage in healthy occupations. *OT Practice Magazine, 17*(13), 10-13, 20.

Buu, A., DiPiazza, C., Wang, J., Puttler, L., Fitzgerald, H.E., & Zucker, R. (2009). Parent, family, and neighborhood effects on the development of child substance use and other psychopathology from preschool to the start of adulthood. *Journal of Studies on Alcohol and Drugs*, *70*(4), 489-498.

Carter, E. W., Lane, K. L., Pierson, M. R., & Glaeser, B. (2006). Self-determination skills and opportunities of transition-age youth with emotional disturbance and learning disabilities. *Exceptional Children, 72*(3)*,* 333-346.

Casey, K. J., Reid, R., Trout, A. L., Duppong Hurley, K., Chmelka, M. B., & Thompson, R. (2010). The transition status of youth departing residential care. *Child & Youth Care Forum 39*(5), 323-340. doi: 10.1007/s10566-010-9106-6

Chassin, L. (2008). Juvenile justice and substance use. *The Future of Children, 25*(2), 165-183. doi: 10.1353/foc.0.0017

Cole, M.B. (2005). Group leadership: Cole's seven steps. In M.B. Cole (eds), *Group dynamics in occupational therapy* (3rd ed.) (pp. 3-23). Thorofare, NJ: SLACK Incorporated.

Cole, M. B., & Tufano, R. (2008). The person-environment-occupation-performance model. In M. Cole & R. Tufano (Eds.), *Applied theories in occupational therapy: A practical approach* (pp. 127-134). Thorofare, NJ: SLACK Incorporated.

Dembo, R., Briones-Robinson, Barrett, K., Winters, K., Schmeidler, J., Ungaro, R.A., … Gulledge, L. (2011). Mental health, substance use, and delinquency among truant youth in a brief intervention project: A longitudinal study. *Journal of Emotional and Behavioral Disorders 21*(3), 176-192. doi: 10.1177/1063426611421006

Dmitrieva, J., Monahan, K. C., Cauffman, E., & Steinberg, L. (2012). Arrested development: The effects of incarceration on the development of psychosocial maturity. *Development and Psychopathology*, *24*, 1073-1090. doi: 10.1017/S0954579412000545

Dunn, L. & Thrall, L. (2012). Development of self-determination across childhood and adolescence. *Journal of Occupational Therapy, Schools, & Early Intervention, 5*(2), 165-181. doi: 10.1080/19411243.2012.701917

Eggers, M., Munoz, J. P., Sciulli, J., & Hickerson Crist, P. A. (2006). The community reintegration project: Occupational therapy at work in a county jail. *Occupational Therapy in Health Care*, *20*(1), 17-37. doi: 10.1300/J003v20n01_02

Farnworth, L. (2000). Time use and leisure occupations of young offenders. *American Journal of Occupational Therapy*, *54*(3), 315-325. doi: 10.5014/ajot.54.3.315

Fette, C.V. & Estes, R. I. (2009). Community participation needs of families with children with behavioral disorders: A systems approach. *Occupational Therapy in Mental Health, 25,* 44-61. doi: 10.1080/01642120802647584

Fink, D. (2013). Creating significant learning experiences: An integrated approach to designing college courses. San Francisco: Jossey-Bass.

Ford, J., Chapman, J., Connor, D., & Cruise, K (2012). Complex trauma and aggression in secure juvenile justice setting. *Criminal Justice and Behavior, 39*(6), 694-724. doi:10.1177/0093854812436957

Gogel, L. P., Cavaleri, M. A., Gardin II, J. G., & Wisdom, J. P. (2011). Retention and ongoing participation in residential substance abuse treatment: Perspectives from adolescents, parents and staff on the treatment process. *The Journal of Behavioral Health Services & Research*, *38*(4), 488-496. doi: 10.1007/s11414-010-9226-7

Goodkind, S., Shook, J., Kim, K., Pohlig, R., & Herring, D. (2013). From child welfare to juvenile justice: Race, gender, and system experiences. *Youth Violence and Juvenile Justice, 11*(3), 249-272. doi: 10.1177/1541204012463409

Gordon, D. M. (2009). The history of occupational therapy. In E. B. Crepeau, E. S. Cohn, & B. A. Boyt-Schell (Eds.), *Willard & spackman's occupational therapy* (11th ed.) (pp. 202-215). Baltimore, MD: Lippincott Williams & Wilkins.

Gibson, R., D'Amico, M., Jaffe, L., & Arbesman, M. (2011). Occupational therapy interventions for recovery in the areas of community integration and normative

life roles for adults with serious mental illness: A systematic review. *American Journal of Occupational Therapy, 65*(3), 247-256. doi: 10.5014/ajot.2011.001297

Grande, T. L., Hallman, J., Rutledge, B., Caldwell, K., Upton, B., Underwood, L. A., … Rehfuss, M. (2012). Examining mental health symptoms in male and female incarcerated juveniles. *Behavioral Sciences and the Law*, *30*(3), 365-369. doi: 10.1002/bsl.2011

Griffith, A. K., Ingram, S. D., Barth, R. P., Trout, A. L., Duppong Hurley, K., Thompson, R. W., & Epstein, M. H. (2009). The family characteristics of youth entering a residential care program. *Residential Treatment for Children and Youth, 26,* 135-150. doi: 10.1080/08865710902914283.

Harder, A., Knorth, E., & Kalverboer, M. (2011). Transition secured? A follow-up study of adolescents who left secure residential care. *Children and Youth Services Review, 33*(12)*,* 2482-2488. doi:10.1016/j.childyouth.2011.08.022

Harr, C., Horn-Johnson, T., Williams, N., Jones, M., & Riley, K. (2013). Personal trauma and risk behaviors among youth entering residential treatment. *Child and Adolescent Social Work Journal*. Advance online publication. doi: 10.1007/s10560-013-0297-1

Heidt, R. (n.d.). *North dakota department of public instruction: Compulsory attendance/truancy*. Retrieved from http://www.dpi.state.nd.us/health/factsheets/truancy.pdf

Holden, M. J., Izzo, C., Nunno, M., Smith, E. G., Endres, T., Holden, J.C., & Kuhn, F. (2010). Children and residential experiences: A comprehensive

strategy for implementing a research-informed program model for residential care. *Child Welfare 89*(2), 131-149.

Huscroft-D'Angelo, J., Trout, A., Epstein, M., Duppong-Hurley, K., & Thompson, R. (2013). Gender differences in perceptions of aftercare supports and services. *Children and Youth Services Review, 35*(5), 916-922. doi: 10.1016/j.childyouth.2013.01.024

Knis-Matthews, L., Richard, L., Marquez, L., & Mevawala, N. (2005). Implementation of occupational therapy services for an adolescent residence program. *Occupational Therapy in Mental Health, 21*(1), 57-72. doi: 10.1300/J004v21n01_04

Koome, F., Hocking, C., & Sutton, D. (2012). Why routines matter: The nature and meaning of family routines in the context of adolescent mental illness. *Journal of Occupational Science*, *19*(4), 312-325. doi: 10.1080/14427591.2012.718245

Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The person-environment-occupation model: A transactive approach to occupational performance. *The Canadian Journal of Occupational Therapy, 63*(1), 9-23.

Lee, J. (2013). *Testimony before the human service committee*. Retrieved from: http://www.nd.gov/dhs/info/testimony/2013/senate-human-services/sb2068-1-14-13-bed-conversion.pdf

Longshore, D., Ellickson, P. L., McCaffrey, D. F., & St. Clair, P. A. (2007). School-based drug prevention among at-risk adolescents: Effects of alert plus. *Health Education & Behavior*, *34*(4), 651-668. doi: 10.1177/1090198106294895

Lopez, A. (2013). PAR FORE: Promoting success through healthy occupations. Unpublished raw data. Retrieved from http://www.parfore.org/

McCamey, J. D. (2010). Reducing recidivism in adolescent sexual offenders by focusing on community reintegration. *Residential Treatment for Children & Youth*, *27*, 55-67. doi: 10.1080/08865710903536291

McCurdy, B. L., & McIntyre, E. K. (2004). 'And what about residential…?' Re-conceptualizing residential treatment as a stop-gap service for youth with emotional and behavioral disorders. *Behavioral Interventions, 19*(3), 137-158. doi: 10.1002/bin.151

Mosey, A. C. (1996). *Applied scientific inquiry in the health professions: An epistemological orientation* (2nd ed.). Bethesda, MD: American Occupational Therapy Association.

National Institute on Drug Abuse, (2012). *Drugfacts: High school and youth trends*. Retrieved from website: http://www.drugabuse.gov/publications/drugfacts/high-school-youth-trends

Nickerson, A. B., Colby, S. A., Brooks, J. L., Rickert, J. M., & Salamone, F. J. (2007). Transitioning youth from residential treatment to the community: A preliminary investigation. *Child Youth Care Forum*, *36*, 73-86. doi: 10.1007/s10566-007-9032-4

Nickerson, A. B., Salamone, F. J., Brooks, J. L., & Colby, S. A. (2004). Promising approaches to engaging families and building strengths in residential treatment. *Residential Treatment for Children & Youth*, *22*(1), 1-18. doi: 10.1300/J007v22n01_01

North Dakota Department of Human Services. (2013, January 01). *North Dakota foster care resource directory*. Retrieved from http://www.nd.gov/dhs/info/pubs/docs/cfs/cfs-directory-of-rccf-prtf-lcpa.pdf

Piquero, A. R. & Steinberg, L. (2010). Public preferences for rehabilitation versus incarceration for juvenile offenders. *Journal of Criminal Justice*, *38*, 1-6. doi: 10.1016/j.jcrimjus.2009.11.001

Price, C. S. (2005). *Testimony before the House Human Service Committee*. Retrieved from website: http://www.nd.gov/dhs/info/testimony/2005/house-human-services/hb1110-2005-01-07.html

Puzzanchera, C., Sladky, A., & Kang, W. (2013). *Easy Access to Juvenile Populations: 1990-2012.* National Center for Juvenile Justice. Retrieved from: http://www.ojjdp.gov/ojstatbb/ezapop/

Ryan, J. P., David, R. K., & Yang, H. (2001). Reintegration services and the likelihood of adult imprisonment: A longitudinal study of adjudicated delinquents. *Research on Social Work Practice*, *11*(3), 321-337. doi: 10.1177/104973150101100303

Sedlak, A., & Bruce, C. (December, 2010). Youth’s characteristics and backgrounds. *Juvenile Justice Bulletin,* 1-12.

Shea, C., & Wu, R. (2013). Finding the key: Sensory profiles of youths involved in the justice system. *OT Practice Magazine, 18*(18), 9-13. doi: 10.7138/otp.2013.1818f1

Shufelt, J. L., & Cocozza, J. J. (2006, June). *Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study*. Retrieved from http://www.ncmhjj.com/pdfs/publications/PrevalenceRPB.pdf

Snyder, H. (2004). An empirical portrait of the youth reentry population. *Youth Violence and Juvenile Justice, 2*(1), 39-55. doi: 10.1177/1541204003260046

Snyder, H. N., & Sickmund, M. (2006). Juvenile offenders and victims: 2006.Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Stoffel, V. C., & Moyers, P. A. (2004). An evidence-based and occupational perspective of interventions for persons with substance-use disorders. *American Journal of Occupational Therapy, 58*(5), 570-586. doi: 10.5014/ajot.58.5.570

Taylor, R. (2008). *The intentional relationship: Occupational therapy and use of self*. Philadelphia, PA: F.A. Davis Company.

Taylor, S., & Mudford, O. (2012). Improving behavior in a residential service for youth in drug and alcohol rehabilitation. *Behavioral Intervention, 27*, 109-128. doi: 10.1002/bim.1342

Trupin, E. J., Kerns, S. E., Walker, S. C., DeRobertis, M. T., & Stewart, D. G. (2011). Family integrated transitions: A promising program for juvenile offenders with co-occurring disorders. *Journal of Child & Adolescent Substance Abuse*, *20*(5), 421-436. doi: 10.1080/1067828X.2011.614889

Unruh, D. K., Gau, J. M., & Waintrup, M. G. (2009). An exploration of factors reducing recidivism rates of formerly incarcerated youth with disabilities participating in re-entry intervention. *Journal of Child and Family Studies 18*, 284-293. doi: 10.1007/s10826.008.9228.8

U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. (2003). *The survey of youth in residential placement.*

Wells, J., Minor, K., Angel, E., & Stearman, K. (2006). A quasi-experimental evaluation of a shock incarceration and aftercare program for juvenile offenders. *Youth Violence and Juvenile Justice, 4*(3), 219-233. doi: 10.1177/1541204006290153

Wooditch, A., Lawton, B., & Taxman, F. (2013). The geography of drug abuse epidemiology among probationers in Baltimore. *Journal of Drug Issues, 43*(2); 231-249. doi: 10.1177/0022042612470643

Youngblade, L. M., Theokas, C., Schulenberg, J., Curry, L., & Huang, I. (2007). Risk and promotive factors in families, schools, and communities: A contextual model of positive youth development in adolescence. *Pediatrics, 119,* S47-53. doi: 10.1542/peds.2006-2089H

Zhang, D., Katsiyannis, A., Barrett, D. E., & Willson, V. (2007). Truancy offenders in the juvenile justice system: Examinations of first and second referrals. *Remedial and Special Education*, *28*(4), 244-56. doi: 10.1177/07419325070280040401

Zhang, S. X., Roberts, E. L. R, & Callanan, V. J. (2006). Preventing parolees from returning to prison through community-based reintegration. *Crime & Delinquency 52*(4), 551-571. doi: 10.1177/001112870528259

APPENDIX

An Occupation-Based Community Re-Integration Program:

Residential Occupational Therapy Services and Aftercare

By: Alexandra Berdal, MOTS, Megan Meyer, MOTS, Nicolet Sadlowsky, MOTS,
& Sarah Nielsen, PhD, OTR/L, Advisor

Copyright 2013 Alexandra Berdal, Megan Meyer, Nicolet Sadlowsky, & Sarah K. Nielsen

Table of Contents

Introduction....3

Problem Development Process....5

Table 1: Systematic Analysis....7

How to Use the Program....11

Figure 1: Program Outcomes....15

Evaluation and Assessment....16

Table 2: Recommended Evaluations....17

Occupation-Based Residential Treatment....19

- Vocation....21
- Leisure....35
- Education....40
- Health Management and Maintenance....46
- Social Participation....53

Community-Based Aftercare....59

- Vocation....71
- Leisure....72
- Education....73
- Health Management and Maintenance....75
- Social Participation....77

References....78

Introduction

The United States Office of Juvenile Justice and Delinquency Prevention (OJJDP) (2003), an office of the United States Department of Justice, conducted a survey in order to assess the characteristics and backgrounds of youth in the juvenile justice system. In 2003, there were 101,040 youth that were placed in various residential facilities due to an encounter with the justice system (Sedlak & Bruce, 2010; OJJDP, 2003). Eighty-five percent of these youth had prior convictions with 10 percent having been in prior custody, probation, or parole, and only 5 percent stating no prior involvement in the juvenile justice system (Sedlak & Bruce, 2010; OJJDP, 2003). With 95 percent of youth in the juvenile justice system having had prior involvement with the juvenile justice system, there is a need to address the skills and abilities required for youth to successfully reintegrate into their communities in hope of preventing recidivism. The costs associated with juvenile justice system will continue to increase with the high rate of recidivism for the youth. *The Survey of Youth in Residential Placement* from 2003 (Snyder & Sickmund, 2006; OJJDP, 2003) found that many of the youth within the juvenile justice system have had more than one committed stay with 62% claiming that they had at least one prior commitment. Due to the large number of youth that re-enter the juvenile justice system, Snyder and Sickmund (2006) and OJJDP (2003) state that there is a need for extensive supervision as well as continued services in order to achieve successful community reintegration.

Youth within the juvenile justice system can be characterized based on developmental stages, gender, age, race, mental health diagnoses, and by traumatic experiences. The time of youth is associated with normal physical and internal changes that humans go through. These changes include puberty, relationships with peers, development of morals, and cognitive functioning, all of which can play a factor in a youth's delinquent behavior trends (Bonham, 2006). Male youth, regardless of race, accounted for 52% of the population in the juvenile justice system in 2012 for youth ranging from 13-17 years of age (Puzzachera, Sladky, & Kang, 2013). Youth males that identify their race as non-Hispanic white or non-Hispanic African American have a higher percent of interactions with the juvenile system. However, male or female youth that identified their race as white were almost four times the amount of youth that

identified as African American (Puzzachera et al., 2013).   In regards to youth having mental health issues on top of delinquent behaviors, it has been found that as high as 65-75% of all youth within the juvenile justice system, regardless of intervention/setting, have been diagnosed with a minimum of one mental health diagnosis (Shufelt & Cocozza, 2006; Snyder, 2004). The most common diagnoses were mood disorders, anxiety disorders, disruptive disorders, and substance related diagnoses (Shufelt & Cocozza, 2006).   Not only do youth experience mental health diagnoses, many have been exposed to trauma within their life. Harr, Horn-Johnson, Williams, Jones, and Riley (2013) reviewed 457 charts from a youth residential treatment center, where only 18 of them having not experienced any reported trauma. This indicates that the majority of youth entering a residential facility have experienced trauma of some sort. Ford, Chapman, Connor, and Wisdom (2012) suggested that the experience of trauma may potentially lead to delinquent behaviors, such as aggression, lack of impulse control, lack of arousal control, and inability to self-regulate.

An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare is based on the understanding that once youth have completed their residential care placement, the youth must transition back to their community. For the transition back into the community, or community reintegration, youth need to have services pre and post discharge from residential facilities to be successful (Altschuler & Brash, 2004). The skills needed to be successful in community reintegration include the occupational areas of education, leisure, social participation with family and peers, work, and the instrumental daily activity of health management and maintenance (Bream, 2013; Eggers, Munoz, Sciulli, & Hickerson Crist, 2006; Gibson, D'Amico, Jaffe, & Arbesman, 2011; Knis-Matthews, Richards, Marquez, & Mevawala, 2005; Lopez, 2013; McCamey, 2010; Unruh, Gau, & Waintrup, 2009; Zhang, Roberts, & Callanan, 2006). Without education and skill building in these areas, youth have difficulty with community reintegration. However, in order for successful community reintegration to occur, the needs of the youth must be understood.

Youth who are in residential treatment centers receive services while they are residents at the facility, but most often, do not incorporate the family in the process. The services are provided to the youth by social workers and counselors. Social workers and

counselors work with the youth on skills during discussion based activities rather than providing them with the opportunity to put their skills to use in the natural environment. This leads to the problem in which the youth are not aware of how to use the skills they have learned during their residential placement when put into real-life situations, which tends to get them back into trouble, leading to recidivism. The recidivism rate and the challenges that the youth have suggest the need for occupational therapy to be included in the treatment of the youth when transitioning into their natural context, returning to their occupational roles and participating in occupations as they occur on a daily basis.

Program Development Process

The Person Environment Occupation (PEO) model was used to guide program development (Law et al., 1996). This model informed the literature review and guided program development due to the unique way the model addresses the individual aspects of the person, the environment, and the occupations, and then incorporates how each of these aspects influence the individual's occupational performance (Cole & Tufano, 2008). Findings from the literature review conducted by Berdal, Meyer, and Sadlowsky (2013) were organized into the categories of person, environment, and occupation. In the PEO model, person aspects include demographic information, mental health issues, experiences of trauma, and developmental risk factors. The environment component of the literature review describes the contexts in which the youth engages in different occupations including the home, community, school, and the treatment placement context. The occupation component includes information regarding the activities that the youth engages in on a regular basis. These occupations include substance use and abuse, education and schooling, and vocation and work.

Once the information was obtained and organized, areas and patterns of deficits for these youth came to the surface. Through a systematic analysis of the occupational performance issues, as shown in Table 1, areas of need were identified using the PEO model. Initially each component, the person, environment, and occupational demands, were assessed individually. Then, the transactions between the person and the occupation, the occupation and the environment, and the person and the environment were assessed. From this systematic analysis and the literature, aspects of intervention

were identified to improve the occupational performance of community social participation for youth transitioning from residential to community settings.

There was limited research based on the intervention aspects of occupational therapy within residential treatment centers. This lead to having aspects of interventions that have been used when working with at-risk youth, criminals, and those with substance abuse issues included. These intervention components were researched and identified through the literature review process. In order to develop the programming for within residential treatment center and for the community-based services, these intervention aspects were utilized.

An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare was developed using a backwards design approach (Fink, 2013). We began by addressing what we anticipated as the overall outcomes of providing services to these at-risk youth within residential treatment centers through their transition into their natural context. With those outcomes, we identified the objectives, activities, and outcomes for the community-based services with the occupational therapist playing a consultation role with the interdisciplinary treatment team. From there, we identified the objectives, activities, and outcomes for the program within the residential treatment center by an occupational therapist. The activities were put together within a manual following Cole's Seven Steps (Cole, 2005) for the group sessions and other aspects of the manual being created based on phases and aspects that are important for occupational performance.

Table 1
Systematic analysis of occupational performance of community social participation

<table>
<tr><td colspan="3">Occupational Performance Issue

Community Social Participation for Individuals Transitioning from Residential to Community Settings: The occupational performance issue is community social participation secondary to difficulty with self-regulation, social skills, communication, and relationship building.</td></tr>
<tr><td colspan="3">Assessment of Main Components</td></tr>
<tr><td><u>Person</u>
Demographics
• Males account for up 50-88% of those within the juvenile justice system (Snyder, 2004; Goodkind, Shook, Kim, Pohlig, & Herring, 2013)
• Cultural identity of White, non-Hispanic accounts for almost four times the amount of those who identified as African American (Puzzachera, Sladky, & Kang, 2013)
Mental Health Conditions
• 60-75% of youth in juvenile justice system have a mental health diagnosis (Shufelt & Cocozza, 2006; Snyder, 2004)
• Females have a significantly higher rate of mental health diagnosis (Grande et al., 2012; Shufelt & Cocozza, 2006)
Trauma
• 25-75% youth have experienced at least one traumatic event in their life (Ford et al., 2012)
• Traumatic experiences have been linked to decreased biopsychosocial development (Ford et al., 2012)
• Youth have difficulty building peer relationships and trusting adults (Ford et al., 2012)</td><td><u>Environment</u>
Home
• Youth's parental and familial issues include substance abuse, improper discipline, abandonment, neglect, unemployment, and isolation (Griffith et al., 2009; Nickerson, Colby, Brooks, Rickert, & Salamone, 2007)
• Youth are often not living with their biological parents (Griffith et al., 2009; Nickerson et al., 2007)
Community
• Neighborhood characteristics have a greater influence on the outcome of youth substance use and psychiatric symptomology than family characteristics (Buu, DiPiazza, Wang, Puttler, Fitzgerald, & Zucker, 2009)
• Safe and connected neighborhoods promote good behavior, social capabilities, and health (Youngblade. Theokas, Schulenberg, Curry, & Huang, 2007)
• Peers are influential of negative</td><td><u>Occupational Demands</u>
Analysis of community social participation
• Self-regulation of emotions
• Appropriate social skills
• Ability to express emotions appropriately
• Building and retaining of interpersonal relationships
• Ability to be involved in organizational activities
• Abstinence of illegal drug and alcohol use
• Avoidance of criminal behaviors
• Following social norms of the community and society
• Ability to express verbally and nonverbally
• Ability to read others' verbal and nonverbal communication</td></tr>
</table>

<table>
<tr>
<td>Developmental Risk Factors
• Youth in an out of home placement are at an increased risk of involvement with the juvenile justice system (Goodkind et al., 2013).
• Youth is a period of hormonal and physical changes (Bonham, 2006)
• Secure confinement effects a youth's normal maturation and development (Dmitrieva, Monahan, Cauffman, & Steinberg, 2012)
Substance Use
• 56% of youth males and 40% of youth females within the juvenile justice system tested positive for drug use (Chassin, 2008)
Education
• Up to 25% of juvenile delinquents have learning disabilities (Altschuler & Brash, 2004)
• Truancy behaviors are a common problem with youth in the juvenile justice system (Zhang, Katsiyannis, Barrett, & Willson, 2007)
Work and Vocation
• Delinquent history affects job opportunities for youth and young adults (Farnworth, 2000)</td>
<td>behaviors and choices of youth (Altschuler & Brash, 2004; Casey et al., 2010)
School
• Youth often do not complete high school or pursue higher education options (Casey et al., 2010)
• Due to zero tolerance policies, youth in the juvenile justice system have difficulty re-entering school (Altschuler & Brash, 2004)
Placement
• Youth single out family as being their first priority (Knis-Matthews et al., 2005; Nickerson et al., 2007)</td>
<td></td>
</tr>
<tr>
<td colspan="3">Assessment of PEO Transactions</td>
</tr>
<tr>
<td>Person – Occupation</td>
<td>Occupation – Environment</td>
<td>Person – Environment</td>
</tr>
<tr>
<td>• Low self-determination limiting occupational performance in education and vocational tasks
• Learning disabilities inhibiting successful education
• Routines support occupational engagement
• Anxiety in social participation and</td>
<td>• Neighborhood influence on substance use
• Limited community resources available to aid in successful community reintegration
• At risk behaviors influenced by unsupportive home and community environments</td>
<td>• At-risk behaviors are influenced by negative home environment, including physical, emotional, or sexual abuse
• Environment influences externalizing behaviors of the adolescent
• Home environment influences personal values and beliefs
• Familial environment influences rate of</td>
</tr>
</table>

<table>
<tr><td>interpersonal relationships
• Restricted interests and occupational participation may negatively influence community social participation</td><td>• Zero tolerance policy leading to educational deficits
• Peer relations influence engagement in occupation</td><td>becoming involved in the justice system
• Difficulties adhering to social norms within community, school, and home environment</td></tr>
<tr><td colspan="3">Intervention/Strategies to Improve Occupational Performance</td></tr>
<tr><td colspan="3">• Interventions will be occupation-based addressing different areas of occupation. These areas of occupation include instrumental activities of daily living (IADLs), education, work, social participation with family and peers, and leisure (Bream, 2013; Eggers, Munoz, Sciulli, & Hickerson Crist, 2006; Gibson et al., 2011; Knis-Matthews et al., 2005; Lopez, 2013; McCamey, 2010; Unruh et al., 2009; Zhang et al., 2006).
• Engagement in occupations will be increased through skill building.
  • Social Skills (AOTA, 2008a; Bazyk & Arbesman, 2013; Knis-Matthews et al., 2005; Longshore, Ellickson, McCaffrey, & St. Clair, 2007: McCamey, 2010; Unruh et al., 2009)
  • Coping Skills (Longshore et al., 2007; Stoffel & Moyers, 2004)
  • Self-determination and Assertiveness (Carter, Lane, Pierson, & Glaeser, 2006; Dunn & Thrall, 2012; Holden et al., 2010)
  • Self-Esteem Building (Holden et al., 2010; Knis-Matthews et al., 2005; Lopez, 2013; Nickerson, Salamone, Brooks, & Colby, 2004; Stoffel & Moyers, 2004; Unruh et al., 2009)
  • Time Management (Lopez, 2013)
  • Vocational Skills
• The building and maintenance of a mentoring relationship will be utilized during the transition process from the residential treatment center to the youth’s natural environment (Bazyk & Arbesman, 2013; Eggers et al., 2006; Huscroft-D’Angelo, Trout Epstein, Duppong-Hurley, & Thompson, 2012; Lopez, 2013; McCamey, 2010; Nickerson et al., 2007; Taylor & Mudford, 2012; Unruh et al., 2009; Wells, Minor, Angel, & Stearman, 2006; Zhang et al., 2006).
• Community involvement for at-risk youth to promote positive behaviors and avoid negative activities such as drugs and gang activity (Blau, Caldwell, Fisher, Kuppinger, & Levison-Johnson, 2010; Brunner, 2012).
• Family will be involved through the whole treatment process (Bazyk & Arbesman, 2013; Blau et al., 2010; Griffith et al., 2009; Holden et al., 2009; Knis-Matthews et al., 2005; Nickerson et al., 2007; Nickerson et al., 2004; Trupin, Kerns, Walker, DeRobertis, & Stewart, 2011). Family involvement throughout treatment as well as having a safe, positive post-discharge environment supports treatment success (Blau et al., 2010; Fette & Estes, 2009; Knis-Matthews et al., 2005; Trupin et al., 2011). Family routine is a source of well-being, structure and support (Koome, Hocking, & Sutton, 2012). Family involvement promotes social competence, self-esteem, positive academic participation, as well as decreased</td></tr>
</table>

internalizing and externalizing behaviors (Youngblade et al., 2007).

- Parents want programs that promote the well-being of youth with mental illness (Fette & Estes, 2009).
- Parent training and education helps parents build positive relationships with their youth and promote a better transition into their natural environment (McCurdy & McIntyre, 2007; Trupin et al., 2011)
- Collaboration and consistency between residential treatment staff and community-based treatment staff promotes successful transition back into the community (Blau et al., 2010)
- Aftercare services provide continued support from a systems approach for the transition process and to reduce recidivism (Eggers et al., 2006; Huscroft-D'Angelo et al., 2012; McCamey, 2010; Nickerson et al., 2007; Taylor & Mudford, 2012; Unruh et al., 2009; Wells et al., 2006; Zhang et al., 2006)

Note. Adapted from "Systematic analysis of occupational performance of dating," by S. Strong & K. R. Gruhl (2011), Person-Environment-Occupation model. In C. Brown & V. C. Stoffel (Eds.), *Occupational therapy in mental health: A vision for participation* (31-46). Philadelphia: F. A. Davis Company.

How to Use the Program

In order to successfully use the manual and implement *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*, it is essential that all involved understand the principles of the program. The principles of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* have been identified through an extensive review of the literature and a systematic analysis of occupational performance to identify the needs of this population. *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* principles include:

- **Self-Determination**: Self-determination includes choice-making, decision-making, problem-solving, goal setting, and self-advocacy (Dunn & Thrall, 2013). Typically, prior to entering residential care, youth did not successfully manage themselves. While in residential care, the schedule and rules of facilities generally limit opportunities for self-determination, a requirement for successful community reintegration. It is essential for this program to address the youth's self-determination prior to returning to the community. By having self-determination, the youth will be able to schedule their time in their community, balance their participation in occupations, and engage in healthy occupations for successful community reintegration.
- **Meaningful Occupations**: For the youth, the occupations in which they engage in on a regular basis are their meaningful occupations. These also provide the youth with the ability to continue in their development from being a youth to being a young adult and community member. Often times residential care focuses on skill building, a necessary component of preparing the youth for return to the community, however *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* places emphasis on using occupational participation.
- **Interdisciplinary Team**: In the residential setting, the interdisciplinary team coordinates the services within the facility and collaborates with

members of the community-based interdisciplinary team for continuation of services. The community-based interdisciplinary team collaborates with the youth to aid in use of skills gained in residential setting to the community environment. The interdisciplinary team consists of those individuals within the community who will be providing support to the youth in order to have continued success following discharge from the residential facility. The interdisciplinary team will include the youth, the youth's family, the youth's case manager, an occupational therapist, a community-based mentor, and a representative from the youth's school, a teacher or the principal.

- **Mentor**: An individual that guides the youth's transition into the community by providing support in emotional and behavioral functioning, psychological and physical health, academic success, employment and career pursuits, as well as evasion of risk-taking behaviors (Avery, 2011). The mentor aids the youth in connecting components of the residential services to the community environment. A mentor may be selected through the Department of Juvenile Services, case management, Guardian Ad Litem, or be a reliable family member.

In North Dakota, residential facilities often offer coping and social skills groups. The purpose of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* is not to duplicate the learning of these skills, but rather provide the youth with the opportunity for application as they prepare for transition into the community. If these skills have not been addressed prior to *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*, it will need to be adapted appropriately to prepare the youth. *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* will be occupation-based in nature and provide the youth with occupational experiences to increase their success in meaningful occupation within their natural community. The areas of occupation that are addressed throughout *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* include: (a) vocation, (b) leisure, (c)

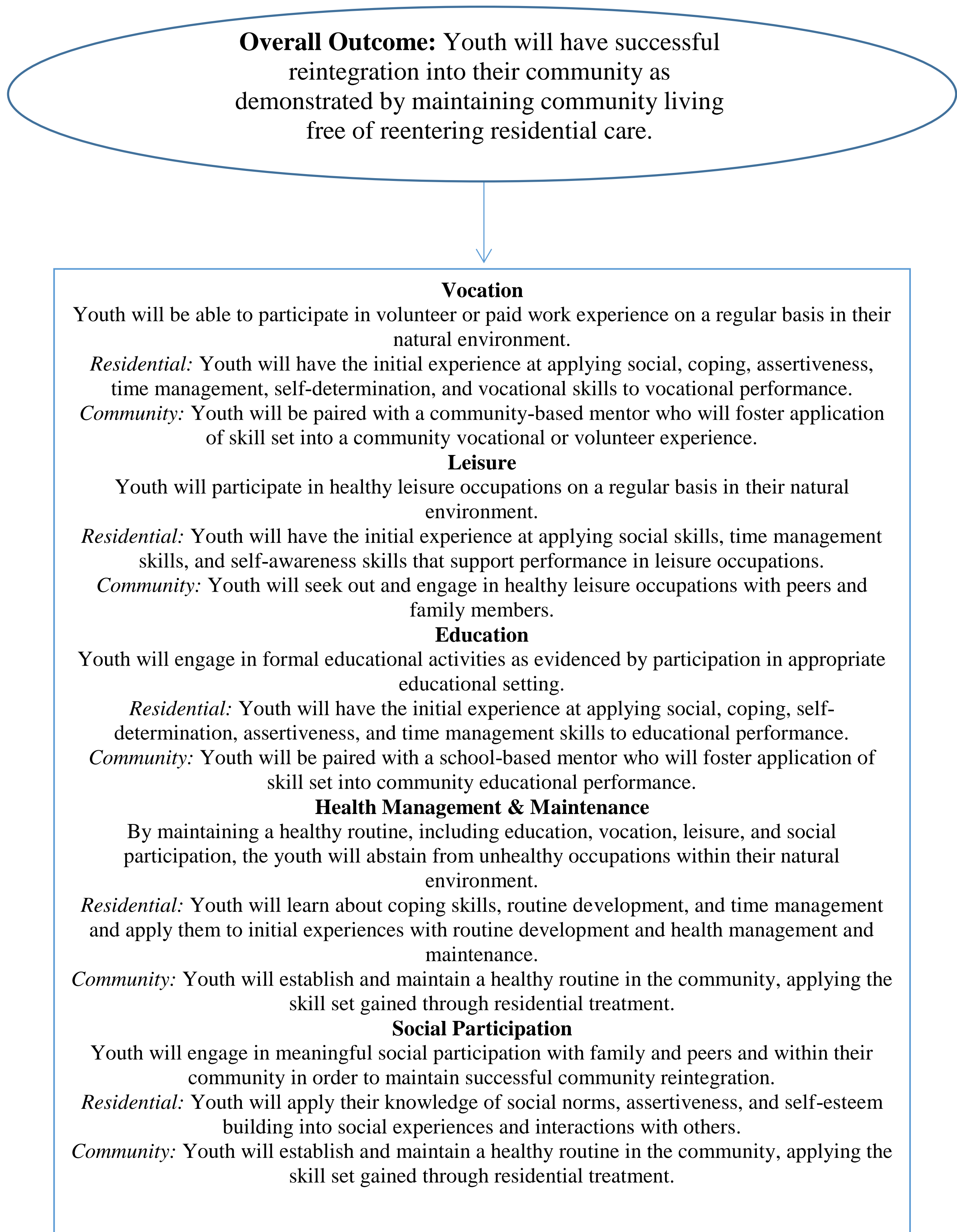
education, (d) health management and maintenance, and (e) social participation. For vocation, this program will address the youth's ability to gain and maintain employment or volunteer experiences while at the residential facility and transfer these skills into vocation experiences in the community. For leisure, this transition program will focus on the youth's ability to seek and engage in leisure opportunities within the residential facility and build upon these skills for leisure in their natural community environment. For education, this program will address the youth's ability to engage in education while at the residential facility and transition smoothly back into their educational setting within their community or higher education. For health management and maintenance, this transition program will focus on the youth's ability to manage and maintain their health through development of routines while in the residential treatment facility and how the youth is able to transfer these skills into their natural environment, managing and balancing their occupational tasks. For social participation, this transition program will focus on the youth's ability to engage in social interactions within the residential facility and the youth's ability to transfer these skills into their meaningful relationships within the community.

This manual is comprised of an integrated residential and community-based transition program. As this program is a pilot, it is suggested to have 6-8 youth participate in this program. The occupation-based residential treatment portion of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* consists of five aspects: (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation. While in the residential treatment facility, *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* members will meet twice a week for eight weeks formally, once to address application of skills into occupation-based activity and once for a weekly reflection group. There is a facilitation guide for each of the occupation-based groups with supplies and handouts provided. In addition to these formal meetings, the youth will meet individually with the occupational therapist and community-based mentor throughout the eight weeks of the program. The occupation-based groups should occur following this order: (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation. In

addition to the formal meetings, the youth will be engaging in occupations within the residential treatment facility on a daily basis and will be able to reflect on their progress through the program.

Once a youth has been discharged from the residential treatment facility, the second part of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* begins the community-based aftercare services. Within the community-based aftercare services of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*, the interdisciplinary team roles and responsibilities are defined regarding how to support the youth in their occupational performance and functioning. The interdisciplinary team defines a schedule for the youth to follow within the community and defines a meeting schedule for the interdisciplinary team as the youth remains in the community. There are resources provided for the interdisciplinary team in regards to each area of occupation, (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation. It is suggested that the longevity of aftercare services should be provided for 12-24 months depending on the specific needs of the youth.

Figure 1:
Program Outcomes



Evaluation and Assessment

The occupational therapist will be responsible for completing the initial evaluation and assessment with the youth as they enter into *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*.

Assessment is the first step in *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare.* Please note that there is a lack of assessments available to use for this population. For each of the youth in the transition program, the Occupational Self Assessment (OSA) (Baron, Kielhofner, Iyenger, Goldhammer, & Wolenski, 2006) or the Child Occupational Self Assessment (COSA) (Keller, Kafkes, Basu, Federico, & Kielhofner, 2005) will be completed in collaboration with the occupational therapist and the youth. It will be up to the occupational therapist's discretion on which version, the OSA or COSA, is most appropriate. The OSA and the COSA provide the occupational therapist with the youth's perceptive of their occupational competence, how important it is to the youth to be successful in their occupational functioning, and how the environment impacts their occupational performance and possible adaptations to be made to the environment (Baron et al., 2006). The reason for choosing the OSA or the COSA for this program is due to the focus it places on the person's occupational performance and how the environment plays a role in the occupational performance, incorporating the transactive approach of the aspects from the PEO model. The OSA and the COSA also address self-determination, as an aspect of the person, which can be seen in statements such as "Accomplishing what I set out to do," "Working towards my goals," and "Identifying and solving problems" (Baron et al., 2006).

It is recommended that the occupational therapist conducts further evaluation and assessment tools in order to gain a better understanding of the youth's performance skills and client factors impacting their occupational performance. These tools will be based on the client's needs. Table 2 illustrates options for assessment; however, it is not an exhaustive list.

Table 2
Recommended Evaluation Tools

Assessment	Purpose	Authors
Activity Card Sort, 2nd Edition	The purpose is to measure the youth's participation and engagement in leisure, social participation, and instrumental activities of daily living occupations.	Baum and Edwards, 2008
Adolescent/Adult Sensory Profile	The purpose is to identify the youth's behavioral responses to sensory stimuli and experiences that occur within the youth's every day functioning	Brown and Dunn, 2002
Adolescent Leisure Interest Profile	The purpose is to identify the leisure occupations the youth is interested in and how often they engage in these occupations.	Henry, 2000
Assessment of Communication and Interaction Skills (ACIS)	The purpose is to observe and gather information on the individual's communication and interaction skills while engaged in occupational tasks with groups of other individuals	Forsyth, Salamy, Simon, and Kielhofner, 1998
Kohlman Evaluation of Living Skills (KELS)	The purpose is to measure an individual's ability to function and complete basic independent living skills and occupations.	Kohlman Thomson, 1992
Role Checklist	The purpose is for the individual to identify roles that they have taken on during their lifespan and then address how important these roles are to them	Oakley, 2006

An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare presents each aspect of the integrated residential and community-based transition program. For each aspect, an overview of the prerequisite skills that are necessary for the youth to have in order to be successful are provided. Within the residential treatment center and within the community, five areas of occupational performance will be addressed: (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation. At the residential treatment facility, each area of occupation is addressed through different phases, incorporating occupation-based experiences, self-determination, and self-reflection on progress and application into their own community after discharge. Within the community, the youth will engage in occupational performance in the natural environment. The youth will have the supports of their interdisciplinary team if problems or difficulties arise. The interdisciplinary team will be provided with resources in order to guide the youth through the transition for continued success in occupational performance.

An Occupation-Based Community Re-Integration Program:

Residential Occupational Therapy Services and Aftercare

Part I: Occupation-Based Residential Treatment

Once assessment is complete, the weekly groups may progress. Table 3 is a potential sequence for the progression of the occupation-based residential groups. In addition to these formal occupational therapy groups, there will one-on-one meetings between the occupational therapist and a youth. Within the proposed eight weeks of the occupation-based residential treatment, a youth should have at least three meetings with their selected mentor via video conference, phone call, or in person.

Table 3
Recommended Group Progression

Week	**Group 1**	**Group 2**
1	Vocational Skills	Vocational Interviewing Skills
2	Leisure Exploration	Weekly Reflection
3	Study Habits	Weekly Reflection
4	Establishing Routines	Weekly Reflection (Plan next session's outing)
5	Leisure Outing	Weekly Reflection
6	Family Meal Planning	Weekly Reflection (Plan next session's outing)
7	Community Outing	Weekly Reflection
8	Peer Party Planning	Reflection

Mentor meetings should occur week 2, 4, 7, or as appropriate. Family planning should occur one week prior to the youth's home visit.

Vocation

Prerequisites: coping skills, time management skills, social skills, and self-determination

Phase 1: Phase one includes two formal group sessions that address the prevocational process including how to seek employment, the development of a resume, completion of a job application, interview skills, and how to approach questions regarding criminal background. Please refer to Vocational Skills Group and Vocational Interviewing Skills Group for the facilitation guide for these group sessions.

Phase 2: The occupational therapist will facilitate the youth in applying for volunteer jobs within the residential facility. This phase requires that the residential treatment facility have vocational opportunities for the youth and that they commit to working with the youth on building their vocational skills. Please refer to Vocational Pursuit Report Card to provide feedback on the youth's pursuit of a vocational experience at the residential facility.

1) The youth will use the tools developed in phase 1, including completion of a job application, interview skills, and how to approach their criminal background in an interview
2) Call departments at the facility about volunteer opportunities
3) Complete interview for volunteer opportunity
4) Employer fills out report regarding youth's performance within the interview

Phase 3: The youth will begin their volunteer opportunity within the facility. Each week their employer will complete a report card that describes the youth's performance within their volunteer opportunity. Staff members will return the report card to the occupational therapist's mailbox. Please refer to Vocational Pursuit Weekly Report Card – Employee Form to provide feedback weekly on the youth's performance in vocational tasks.

Phase 4: The occupational therapist will be available to consult with the staff member regarding the youth's performance through an onsite shadow of the volunteer experience. Refer to on-site job analysis for guide to conduct job analysis.

Phase 5: The youth will bring problems that have occurred while on their job and problem solve with the occupational therapist and peers. This will occur during the weekly reflection group with the occupational therapist and the youth. Please refer to Vocational Pursuit Self Reflection for the youth to assess their strengths and areas of improvement.

Phase 1 of Vocation
Name of Group: VOCATIONAL SKILLS GROUP

Group Purpose and Objectives: The purpose of this session is to gain an understanding of vocational skills, including how to locate jobs available to them and how to complete a job application.

- The youth will be able to locate job listings through different resources.
- The youth will demonstrate the ability to thoroughly complete a job application.

Supplies/Materials:

- Whiteboard and markers
- Pens and pencils
- Facility specific job openings for the youth
- Blank job applications for facility specific jobs
- Newspaper, internet screen shots of job listings
- State law regarding work of youth
    - North Dakota Department of Labor and Human Rights. (2013). *Employment and age certificate-minors*. Retrieved from http://www.nd.gov/eforms/Doc/sfn04598.pdf

1) **Introduction:** The occupational therapist states, "Welcome to group, today we are going to address skills necessary for employment. These skills include locating job openings and completing a job application. The reason for addressing successful engagement in vocational interests while at the residential facility increases your likelihood of being successful in your community re-entry. It is known from the 2003 Survey of Youth in Residential Placement that there is a 62% chance of returning to a residential placement" (Snyder & Sickmund, 2006; OJJDP, 2003).
   Expectation of participation: The occupational therapist states, "All participants are expected to engage in group discussion and activities, actively listen when an individual is talking, and ask clarifying questions when they arise."
   Warm up: Occupational therapist poses the question, "What skills or abilities, aspects of a person do employees look for when hiring for an open position at their facility?" The occupational therapist will write down the responses from the youth on the whiteboard in the room.

2) **Activity:** The occupational therapist will discuss with the youth the different ways to locate job openings, including newspaper listings and postings on different internet websites. The occupational therapist will inform the youth that there are specific laws that refer to youth's age and the jobs in which they can performance for reference

when they return to their community. The occupational therapist will provide the youth with different job listings for jobs that they can apply for at the facility. The youth will pick one of the jobs that are of interest to them. Once the youth have each picked a job to apply for, the occupational therapist will provide them with blank job applications and ask them to fill them out completely. If the youth have questions while filling out the application, the occupational therapist will ask the other group members to discuss the answer to the question. Once the application is complete, the occupational therapist will look over the application to ensure completion and appropriateness of responses.

3) **Sharing:** The occupational therapist asks each of the youth, "What is the biggest take away message from today's session for you?"

4) **Processing:** The occupational therapist asks the youth, "Where can you locate possible job openings for yourself? What aspects of a person do employers look for when hiring an employee? If problems arise when filling out a job application, who or where can you go for help solving these problems?"

5) **Generalization:** The occupational therapist will summarize the main themes of the group and may ask for additional themes that the youth saw from the session.

6) **Application:** The occupational therapist asks each of the youth, "How will you use this information in your everyday life?"

7) **Summary:** The occupational therapist will lead the summary of this session. In the summary the therapist will:
   - Review how group members felt about the activity and what occurred.
   - Ask participants what they have learned.
   - Ask if there are any additional questions regarding today's session.
   - Inform participants about the upcoming group and ask if there are any questions.
   - Thank the youth for coming and participating in today's session.

Phase 1 of Vocation
Name of Group: VOCATIONAL INTERVIEWING SKILLS GROUP

Group Purpose and Objectives: The purpose of this group is for the youth to gain an understanding of appropriate interviewing skills and how to address their criminal history when gaining employment.

- The youth will demonstrate appropriate social skills and interactions during an interview.
- The youth will verbalize how they have grown from their criminal history through their treatment process.

Supplies/Materials:

- Tips for Interviewing handout for youth
- Role playing interview questions

1) **Introduction:** The occupational therapist states, "Welcome to group, today we are going to address interviewing skills necessary for employment. These skills include appropriate interviewing skills and how to address your criminal history when interviewing for a job."

    Expectation of participation: The occupational therapist states, "All participants are expected to engage in group discussion and activities, actively listen when an individual is talking, and ask clarifying questions when they arise."

    Warm up: The occupational therapist poses the question, "What type of questions have you been asked during interviews for employment?"

2) **Activity:** The occupational therapist will provide the youth with Tips for Interviewing handout and then go over the handout. The occupational therapist and other staff within the residential treatment center will then conduct short, mock interviews with each of the youth. Mock interview questions are provided, refer to Interview Question handout.

3) **Sharing:** The occupational therapist asks each of the youth, "What is the biggest take away message from today's group for you?"

4) **Processing:** The occupational therapist asks the youth, "What are some important tips for interviewing for employment? How will you address your criminal record when applying and interviewing for a job?"

5) **Generalization:** The occupational therapist will summarize the main themes of the group and may ask for additional themes that the youth saw from the group.

6) **Application:** The occupational therapist asks each of the youth, “How will you use this information in your everyday life?”

7) **Summary:** The occupational therapist will lead the summary of this group. In the summary, the therapist will:
   - Review how group members felt about the activity and what occurred.
   - Ask participants what they have learned.
   - Ask if there are any additional questions regarding today’s group.
   - Inform participants about the upcoming group and ask if there are any questions.
   - Thank participants for coming.

Tips for Interviewing

When interviewing for a job, there are importance aspects to consider:

Appearance:

- Bathe or shower prior to an interview
- Wear clothing that is clean and pressed
- Wear appropriate clothing and footwear
- Hair should be clean and combed, hands are clean, and fingernails are clean and clipped
- Brush your teeth (no gum)
- Avoid sent (cologne/perfume)
- Wear conservative makeup, accessories, and jewelry
- Wear matching socks/hosiery

Body Language:

- Smile
- Shake hands firmly
- Use good posture
- Show that you are listening (nod)
- Avoid negative messages (yawning)
- Be composed (no fidgeting)

Do:

- Focus on your skills
- Practice interviewing with others
- Arrive on time
- Learn about the company
- Do not memorize interview questions
- Maintain poise and self-control
- Indicate flexibility and readiness to learn
- Be optimistic in your attitude
- Answer honestly

DON'T:

- Speak with a muffled voice
- Arrive late
- Express ideas about compensation and hours early in the interview
- Stress your need for a job
- Display feelings of inferiority
- Discuss previous experiences that do not relate to job situations
- Be a "know it all"

(Adapted from: Workforce Solutions. (n.d.). *Interview checklist*. Retrieved from http://files.meetup.com/1520221/Interview checklist (impression).pdf)

Interview Questions

- Why do you feel you are the best candidate for this position?
- Do you have any experience in this type of position?
- How would you handle working with someone you don't particularly like?
- Why should I hire you?
- Describe your strongest professional skills and provide an example of when you demonstrated these skills.
- Have you ever been convicted of a felony? How have you grown from this experience? What aspects about you have changed since then?
- What is one word that best describes you?
- What is one word your teachers would say best describes you?
- What is one word your peers would say best describes you?
- What is your long-term career goal? How will this position help you reach your goals?

Phase 2 of Vocation
Title: VOCATIONAL PURSUIT REPORT CARD

Purpose: This report card is made for potential employers at the facility to fill out in regards to the youth's occupational performance in relation to the tasks needed to complete a vocational pursuit. The youth will identify a position within the facility that interests them and will use the skills from Phase 1 of Vocation in order to obtain the position. The youth should be given a letter grade for each task, as well as strengths and areas of improvement to expand upon in future vocational pursuits.

Task	Grade	Strengths	Areas of Improvement
Seeking vocational opportunities at the residential facility (e.g.- phone call, e-mail, in person)			
Application completion			
Interview			
Answering questions about criminal background			
Social skills (e.g.- verbal and non-verbal)			

Phase 3 of Vocation
Title: VOCATIONAL PURSUIT WEEKLY REPORT CARD – EMPLOYEE FORM

Purpose: This report card is for the employer to fill out each week on the youth to address things that are strengths and things that are areas of improvement in regards to his or her vocational pursuit. This report card should serve as a discussion guide between the employer and the youth in regards to occupational performance.

Week	Grade	Strengths	Areas of Improvement
1			
2			
3			
4			
5			
6			
7			
8			

Phase 4 of Vocation
Title: ON-SITE JOB ANALYSIS

Purpose: The purpose of the occupational therapist completing an on-site job analysis is to identify the problem areas for the youth performing job tasks and making recommendations for the youth and the supervisor of the youth to implement to increase the youth's vocational occupational performance. In order to complete the on-site job analysis, the supervisor will need to request the job analysis to the occupational therapist. Once the occupational therapist has received the request, the occupational therapist will schedule a time to complete the job analysis of the youth and the job. With the job analysis, the occupational therapist will identify the problem areas, take notes on their observation of the youth's performance, and provide recommendations.

Phase 4 of Vocation
Title: ON-SITE JOB ANALYSIS

Youth's Name:
Date of On-site Job Analysis:
Position at Facility:
Date of Request by Supervisor:

Problem Area:

Observation Notes:

Recommendations to Improve Occupational Performance:

____ ______________
Occupational Therapist's Signature Date

____ ______________
Youth's Signature Date

____ ______________
Youth's Vocational Supervisor's Signature Date

Phase 5 of Vocation
Name of Group: VOCATIONAL PURSUIT REFLECTION

Group Purpose and Objectives: The purpose of this group is to reflect on aspects of the vocational pursuit that were strengths, as well as areas that could be improved upon.

- The youth will understand their strengths and areas of improvement in relation to their vocational pursuit at the residential facility.
- The youth will identify ways in which they can improve their occupational performance in regards to vocational pursuit.
- The youth will identify a vocational opportunity within his or her discharge community and develop a plan to obtain employment or volunteer positions.

Supplies/Materials:

- Pens and pencils
- Vocational Pursuit Reflection Worksheets, the youth brings this with them

1) **Introduction:** The occupational therapist states, "Hello and welcome to occupational therapy group. Today we are going to reflect on the vocational pursuit process that we have been working on. We will want to reflect upon what went well and what each of us could improve upon. Additionally, we will address any further questions that you may have in regards to pursuing vocational opportunities in the future."

    Expectation of participation: The occupational therapist states, "All participants are expected to engage in group discussion and activities, actively listen when an individual is talking, and ask clarifying questions when they arise."

    Warm up: The occupational therapist poses the question, "What did each of you like or dislike about the process of having a vocational experience at this facility?"

2) **Activity:** The occupational therapist will provide the youth with the Vocational Pursuit Self-Reflection Worksheet. The youth will be instructed to fill out strengths and areas of improvement for each area of the worksheet if not already filled out. The occupational therapist will state that if anyone has questions to ask the occupational therapist or another member of the group. Once everyone has completed the worksheet, the group will come together for discussion.

3) **Sharing:** The occupational therapist will ask, "What was your biggest strength and areas of weakness and why?"

4) **Processing:** The occupational therapist will ask the youth, "How can you highlight your strengths when seeking vocational opportunities? How will you address yours areas of improvement? What do you feel you can bring to a workplace or volunteer site? How has this experience impacted you?"

5) **Generalization:** The occupational therapist will summarize the main themes of the group and may ask for additional themes that the youth saw from the session.

6) **Application:** They occupational therapist will ask the youth, “How will you use this information in your future vocational pursuit?”

7) **Summary:** The occupational therapist will lead the summary of this group. In the summary, the therapist will:
   - Review how group members felt about the activity and what occurred.
   - Ask participants what they have learned.
   - Ask if there are any additional questions regarding today’s session.
   - Inform participants about the upcoming group and ask if there are any questions.
   - Thank participants for coming.

Phase 5 of Vocation
Title: VOCATIONAL PURSUIT SELF REFLECTION

Purpose: This document should be filled out in whole as a reflection of your vocational experience. The areas of strength and areas of improvement will include vocational tasks at the facility. The youth should come prepared to the weekly self-reflection group with this worksheet. The youth may fill it out or be prepared to discuss the strengths and areas of improvement for their vocational tasks during the week.

Task	Strength	Area of Improvement
Interview process		
Vocational etiquette (e.g.- showing up on time, dressing appropriately)		
Social skills		
Job performance		

Task to Improve	Plan

Leisure

Prerequisites: social skills, assertiveness, time management, and self-determination

Phase 1: The occupational therapist will facilitate a group session that completes leisure exploration through the Activity Card Sort (Baum & Edwards, 2008) or Adolescent Leisure Interest Profile (Henry, 2000). Please refer to Leisure Exploration Group for the facilitation guide for this group session.

Phase 2: The youth will engage in a variety of community outings to complete leisure occupations or leisure occupations within the residential facility. To assist in the overlap of leisure pursuits within the community, the youth will be in charge of planning two of the leisure sessions. The occupational therapist will provide the youth with 3 choices at a time to choose from to plan their leisure pursuit session. Additionally, the occupational therapist will plan community outings for the youth to further pursue healthy leisure occupations. Please refer to Community Outing for the facilitation guide for the processing of the leisure experience for the youth.

Phase 1 of Leisure
Name of Group: LEISURE EXPLORATION GROUP

Group Purpose and Objectives: The purpose of this group is for the youth to explore leisure occupations that they would like to engage in.

- The youth will verbalize three leisure occupations to engage in.
- The youth will understand the importance of healthy leisure occupations within their balanced life.

Supplies/Materials:

- Activity Card Sort Assessment (Baum & Richards, 2008) or Adolescent Leisure Interest Profile (Henry, 2000)
- Paper
- Pens and pencils

1) **Introduction:** The occupational therapist states, "Welcome to group, today we are going to explore leisure opportunities and leisure opportunities within the community. The reason to address leisure is that when back in the community, having unstructured time in your day leads to an increased chance of returning into a residential treatment placement."
   Expectation of participation: The occupational therapist states, "All participants are expected to engage in group discussion and activities, actively listen when an individual is talking, and ask clarifying questions when they arise."
   Warm up: The occupational therapist poses the question, "What do you like to do during your free time for leisure occupations?"

2) **Activity:** The occupational therapist will educate the youth on the importance of healthy leisure occupations to maintain a balanced lifestyle. Then, the occupational therapist will conduct the Activity Card Sort assessment or Adolescent Leisure Interest Profile with the youth during the group. The youth will be instructed to write down leisure occupations they would be interested in trying or do enjoy when the therapist shows them the card with that leisure activity on it. The youth can also write down other leisure occupations that are not demonstrated within the assessment.

3) **Sharing:** The occupational therapist asks each of the youth, "What are three leisure occupations you would like to try?"

4) **Processing:** The occupational therapist asks the youth, "Why is it important to have healthy leisure occupations as a part of your balanced lifestyle?"

5) **Generalization:** The occupational therapist will summarize the main themes of the group and may ask for additional themes that the youth saw from the group.

6) **Application:** The occupational therapist asks each of the youth, “How will you use this information in your everyday life? How can you incorporate your family into these leisure occupations?”

7) **Summary:** The occupational therapist will lead the summary of this group. In the summary, the therapist will:
   - Review how group members felt about the activity and what occurred.
   - Ask participants what they have learned.
   - Ask if there are any additional questions regarding today’s session.
   - Inform participants that they will be planning the next leisure outing within the community or at the facility during the next weekly reflection group.
   - Inform participants about the upcoming group and ask if there are any questions.
   - Thank participants for coming.

Phase 2 of Leisure
Name of Group: COMMUNITY OUTING

Session Purpose and Objectives: The purpose of this group is to explore different leisure activities within the community that youth could implement in their hometown communities with their family and friends.

- The youth will be able to select a leisure activity to participate in within the community.
- The youth will appropriately engage in the leisure activity with other members of the group.
- The youth will understand how to engage in healthy leisure occupations with friends and family.

Supplies/Materials:

- Facility vehicle or transportation service
- Materials for selected leisure activity

1) **Introduction:** The occupational therapist states, "Hello and welcome to group. Today we are going to explore leisure participation within the community." The planning of this outing is completed either by the occupational therapist or by the members of the program. The planning will be completed by the youth during the weekly reflection group.

   Expectation of participation: The occupational therapist states, "All participants are expected to engage in group discussion and activities, actively listen when an individual is talking, and ask clarifying questions when they arise."

2) **Activity:** The group will complete a leisure occupation within the residential facility grounds, or go on a leisure community outing.

3) **Sharing:** The occupational therapist will ask each of the youth, "What was the benefit of participating in the leisure activity?"

4) **Processing:** The occupational therapist asks the youth, "What leisure activities could you do within your own community? How could you include your family and friends in leisure activities? What difficulties may arise during leisure activities?"

5) **Generalization:** The occupational therapist will summarize the main themes of the group and may ask for additional themes that the youth saw from the session.

6) **Application:** The occupational therapist asks each of the youth, "How will you use this information in your everyday life?"

7) **Summary:** The occupational therapist will lead the summary of this session. In the summary the therapist will:
   - Review how group members felt about the activity and what occurred.
   - Ask participants what they have learned.
   - Ask if there are any additional questions regarding today's session.
   - Inform participants about the upcoming group and ask if there are any questions.
   - Thank participants for coming.

Education

Prerequisites: social skills, self-determination, assertiveness, coping skills, and time management skills

Phase 1: The youth will participate in the appropriate educational setting while at the residential facility. The educational provider/teacher will complete the Teacher Report Card. The Teacher Report Card will be returned to the occupational therapist every week to provide feedback on progress and performance within the educational setting. Additionally, the Teacher Report Card will be used to guide discussion between the occupational therapist and the youth regarding areas of strength and weakness during the weekly reflection group between the occupational therapist and transition group members. Please refer to the Teacher Report Card handout for this phase.

Phase 2: The occupational therapist will facilitate a group session that addresses study habit skills while at the facility, but will be utilized within their natural environment. Please refer to Study Habits Group for the facilitation guide for this group. It may become apparent that a youth needs further intervention for setting up an effective study environment. It is recommended that the occupational therapist complete the Adolescent/Adult Sensory Profile (Brown & Dunn, 2002) and work with the youth to develop effective strategies based of the results of the assessment.

Phase 3: The youth will assess their personal beliefs regarding their strengths and weaknesses in regards to their ability to implement the learned study habit skills and performance within the educational setting. This will occur during the weekly reflection group between the occupational therapist and transition group members. Please refer to Educational Self-Reflection handout for this phase.

Phase 1 of Education
Title: TEACHER REPORT CARD

Purpose: This report card is for the youth's teacher to fill out in regards to aspects of being a successful student in their appropriate educational setting. The teacher will complete the report card, providing a grade for each component, as well as the strengths and areas of improvement. A new report card should be completed each week to document progression.

Component	Grade	Strengths	Areas of Improvement
Study habits			
Social Participation			
Behaviors			
Time Management (e.g.- arriving to class on time, completing assignments on time)			
Self-determination			

Self-determination includes: choice making, decision making, problem-solving, goal setting, and self-advocacy (Dunn & Thrall, 2013).

Phase 2 of Education
Name of Group: STUDY HABITS GROUPS

Group Purpose and Objectives: The purpose of this group is to assist the youth in developing an educational routine with healthy study habits for success in educational occupations.

- The youth will identify healthy study habits for themselves.
- The youth will demonstrate the ability to develop a daily routine for educational tasks.
- The youth will identify how to set up an appropriate study area in their natural environment in order to be successful in educational tasks.

Supplies/Materials:

- Pens, pencils, highlighters
- Paper
- Study Habits handout for Occupational Therapist
- Youth will bring their planner from the facility/school
- Pictures of study habit environments
- Where appropriate, Adolescent/Adult Sensory Profile evaluation form for youth who have difficulties with sensory processing in educational tasks

1) **Introduction:** The occupational therapist states, "Welcome to group, today we are going to address study habits and routines for educational purpose. The reason for addressing successful educational tasks while at the residential facility increases your likelihood of being successful in your community re-entry. It is known from the 2003 Survey of Youth in Residential Placement that there is a 62% chance of returning to a residential placement" (Snyder & Sickmund, 2006; OJJDP, 2003).
   Expectation of participation: The occupational therapist states, "All participants are expected to engage in group discussion and activities, actively listen when an individual is talking, and ask clarifying questions when they arise."
   Warm up: The occupational therapist poses the question, "What study habits do you currently have and are they beneficial to you?"

2) **Activity:** The occupational therapist will have Study Habits handout for reference. The youth will fill out a table describing study habits and techniques that work for them and ones that do not work for them. Incorporating these study habits that work for them, the youth will then each complete a weekly schedule of their educational tasks to be completed as well as set daily study time with goals of what will be completed during that time. The occupational therapist will pass around pictures of

study environments, with positive and negative aspects to each. The youth will identify what are the positive and negative aspects to these through discussion. The youth will then discuss which aspects of the study environment are beneficial to them. The occupational therapist will ask the youth to focus on implementing this schedule throughout the week and the study environment and be prepared to discuss what went well and what was difficult for the educational self-reflection.

3) **Sharing:** The occupational therapist asks each of the youth, "What is the biggest take away message from today's group for you?"

4) **Processing:** The occupational therapist will ask, "What are 5 study habits that you can implement into your life? Why is it important to develop a routine for studying and educational tasks?"

5) **Generalization:** The occupational therapist will summarize the main themes of the group and may ask for additional themes that the youth saw from the group.

6) **Application:** The occupational therapist asks each of the youth, "How will you use this information in your everyday life?"

7) **Summary:** The occupational therapist will lead the summary of this group. In the summary, the therapist will:
   - Review how group members felt about the activity and what occurred.
   - Ask participants what they have learned.
   - Ask if there are any additional questions regarding today's group.
   - Inform participants about the upcoming group and ask if there are any questions.
   - Thank participants for coming.

Study Habits

In order to be successful in educational pursuits, it is essential to have healthy study habits. Here is a list of possible study habits for you to implement into your life.

- Write Down Assignments and Tests in Your Planner
- Bring your Homework and Textbooks to Class Everyday
- Organize Your Planner and Schoolwork with Colors
- Establish a Study Area for Yourself
- Know Your Dominant Learning Style
- Take Notes during Class
- Begin Assignments Right Away, Complete Tasks on Time
- Prepare for Exams
- Take Care of Yourself

Phase 3 of Education
Title: EDUCATIONAL SELF-REFLECTION

Purpose: This self-reflection worksheet is for the youth to address their areas of strength and areas of improvement. The areas of strength and areas of improvement will include tasks in the school setting and also their study habits at the residential facility. The youth should come prepared to the weekly self-reflection group with this worksheet. The youth may fill it out or be prepared to discuss the strengths and areas of improvement for their educational tasks during the week.

Week	Strengths	Areas of Improvement
1		
2		
3		
4		
5		
6		
7		
8		

Health Management & Maintenance

Prerequisites: ability to identify triggers, coping skills group, self-determination, assertiveness, and knowledge on abstaining from drugs and alcohol

Phase 1: The occupational therapist will facilitate a group on building balance with healthy routines. This group will focus on the youth being able to schedule their own time and create their own routines, facilitating self-determination in the youth. Please refer to Establishing Routines Group for facilitation guide for this group.

Phase 2: This phase will be a group that is completed on an individual basis with the mentor and family either in person or through a conference call. The goal is to create a schedule for a weekend home visit. Please refer to Weekend Family Planning Group for the facilitation guide for this group.

Phase 3: The dorm staff will fill out the Time Usage Evaluation on the youth. This evaluation assesses the positive and negative time usage by the youth during their free time. Please refer to Time Usage Evaluation for the staff members.

Phase 4: The youth will bring problems that have occurred while structuring and scheduling their own time and problem solve with the occupational therapist and peers. This will occur during the weekly reflection group with the occupational therapist and transition program members. Please refer to Time Usage Self Reflection for the youth to assess their strengths and areas of improvement.

Phase 1 of Health Management and Maintenance
Name of Group: ESTABLISHING ROUTINES GROUP

Session Purpose and Objectives: The purpose of this group to assist the youth in understanding the need for balance within various aspects of their daily life.

- Youth will create a daily schedule to facilitate and improve occupational balance.
- Youth will write two positive goals in order to increase confidence and self-determination in routine occupational tasks to promote health and wellness.

Supplies/Materials:

- Hour by hour weekly schedule
- Pens and pencils

1) **Introduction:** The occupational therapist states, "Welcome to group, today we will be addressing occupational balance and routine development for management and maintenance of personal well-being. Without a developed routine and time management, having unstructured time when back into the community increases your chances to return to a residential treatment center or the juvenile justice system."
   Expectation of participation: The occupational therapist states, "All participants are expected to engage in group discussion and activities, actively listen when an individual is talking, and ask clarifying questions when they arise."
   Warm up: The occupational therapist poses the question, "What is one activity you wish you had more time for in your daily routine?"

2) **Activity:** The occupational therapist will provide the youth with a weekly schedule that is set up on an hourly basis. The youth will be asked to fill out their weekly schedule for the week, incorporating balance with vocation, education, leisure, and social participation occupations. The youth will then write two goals for themselves activities they would like to fit into their schedules on a regular basis. The youth will be required to create a schedule for two days of the week, one during the week and one on the weekend, in order to increase self-determination prior to returning to the community, having to schedule their own time.

3) **Sharing:** The occupational therapist asks each of the youth, "What is the biggest take away message from today's group for you?"

4) **Processing:** The occupational therapist will ask, "How do you feel on days that you have too much going on? Do any of you feel as though there is too much time in a day? If so, how does this extra time impact your overall mood or wellbeing?"

5) **Generalization:** The occupational therapist will summarize the main themes of the group and may ask for additional themes that the youth saw from the group.

6) **Application:** The occupational therapist asks each of the youth, "How will you use this information in your everyday life?"

7) **Summary:** The occupational therapist will lead the summary of this group. In the summary, the therapist will:
   - Review how group members felt about the activity and what occurred.
   - Ask participants what they have learned.
   - Ask if there are any additional questions regarding today's session.
   - Inform participants about the upcoming group and ask if there are any questions.
   - Thank participants for coming.

Phase 2 of Health Management and Maintenance
Name of Group: WEEKEND FAMILY PLANNING GROUP

Session Purpose and Objectives: The purpose of this group is to plan for a successful weekend home visit incorporating occupational balance.

- Parents and youth will establish a weekend routine.
- Youth will demonstrate emotional regulation and appropriate social skills in order to complete the activity and discussion.

Supplies/Materials:

- Pens and pencils
- Weekend hourly schedule
- Phone if phone conference
- Computer if video conference

1) **Introduction:** The occupational therapist states, "Welcome and thank you for agreeing to participate in this discussion today. The goal for today's discussion is to plan ahead for the home visit that is coming up."
   Set the Mood: The occupational therapist states, "The reason for this is to promote positive interaction for the family, educate the family on the youth's learning and progress while at the facility, and to provide the youth with a successful experience during their home visit. As the occupational therapist, I am here to assist in the process, but your child will be facilitating most of the planning for their home visit."
   Expectation of participation: The occupational therapist states, "All participants are expected to engage in group discussion, actively listen when an individual is talking, and to ask clarifying questions when they arise."

2) **Activity:** The youth will facilitate the discussion and planning with their parents and mentor in order to schedule the time that they will be spending with them during the home visit. The occupational therapist will be available to consult and collaborate if difficulties arise during the process.

3) **Sharing:** The occupational therapist asks each member, "What are you looking forward to the most about the home visit?"

4) **Processing:** The occupational therapist will ask, "If difficulties arise during the home visit, how will they be handled? What is the importance of having a balanced, occupational routine that incorporates all members of the family?"

5) **Generalization:** The occupational therapist will summarize the main themes of the discussion.

6) **Application:** The occupational therapist asks each member of the group, "How will you use the information completed together once the youth is back in the community?"

7) **Summary:** The occupational therapist will lead the summary of this group. In the summary, the therapist will:
   - Review how group members felt about the activity and what occurred.
   - Ask if there are any additional questions regarding today's session.
   - Thank participants for participating.

Phase 3 of Health Management and Maintenance
Title: TIME USAGE EVALUATION

Purpose: This evaluation is for a supervising individual to complete on the time usage in regards to self-determination of the youth during periods of down time. This should be completed daily in order to evaluate progress in the youth's ability to manage themselves in regards to health management and maintenance.

Instructions: The supervising individual should check the boxes on whether or not the youth created and followed a schedule during down time. In addition, the supervising individual should note how the youth did or did not demonstrate self-determination during down time. Self-determination includes: choice making, decision making, problem-solving, goal setting, and self-advocacy (Dunn & Thrall, 2013).

Day	**Did the youth schedule his/her time?**	**Did the youth follow the schedule?**	**How did the youth demonstrate self-determination?**	**How did the youth not demonstrate self-determination?**
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Phase 4 of Health Management and Maintenance
Title: TIME USE SELF REFLECTION

Purpose: This self-reflection worksheet is for the youth to address their areas of strength and areas of improvement. The areas of strength and areas of improvement will include tasks that occur during the residential treatment facility during downtime. The youth should come prepared to the weekly self-reflection group with this worksheet. The youth may fill it out or be prepared to discuss the strengths and areas of improvement for their routine development and time usage during the week.

Week	Strengths	Areas of Improvement
1		
2		
3		
4		
5		
6		
7		
8		

Social Participation

Prerequisites: social skills, coping skills, emotional regulation, self-determination, and assertiveness

Phase 1: The occupational therapist will facilitate a group to help the youth identify a potential community mentor within their community that will provide them support through the remainder of their residential stay and the once they return back to their community.

Phase 2: The occupational therapist will facilitate a group regarding the use of appropriate social skills, the ability to collaborate, problem solve, and make decisions in order to complete an occupational activity with others that involve healthy leisure opportunities. Please refer to Peer Party Planning Group for the facilitation guide to this group.

Phase 3: The occupational therapist will facilitate a group regarding the use of appropriate social skills, the ability to collaborate, problem solve, and make decisions in order to complete an occupational activity with others. Please refer to Family Meal Planning Group for the facilitation guide to this group.

Phase 1 of Social Participation
Title: SELECTING A MENTOR

Purpose: The youth will identify and select a mentor provided by the Department of Juvenile Justice, case management, Guardian Ad Litem, or a reliable family member that encompass positive characteristics that will facilitate a successful transition into the community once they leave the residential setting.

Instructions: The youth will communicate with the mentor on at least three occasions. During these meetings the youth and mentor will want to get to know each other better and discuss the relationship and what is expected in order to make the mentorship work to the benefit of the youth.

1) **Initial Contact:** Initial contact with a community-based mentor should be completed within the first two weeks of intervention. In order for the youth to develop a trusting relationship with a mentor, the youth will individually engage in a video conference, phone call, or in person meeting. The youth will inform the mentor about their current situation and discuss goals of community reintegration.
    Potential Questions for the Mentor: How will you support my transition? What opportunities within the community can you help me become involved in?
    Potential Questions for the Youth: What are your goals when you return home? What are your concerns? What role would you like me to play in your transition?

2) **Progress Meeting:** The progress meeting should be completed half way, or four weeks into intervention. The youth and mentor will have an individual video conference, phone call, or in person meeting. The youth and mentor will discuss progress, concerns, goals, and get to know each other to increase comfort.
    Potential Questions for the Mentor: Do you have any ideas how I can reach my goals within the community?
    Potential Questions for the Youth: What sort of activities do you like? What would you to become more involved with in the community? How are you working toward your goals? What do you need from me?

3) **Transitional Meeting:** The transitional meeting should be completed within the last two weeks of intervention. The youth and mentor will have an individual video conference, phone call, or in person meeting. The youth and mentor should discuss progress, concerns, goals, needs for successful community transition, and schedule their first meeting in the community.
    Potential Questions for the Mentor: How can I contact you?
    Potential Questions for the Youth: What do you need from me as you return to the community? How will you apply things you have learned in the residential setting? Are you feeling confident in implementing a healthy routine?

Phase 2 of Social Participation
Name of Group: PEER PARTY PLANNING GROUP

Group Purpose and Objectives: The purpose of this group is for the youth to use their social skills, decision making abilities, and problem solving strategies during an occupational activity.

- The youth will demonstrate ability to collaborate and problem solve to plan a social gathering in preparation for return to their natural environment.
- The youth will verbalize what skills and strategies are essential for planning and implementing an occupational activity with others, peers and family in their natural environment.

Supplies/Materials:

- Paper
- Pens and pencils

1) **Introduction:** The occupational therapist states, "Welcome to group, today we are going to address the application of social skills such as decision making and problem solving when working with others to plan an occupational activity. Our occupational activity for this group is the planning of a party or social gathering with engagement in healthy occupations."
   Expectation of participation: The occupational therapist states, "All participants are expected to engage in group discussion and activities, actively listen when an individual is talking, and ask clarifying questions when they arise."
   Warm up: The occupational therapist poses the question, "What are common activities that are completed with others during social gatherings?"

2) **Activity:** The youth will positively communicate with one another while planning a party or game night at the facility for the members of the program. The occupational therapist will be present if problems arise in the decision making and problem solving aspects of planning a social gathering, party, or game night. It will be important to guide the youth in how to plan a social gathering that does not include alcohol or drugs, but instead the members participate in healthy occupations.

3) **Sharing:** The occupational therapist asks each youth, "What is the biggest take away message from today's group for you?"

4) **Processing:** The occupational therapist asks the youth, "How will you overcome challenges in problem solving and decision making in other aspects of your life? Why is it important to use positive interaction skills when working with others?"

5) **Generalization:** The occupational therapist will summarize the main themes of the group and may ask for additional themes that the youth saw from the group.

6) **Application:** The occupational therapist asks each of the youth, "How will you use this information in your everyday life?"

7) **Summary:** The occupational therapist will lead the summary of this group. In the summary, the therapist will:
   - Review how group members felt about the activity and what occurred.
   - Ask participants what they have learned.
   - Ask if there are any additional questions regarding today's session.
   - Inform participants about the upcoming group and ask if there are any questions.
   - Thank participants for coming.

Phase 3 of Social Participation
Name of Group: FAMILY MEAL PLANNING GROUP

Session Purpose and Objectives: The purpose of this group is for the youth to use their social skills, decision making abilities, and problem solving strategies during an occupational activity.

- The youth will demonstrate ability to collaborate and problem solve to plan a meal in preparation for return to their natural environment.
- The youth will verbalize what skills and strategies are essential for planning and implementing an occupational activity with others, peers and family.

Supplies/Materials:

- Paper
- Pens and pencils

1) **Introduction:** The occupational therapist states, "Welcome to group, today we are going to address the application of social skills such as decision making and problem solving when working with others to plan an occupational activity. Our occupational activity for this group is going to be planning a meal."
   Expectation of participation: The occupational therapist states, "All participants are expected to engage in group discussion and activities, actively listen when an individual is talking, and ask clarifying questions when they arise."
   Warm up: The occupational therapist poses the question, "What are ways to positively communicate with others?"

2) **Activity:** The youth will positively communicate with one another while planning a meal for the residents at the facility. The occupational therapist will be present if problems arise in the decision making and problem solving aspects of meal planning. At the end of the activity, the occupational therapist will assign the members with a homework assignment pertaining to this group. The homework assignment is for the youth to plan a meal and make it with their family during their next home visit.

3) **Sharing:** The occupational therapist asks each of the youth, "What is the biggest take away message from today's group for you?"

4) **Processing:** The occupational therapist asks the youth, "How will you overcome challenges in problem solving and decision making in other aspects of your life? Why is it important to use positive interaction skills when working with others?"

5) **Generalization:** The occupational therapist will summarize the main themes of the group and may ask for additional themes that the youth saw from the group.

6) **Application:** The occupational therapist asks each of the youth, "How will you use this information in your everyday life? How will you use this information with your family once back in your community?"

7) **Summary:** The occupational therapist will lead the summary of this group. In the summary, the therapist will:
   - Review how group members felt about the activity and what occurred.
   - Ask participants what they have learned.
   - Ask if there are any additional questions regarding today's session.
   - Inform participants about the upcoming group and ask if there are any questions.
   - Thank participants for coming.

An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare

Part II: Community-Based Aftercare

How to Use the Program

In order to successfully use the manual and implement the program, it is essential that all involved understand the principles of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*. The principles of the *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* have been identified through an extensive review of the literature and a systematic analysis of occupational performance to identify the needs of this population. The program principles include:

- **Self-Determination**: Self-determination includes choice making, decision making, problem-solving, goal setting, and self-advocacy (Dunn & Thrall, 2013). It is essential for this program to address the youth's self-determination prior to returning to the community. By having self-determination, the youth will be able to schedule their time in their community, balance their participation in occupations, and engage in healthy occupations for successful community reintegration. Typically, prior to entering residential care, youth did not successfully manage themselves. While in residential care, the schedule and rules of facilities generally limit opportunities for self-determination, a requirement for successful community reintegration.
- **Meaningful Occupations**: For the youth, the occupations in which they engage in on a regular basis are their meaningful occupations. These also provide the youth with the ability to continue in their development from being a youth to being a young adult and community member. Often times residential care focuses on skill building, a necessary component of preparing for return to the community; however, *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* places emphasis on using occupational participation.
- **Interdisciplinary Team**: In the residential setting, coordinates the services within the facility and collaborates with members of the community-based interdisciplinary team for continuation of services. The community-based interdisciplinary team collaborates with the youth to aid

in use of skills gained in residential setting to the community environment. The interdisciplinary team consists of those individuals within the community who will be providing support to the youth in order to have continued success following discharge from the residential facility. The interdisciplinary team will include the youth, the youth's family, the youth's case manager, an occupational therapist, a community-based mentor, and a representative from the youth's school, a teacher or the principal.

- **Mentor**: An individual that guides the youth's transition into the community by providing support in emotional and behavioral functioning, psychological and physical health, academic success, employment and career pursuits, as well as evasion of risk-taking behaviors (Avery, 2011). The mentor aids the youth in connecting components of the residential services to the community environment. A mentor may be selected through the Department of Juvenile Services, case management, Guardian Ad Litem, or be a reliable family member.

An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare is comprised of an integrated residential and community-based transition services. As *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* is a pilot, it is suggested to have 6-8 youth participate in this program. The occupation-based residential treatment portion of the manual consists of five aspects: (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation occupational performance. While in the residential treatment facility, *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* members will meet twice a week for eight weeks formally, once to address application of skills into occupation-based activity and once for a weekly reflection group. There is a facilitation guide for each of the occupation-based groups with supplies and handouts provided. In addition to these formal meetings, the youth will meet individually with the occupational therapist and community-based mentor throughout the eight weeks of the program. The occupation-based groups should

occur following this order: (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation. In addition to the formal meetings, the youth will be engaging in occupations within the residential treatment facility on a daily basis and will be able to reflect on their progress through *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*.

Once the youth has discharged from the residential treatment facility, the second part of the manual is utilized, the community-based aftercare services. Within this section of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*, the interdisciplinary team roles and responsibilities are defined regarding how to support the youth in their occupational performance and functioning. The interdisciplinary team defines a schedule for the youth to follow within the community and defines a meeting schedule for the interdisciplinary team as the youth remains in the community. There are resources provided for the interdisciplinary team in regards to each area of occupation, (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation.

In order for the youth to be successful in the transition from residential care back into the community, it has been found that providing supports to the youth for aftercare increases the youth's success in their community. The supports for the youth include a community based member, the parents, the youth's case manager, an occupational therapist, and a representative from the youth's school, a teacher or the principal. The general roles of the interdisciplinary community team members are as follows:

Youth: The youth is going to be responsible for demonstrating self-determination during the engagement of these areas to promote successful re-entry to the community

Mentor: An individual that guides the youth's transition into the community by providing support in emotional and behavioral functioning, psychological and physical health, academic success, employment and career pursuits, as well as evasion of risk-taking behaviors (Avery, 2011).

Parent(s): The parents will provide the youth with a positive home environment in order to be successful at the reintegration into the community and in their meaningful occupations.

Case Manager: The case manager will ensure that all required aspects to maintain independence and community living are achieved by the youth. The care manager role may be fulfilled by a variety of individuals dependent upon a youth's situation. Examples include county social worker, case management programs, Division of Juvenile Service Case Management.

Occupational Therapist: An occupational therapist will be present as a consultant to increase the youth's occupational performance and success in their natural environment.

School Representative: An individual from the school, a principal or a teacher, that guides the youth's success in the school environment, becoming successful in educational tasks.

These supports will provide the youth with assistance in their success within five different occupational areas: (a) vocation, (b) leisure, (c) education, (d) health management and maintenance, and (e) social participation. In order for the youth to be successful in these occupational areas, the youth have developed skills and participated in occupations within the residential facility. These skills include time management, routine development, vocational, social skills, self-determination, assertiveness, and emotional regulation. The youth have also engaged in educational tasks, a volunteer experience, participated in community outings to expand their leisure interests, developed and managed their own time, and interacted with others following social norms within the community, at school, and at the residential facility. To gain a better understanding of what the youth learned, refer to Part I of *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare*. The roles for the community supports have been identified for each of these occupational areas. These can be found in the subsequent pages of this guide to the community supports along with additional resources for the interdisciplinary team to access to assist the youth in the community. Although the specific roles are set forth, certain individuals may be better suited for particular roles; therefore, roles should still be negotiated among

the interdisciplinary team members. It is important for this team to meet at the beginning of the youth's transition into the community in order to identify the roles and decide on a meeting frequency and a scheduled time for the meetings. An example of how this initial meeting should occur can be found on the next page, Initial Interdisciplinary Meeting in the Community.

Initial Interdisciplinary Meeting in the Community

Note: Prior to the meeting, it is recommended that each member of the interdisciplinary team independently review *An Occupation-Based Community Re-Integration Program: Residential Occupational Therapy Services and Aftercare* in order to better understand the process.

Meeting Purpose and Objectives: The purpose of this meeting is to identify the roles in which the different members of the interdisciplinary team will have in the care of this youth in the community.

- Identify the roles of the interdisciplinary members. Team roles have been provided as a guide (use this manual as a guide for these roles).
- Identify a regular meeting time for the entire team.

1) **Introduction:** "Welcome and thanks for meeting today. Our goal of today's meeting is to identify each person's role within the care of the youth in the community and how often this team will get together to discuss the youth's performance in the community." Each member will introduce themselves to the rest of the interdisciplinary team. Although the specific roles are set forth, certain individuals may be better suited for particular roles; therefore, roles should still be negotiated among the interdisciplinary team members.

   Members to be Present:
   - Youth
   - Community Mentor
   - Occupational Therapist
   - Parent(s)
   - Case Manager
   - School Representative

2) **Meeting:** Within the meeting, the roles of each team member will be identified. Use the Interdisciplinary Team Responsibilities document to alter the specific roles of the team members as needed. Also within the meeting, the members will agree upon a scheduled meeting time and how often the team will meet in order to assess the youth's performance within the community. In order to be successful within the community, the youth needs to spend their time in structured activities. Have the youth fill out the Youth Preliminary Schedule with assistance from the interdisciplinary team.

3) **Summary:** The summary will include:
   - Ask if there are any additional questions regarding today's meeting.
   - Inform team members about the upcoming meeting and ask if there are any questions.
   - Thank interdisciplinary team for coming.

Interdisciplinary Team Responsibilities

This document can be used to alter the specific roles of the interdisciplinary team members for specific youth.

Role	Vocation • Securing volunteer or job opportunity • Assist in employment opportunities	Leisure • Explore health leisure activities • Engage in leisure activities with peers and family	Education • Attend appropriate educational setting • Utilize study habit skills	Health Management & Maintenance • Create a balanced routine • Abstain from drugs & alcohol	Social Participation • Engage with peers and family • Sustain positive relationships
Youth					
Mentor					
Parent(s)					

Case Manager					
Occupational Therapist					

Preliminary Youth Schedule

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12:00am							
1:00am							
2:00am							
3:00am							
4:00am							
5:00am							
6:00 am							
7:00am							
8:00am							
9:00am							
10:00am							
11:00am							
12:00pm							
1:00pm							
2:00pm							
3:00pm							
4:00pm							
5:00pm							
6:00pm							
7:00pm							
8:00pm							
9:00pm							
10:00pm							
11:00pm							

Resources

Throughout the community based programing these resources will benefit the corresponding roles in effectively meeting the requirements of their role and the needs of the youth. Additional resources are provided within each section of this manual that parallels with occupation.

Specifically for the Mentor:

Guardian ad Litem: (North Dakota website: http://www.ndguardian.net/)

Research in Action Mentoring: A Key Resource for Promoting Positive Youth Development http://www.mentoring.org/downloads/mentoring_382.pdf

Specifically for the Parent(s):

Parenting Skills: Tips for Raising Teens http://www.mayoclinic.com/health/parenting-tips-for-teens/MY00481

How to Communication with and Listen to your Teen http://www.healthychildren.org/English/family-life/family-dynamics/communication-discipline/pages/How-to-Communicate-with-a-Teenager.aspx

Specifically Occupational Therapist:

AOTA Fact Sheet: Transitions for Children and Youth *How Occupational Therapy Can Help* http://www.aota.org/-/media/Corporate/Files/AboutOT/Professionals/WhatIsOT/CY/Fact-Sheets/Transitions.ashx

Vocation

Overall Community Goal for Vocation: Youth will be paired with a community-based mentor who will foster application of skill set into a community vocational or volunteer experience.

Within the community vocational opportunities will be addressed through a team approach. The team will include the following team members: mentor, parent(s), case manager, an occupational therapist, and the youth. The roles for these team members are descried as followed:

Youth: The youth will take control of completing pre-vocation tasks (seeking for volunteer/vocation opportunities, job application, setting up an interview). They will hold themselves accountable for their performance and asking for assistance from their employer/volunteer supervisor, mentor, parents, case manager, and occupational therapist.

Mentor: The mentor will assist the youth in finding volunteer or job opportunities within the community. The mentor will also be available to the youth as a reference regarding questions and concerns with the pre-vocation steps.

Parent(s): The parent will either provide transportation or find appropriate transportation to and from the youth's volunteer or vocation experience.

Case Manager: The case manager will be responsible for documenting progress made and reporting it back to the juvenile justice system. They will be required to collaborate with the other team members to fully understand the youth's performance in vocational experiences.

Occupational Therapist: The occupational therapist will be available for consultation regarding vocation/volunteer concerns. Additionally, the occupational therapist can complete job shadows of the youth's performance to address concerns within treatment.

Resources:

- Youth Employment in North Dakota: State and Federal Laws and Regulations http://www.nd.gov/labor/publications/docs/youth.pdf
- OSHA: Safe Work for Young Workers https://www.osha.gov/youngworkers/workers.html
- Look at local volunteer organizations and job opportunities

Leisure

Overall Community Goal for Leisure: Youth will seek out and engage in healthy leisure occupations with peers and family members.

Within the community leisure will be addressed through a team approach. The team will include the following team members: mentor, parents, case manager, an occupational therapist, and the youth. The roles for these team members are descried as followed:

> **Youth:** The youth will choose healthy and meaningful leisure occupations within their community to engage in. They will hold themselves accountable to avoid negative leisure occupations and talking with a team member if they are having difficulty maintaining healthy participation.
>
> **Mentor:** The mentor will assist the youth in finding healthy leisure opportunities within the community.
>
> **Parent(s):** The parents will provide or assist in obtaining transportation to and from leisure activities. They will assist as able in providing required materials to engage in leisure activities. The parents should engage in the healthy leisure occupations when appropriate.
>
> **Case Manager:** The case manager will be responsible for the coordination of information from the other team members regarding the youth's engagement in leisure activities. Additionally, the case manager will likely have information to assist with financial opportunities to aid low socioeconomic status families in engaging in leisure activities.
>
> **Occupational Therapist:** The occupational therapist will be used a consult for the team and the youth regarding skills and modifications needed to allow the youth to engage in chosen leisure activities.

Resources

- Raising Children Network: Teenagers and Free Time http://raisingchildren.net.au/articles/teenagers_and_free_time.html/context/1105
- Education.com: Teens and Free Time http://www.education.com/reference/article/Ref_Teens_Free_Time/
- Look a local leisure opportunities such as: sporting activities, church youth groups, etc.

Education

Overall Community Goal for Education: Youth will be paired with a school-based mentor who will foster application of skill set into community educational performance.

Within the community education will be addressed through a team approach. The team will include the following team members: mentor, parent(s), case manager, an occupational therapist, school representative, and the youth. The roles for these team members are descried as followed:

Youth: The youth will responsible for applying the skills gained while in the residential facility into their educational opportunities within the community. The skills they have gained from the residential facility include coping skills, assertiveness, time management, social skills, and self-determination.

Mentor: The mentor will be available for the youth to discuss challenges within the educational setting.

Parent(s): The parent(s) will ensure that the youth has transportation to and from the educational facility. Additionally, the parent will discuss with the youth regarding challenges within education and provide support as able.

Case Manager: The case manager will collaborate with other team members regarding the youth's improvements in the area of education. It will be the responsibility of the case manager to report performance to the juvenile justice system.

Occupational Therapist: The occupational therapist will be available to consult with the youth and other team members regarding the youth's educational performance.

School Representative: The teacher and/or principal will communicate with the team members regarding the youth's performance within school including: externalized behaviors, classroom performance, and interactions with peers and others.

Resources:

- Study Habit Skills
- ND Department of Public Instruction: Education Legislation Information http://www.dpi.state.nd.us/
- AOTA Fact Sheet: Occupational Therapy and School Mental Health http://www.aota.org//media/Corporate/Files/AboutOT/Professionals/WhatIsOT/CY/FactSheets/OT%20%20School%20Mental%20Health%20Fact%20Sheet%20for%20web%20posting%20102109.ashx

Study Habits

In order to be successful in educational pursuits, it is essential to have healthy study habits. Here is a list of possible study habits for you to implement into your life.

- Write Down Assignments and Tests in Your Planner
- Bring your Homework and Textbooks to Class Everyday
- Organize Your Planner and Schoolwork with Colors
- Establish a Study Area for Yourself
- Know Your Dominant Learning Style
- Take Notes during Class
- Begin Assignments Right Away, Complete Tasks on Time
- Prepare for Exams
- Take Care of Yourself

Health Management & Maintenance

Overall Community Goal for Health Management & Maintenance: Youth will establish and maintain a healthy routine in the community, applying the skill set gained through residential treatment.

Within the community, health management & maintenance will be addressed through a team approach. The team will include the following team members: mentor, parent(s), case manager, an occupational therapist, and the youth. The roles for these team members are described as followed:

> **Youth:** The youth will be responsible for creating and implementing a weekly routine that contains healthy lifestyle choices and balance within all areas of occupation (leisure, vocation, education, and social participation). They will be expected to approach their parent(s) to gain information on family events and getting approval from their parent(s) on their schedule.
>
> **Mentor:** The mentor will serve as a role model by demonstrating healthy routines and engaging in healthy lifestyle choices. The mentor will be available to the youth when they have difficulties dealing with triggers or other risk taking behaviors.
>
> **Parent(s):** The parent(s) will support the youth's pursuit of healthy routines and lifestyle choices. They will also create and emphasis on family routines and a feeling family connectedness. This will include reviewing their weekly schedule and keeping the youth informed of family activities.
>
> **Case Manager:** The case manager will serve as a referral source regarding youth chooses to engage in positive or negative lifestyle choices. Also they will serve as a resource to deal with common difficult situations.
>
> **Occupational Therapist:** The occupational therapist will consult with the youth and family to evaluate progress in creating and engaging in routines and avoiding poor lifestyle choices. The occupational therapist can be brought in for additional skills and resources to foster success within the community.

Within the community in regards to health management and maintenance, the youth may also be attending Alcohols Anonymous and other 12 step groups, meeting with psychologists and other health professionals, and completing aftercare treatment and appointments for the juvenile justice system.

Resources:

- World Health Organization: Adolescent Health
  http://www.who.int/topics/adolescent_health/en/

- Center for Disease Control and Prevention: Adolescent and School Health
http://www.cdc.gov/HealthyYouth/
- ND Department of Human Service Centers Crisis Line
http://www.nd.gov/ndyouth/crisis

Social Participation

Overall Community Goal for Social Participation: Youth will develop meaningful social relationships with family, peers, and community members using the skill set gained through residential treatment.

Within the community social participation will be addressed through a team approach. The team will include the following team members: mentor, parent(s), case manager, an occupational therapist, and the youth. The roles for these team members are described as followed:

Youth: The youth will be responsible for educating their friends on their current needs and goals following treatment. The youth will need to initiate communication with their mentor and parent(s) to promote self-determination. The youth will need to determine if their current peer relationship are healthy or if they need healthy ones.

Mentor: The mentor will serve as a role model for positive relationships and social engagement. The mentor will also be available to the youth when they are having difficulties engaging in social participation (such as: anti-bullying, difficulties dealing with family members, difficulties dealing with peers)

Parent(s): The parent(s) will be responsible for setting aside time to talk with the youth and allow time for the youth to talk and express their feelings. The parent(s) will be approachable and non-judgmental in order to promote continued youth communication and positive relationships.

Case Manager: The case manager will be responsible for coordinating with the team members to understand the youth's positive and negative aspects of social participation. Also, they will be available for trouble shooting difficult situations as they can be considered an outsider.

Occupational Therapist: The occupational therapist will serve as a resource for skills and troubling shooting difficult social encounters the youth has. The occupational therapist is a reference for both the youth and their parents.

Resources

- Office of Adolescent Health: Talking with Teens http://www.hhs.gov/ash/oah/resources-and-publications/info/parents/
- Talk with school counselor for possible school organizations the youth can engage in

References

Altschuler, D. M., & Brash, R. (2004). Adolescent and teenage offenders confronting the challenges and opportunities of reentry. *Youth Violence and Juvenile Justice*, *2*(1), 72-87. doi: 10.1177/1541204003260048

American Occupational Therapy Association. (2008). *Transitions for children and youth: How occupational therapy can help*. Bethesda, MD: Author. Retrieved from: http://www.aota.org/~/media/Corporate/Files/AboutOT/Professionals/WhatIsOT/CY/Fact-Sheets/Transitions.ashx

Avery, R. J. (2011). The potential contribution of mentor programs to relational permanency for youth aging out of foster care. *Child Welfare*, *90*(3), 9-26.

Baron, K., Kielhofner, G., Iyenger, A., Goldhammer, V., & Wolenski, J. (2006). *The Occupational Self Assessment (version 2.2)*. Chicago: Model of Human Occupation Clearinghouse, Department of Occupational Therapy, College of Applied Health Sciences, University of Illinois at Chicago.

Baum, C. M., & Edwards, D. (2008). *ACS: Activity Card Sort.* Bethesda, MD: AOTA Press, American Occupational Therapy Association.

Bazyk, S., & Arbesman, M. (2013). *Occupational therapy practice guidelines for mental health promotion, prevention, and intervention for children and youth*. Bethesda, MD: American Occupational Therapy Association.

Berdal, A., Meyer, M., & Sadlowsky, N. (2013). *Reducing recidivism for youth through an integrated residential and community-based program* (Unpublished master's scholarly project). University of North Dakota, Grand Forks, ND.

Blau, G. B., Caldwell, B., Fisher, S. K., Kuppinger, A., & Levison-Johnson, J. (2010). The building bridges initiative: Residential and community-based providers, families, and youth coming together to improve outcomes. *Child Welfare*, *89*(2), 21-38.

Bonham, E. (2006). Adolescent mental health and the juvenile justice system. *Pediatric Nursing, 32*(6), 591-595.

Bream, S. (2013). The history of occupational therapy in adolescent mental health practice. *OT Practice Magazine*, *18*(5), CE1-CE8.

Brown, C., & Dunn, W. (2002). *Adolescent/Adult Sensory Profile user's manual.* San Antonio, TX: Psychological Corporation.

Brunner, J. (2012). Time well spent: Empowering communities to help at-risk youth engage in healthy occupations. *OT Practice Magazine, 17*(13), 10-13, 20.

Buu, A., DiPiazza, C., Wang, J., Puttler, L., Fitzgerald, H.E., & Zucker, R. (2009). Parent, family, and neighborhood effects on the development of child substance use and other psychopathology from preschool to the start of adulthood. *Journal of Studies on Alcohol and Drugs*, *70*(4), 489-498.

Carter, E. W., Lane, K. L., Pierson, M. R., & Glaeser, B. (2006). Self-determination skills and opportunities of transition-age youth with emotional disturbance and learning disabilities. *Exceptional Children, 72*(3)*,* 333-346.

Casey, K. J., Reid, R., Trout, A. L., Duppong Hurley, K., Chmelka, M. B., & Thompson, R. (2010). The transition status of youth departing residential care. *Child & Youth Care Forum 39*(5), 323-340. doi: 10.1007/s10566-010-9106-6

Chassin, L. (2008). Juvenile justice and substance use. *The Future of Children, 25*(2), 165-183. doi: 10.1353/foc.0.0017

Cole, M.B. (2005). Group leadership: Cole's seven steps. In M.B. Cole (eds), *Group dynamics in occupational therapy* (3rd ed.) (pp. 3-23). Thorofare, NJ: SLACK Incorporated.

Cole, M. B., & Tufano, R. (2008). *Applied theories in occupational therapy: A practical approach.* (pp. 127-133). Thorofare, NJ: SLACK Incorporated.

Dmitrieva, J., Monahan, K. C., Cauffman, E., & Steinberg, L. (2012). Arrested development: The effects of incarceration on the development of psychosocial maturity. *Development and Psychopathology*, *24*, 1073-1090. doi: 10.1017/S0954579412000545

Dunn, L., & Thrall, L. (2012). Development of self-determination across childhood and adolescence. *Journal of Occupational Therapy, Schools, & Early Intervention, 5*(2), 165-181. doi: 10.1080/19411243.2012.701917

Eggers, M., Munoz, J. P., Sciulli, J., & Hickerson Crist, P. A. (2006). The community reintegration project: Occupational therapy at work in a county jail. *Occupational Therapy in Health Care*, *20*(1), 17-37. doi: 10.1300/J003v20n01_02

Farnworth, L. (2000). Time use and leisure occupations of young offenders. *American Journal of Occupational Therapy*, *54*(3), 315-325. doi: 10.5014/ajot.54.3.315

Fette, C.V., & Estes, R. I. (2009). Community participation needs of families with children with behavioral disorders: A systems approach. *Occupational Therapy in Mental Health, 25,* 44-61. doi: 10.1080/01642120802647584

Fink, D. (2013). *Creating significant learning experiences: An integrated approach to designing college courses*. San Francisco: Jossey-Bass.

Ford, J., Chapman, J., Connor, D., & Cruise, K (2012). Complex trauma and aggression in secure juvenile justice setting. *Criminal Justice and Behavior, 39*(6), 694-724. doi:10.1177/0093854812436957

Forsyth, K., Salamy, M., Simon, S., & Kielhofner, G. (1998). *A user's guide to the Assessment of Communication and Interaction Skills (ACIS) (version 4.0).* Chicago: Model of Human Occupation Clearinghouse, Department of Occupational Therapy, College of Applied Health Sciences, University of Illinois at Chicago.

Gibson, R., D'Amico, M., Jaffe, L., & Arbesman, M. (2011). Occupational therapy interventions for recovery in the areas of community integration and normative life roles for adults with serious mental illness: A systematic review. *American Journal of Occupational Therapy, 65*(3), 247-256. doi: 10.5014/ajot.2011.001297

Goodkind, S., Shook, J., Kim, K., Pohlig, R., & Herring, D. (2013). From child welfare to juvenile justice: Race, gender, and system experiences. *Youth Violence and Juvenile Justice, 11*(3), 249-272. doi: 10.1177/1541204012463409

Grande, T. L., Hallman, J., Rutledge, B., Caldwell, K., Upton, B., Underwood, L. A., … Rehfuss, M. (2012). Examining mental health symptoms in male and female incarcerated juveniles. *Behavioral Sciences and the Law*, *30*(3), 365-369. doi: 10.1002/bsl.2011

Griffith, A. K., Ingram, S. D., Barth, R. P., Trout, A. L., Duppong Hurley, K., Thompson, R. W., & Epstein, M. H. (2009). The family characteristics of youth entering a residential care program. *Residential Treatment for Children and Youth, 26,* 135-150. doi: 10.1080/08865710902914283.

Harr, C., Horn-Johnson, T., Williams, N., Jones, M., & Riley, K. (2013). Personal trauma and risk behaviors among youth entering residential treatment. *Child and Adolescent Social Work Journal*. Advance online publication. doi: 10.1007/s10560-013-0297-1

Henry, A. D. (2000). *Pediatric Interest Profiles*. Tucson, AZ: Therapy Skill Builders.

Holden, M. J., Izzo, C., Nunno, M., Smith, E. G., Endres, T., Holden, J.C., & Kuhn, F. (2010). Children and residential experiences: A comprehensive strategy for implementing a research-informed program model for residential care. *Child Welfare 89*(2), 131-149.

Huscroft-D'Angelo, J., Trout, A., Epstein, M., Duppong-Hurley, K., & Thompson, R. (2013). Gender differences in perceptions of aftercare supports and services. *Children and Youth Services Review, 35*(5), 916-922. doi: 10.1016/j.childyouth.2013.01.024

Keller, J., Kafkes, A., Basu, S., Federico, J., & Kielhofner, G. (2005). *The Child Occupational Self Assessment (version 2.1).* Chicago: Model of Human Occupation Clearinghouse, Department of Occupational Therapy, College of Applied Health Sciences, University of Illinois at Chicago.

Knis-Matthews, L., Richard, L., Marquez, L., & Mevawala, N. (2005). Implementation of occupational therapy services for an adolescent residence program. *Occupational Therapy in Mental Health, 21*(1), 57-72. doi: 10.1300/J004v21n01_04

Kohlman Thomson, L. (1992). *The Kohlman Evaluation of Living Skills*. (3 ed.). Bethesda, MD: American Occupational Therapy Association, Inc.

Koome, F., Hocking, C., & Sutton, D. (2012). Why routines matter: The nature and meaning of family routines in the context of adolescent mental illness. *Journal of Occupational Science*, *19*(4), 312-325. doi: 10.1080/14427591.2012.718245

Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The Person-Environment-Occupation Model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy, 63*(1), 9-23.

Longshore, D., Ellickson, P. L., McCaffrey, D. F., & St. Clair, P. A. (2007). School-

based drug prevention among at-risk adolescents: Effects of alert plus. *Health Education & Behavior*, *34*(4), 651-668. doi: 10.1177/1090198106294895

Lopez, A. (2013). PAR FORE: Promoting success through healthy occupations. Unpublished raw data. Retrieved from http://www.parfore.org/

McCamey, J. D. (2010). Reducing recidivism in adolescent sexual offenders by focusing on community reintegration. *Residential Treatment for Children & Youth*, *27*, 55-67. doi: 10.1080/08865710903536291

McCurdy, B. L., & McIntyre, E. K. (2004). 'And what about residential…?' Re-conceptualizing residential treatment as a stop-gap service for youth with emotional and behavioral disorders. *Behavioral Interventions, 19*(3), 137-158. doi: 10.1002/bin.151

Nickerson, A. B., Colby, S. A., Brooks, J. L., Rickert, J. M., & Salamone, F. J. (2007). Transitioning youth from residential treatment to the community: A preliminary investigation. *Child Youth Care Forum*, *36*, 73-86. doi: 10.1007/s10566-007-9032-4

Nickerson, A. B., Salamone, F. J., Brooks, J. L., & Colby, S. A. (2004). Promising approaches to engaging families and building strengths in residential treatment. *Residential Treatment for Children & Youth*, *22*(1), 1-18. doi: 10.1300/J007v22n01_01

Oakley, F. (2006). *The Role Checklist (revised*). Bethesda: National Institutes of Health.

Puzzanchera, C., Sladky, A., & Kang, W. (2013). *Easy Access to Juvenile Populations: 1990-2012.* National Center for Juvenile Justice. Retrieved from: http://www.ojjdp.gov/ojstatbb/ezapop/

Sedlak, A., & Bruce, C. (December, 2010). Youth's characteristics and backgrounds. *Juvenile Justice Bulletin,* 1-12.

Shufelt, J. L., & Cocozza, J. J. (2006, June). *Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study*. Retrieved from http://www.ncmhjj.com/pdfs/publications/PrevalenceRPB.pdf

Snyder, H. (2004). An empirical portrait of the youth reentry population. *Youth Violence and Juvenile Justice, 2*(1), 39-55. doi: 10.1177/1541204003260046

Snyder, H. N., & Sickmund, M. (2006). *Juvenile offenders and victims: 2006.*Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Stoffel, V. C., & Moyers, P. A. (2004). An evidence-based and occupational perspective of interventions for persons with substance-use disorders. *American Journal of Occupational Therapy, 58*(5), 570-586. doi: 10.5014/ajot.58.5.570

Taylor, S., & Mudford, O. (2012). Improving behavior in a residential service for youth in drug and alcohol rehabilitation. *Behavioral Intervention, 27*, 109-128. doi: 10.1002/bim.1342

Trupin, E. J., Kerns, S. E., Walker, S. C., DeRobertis, M. T., & Stewart, D. G. (2011). Family integrated transitions: A promising program for juvenile offenders with co-occurring disorders. *Journal of Child & Adolescent Substance Abuse*, *20*(5), 421-436. doi: 10.1080/1067828X.2011.614889

U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. (2003). *The survey of youth in residential placement.*

Unruh, D. K., Gau, J. M., & Waintrup, M. G. (2009). An exploration of factors reducing recidivism rates of formerly incarcerated youth with disabilities participating in re-entry intervention. *Journal of Child and Family Studies 18*, 284-293. doi: 10.1007/s10826.008.9228.8

Wells, J., Minor, K., Angel, E., & Stearman, K. (2006). A quasi-experimental evaluation of a shock incarceration and aftercare program for juvenile offenders. *Youth Violence and Juvenile Justice, 4*(3), 219-233. doi: 10.1177/1541204006290153

Youngblade, L. M., Theokas, C., Schulenberg, J., Curry, L., & Huang, I. (2007). Risk and promotive factors in families, schools, and communities: A contextual model of positive youth development in adolescence. *Pediatrics, 119,* S47-53. doi: 10.1542/peds.2006-2089H

Zhang, D., Katsiyannis, A., Barrett, D. E., & Willson, V. (2007). Truancy offenders in the juvenile justice system: Examinations of first and second referrals. *Remedial and Special Education*, *28*(4), 244-56. doi: 10.1177/07419325070280040401

Zhang, S. X., Roberts, E. L. R, & Callanan, V. J. (2006). Preventing parolees from

returning to prison through community-based reintegration. *Crime & Delinquency 52*(4), 551-571. doi: 10.1177/0011128705282594