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# Analysis of Social Determinants of Health in Justice-Involved Youth: Relevance in the Context of Poverty

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## Abstract

The current study will address the gap in the literature to identify and understand the significant relationship between the social determinants of health and poverty to target the needs of young offenders more effectively by referring youth to agencies and community-based services relevant for successful rehabilitation. The study reviewed 281 assessment files of young offenders at an urban-based court clinic in London, ON. Results indicated a significant relationship between the extent of poverty and compromised social determinants of health. Offending youth who experienced high poverty also demonstrated higher frequencies in experiencing family structure instability, a lack of parent involvement or concern, greater grade failure and lack of educational attainment, lack of organized leisure activities and greater gang affiliation within the community. Additionally, regression analyses indicated that the degree of experienced poverty predicted likelihood of reoffending and gaining access to relevant services. Implications for clinical practice including sensitivity from service workers and further consideration of changes in social policy and response from the justice system are discussed.


*Keywords:* social determinants of health, poverty, justice-involved youth, service access

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# Introduction

The social determinants of health affect the health outcomes of each individual in society and it is imperative to examine how these social contexts influence the adolescent population, given that this developmentally sensitive period largely determines their health outcomes as they transition to adulthood (Viner, Ozer, Denny, Marmot, Resnick, Fatusi, & Currie, 2012; World Health Organization, 2010). Individuals who experience compromised social determinants of health, in addition to the marginalization of poverty, are at a greater risk of experiencing barriers to accessing the services and resources necessary for both positive development and future success (Benner & Wang, 2014; Mikkonen & Raphael, 2010; Najman, Clavarino, McGee, Bor, Williams, & Hayatbakhsh, 2010; Odgers, Donley, Caspi, Bates, & Moffitt, 2015; Wright, Kim, Chassin, Losoya, & Piquero, 2014). More specifically, understanding how current conditions within the primary domains of family, school, and community can be modified for vulnerable adolescents is imperative for these marginalized youth to achieve the best health outcomes and success in adulthood.

## Theoretical Framework

The current study explored the prevalence and extent that social determinants of health contribute to understanding the rehabilitation needs of young offenders. These results are interpreted within the theoretical framework of the social psychology of crime. As described by Andrews and Bonta (2010), the social psychology of crime accounts for individual differences in the decision to commit crime in considering attitudes, cognitions and behaviours of the individual as well as how interactions within the environmental context promote or desist the likelihood of engaging in criminal behaviour.

## Literature Review

### Social Determinants of Health

Current literature has sought to understand the psychology of criminal conduct of adolescents from a life course perspective, emphasizing how individual differences can influence outcomes (Fomby, 2013; Najman et al., 2014; Wilczak, 2014). Similarly, several studies have highlighted the significance of the environmental context in defining the outcome of high-risk adolescents from an ecological perspective (Fruiht & Wray-Lake, 2013; Slattery & Meyers, 2014). Although these perspectives have made significant contributions in understanding the antisocial attitudes and behaviours of young adolescents and their motivation to engage in high-risk behaviour, the social psychology of crime integrates this understanding both within the individual differences in offender attitudes and behaviours as well as how the environmental context can influence these outcomes.

The social determinants of health refer to living and working conditions that dictate or influence the health disparities and outcomes within the population (Mikkonen & Raphael, 2010; Viner et al., 2012; World Health Organization, 2012). Underprivileged conditions and experiences derived from family, school, and community can further contribute to the barriers and marginalization of adolescents already impacted by poverty, leading to the engagement in unhealthy behaviours, including delinquent behaviour (Benner & Wang, 2014; Najman et al. 2012; Odgers et al. 2015). For youth in the justice system, persistent poverty and compromised social determinants of health can reinforce antisocial attitudes and behaviours that contribute to ongoing participation in the justice system and mitigate future successful outcomes (Bennett, Wood, Butterfield, Kraemer, & Goldhagen, 2014; Corrado, Leschied, & Lussier, 2015; Wright et al, 2014).

Social determinants of health focus on the social contexts that are predetermined by the quality of the communities, work settings, health and social services within which individuals have everyday interactions, along with the perceived quality of those interactions and how they shape present and future health outcomes (Viner et al., 2012; WHO, 2012). Individuals who experience positive social and living conditions have greater agency and control over their health behaviours and outcomes compared to individuals who experience adverse living conditions that promote the comparison of societal status, possessions and life circumstances with others, which ultimately can reinforce chronic stress and negative health behaviours and outcomes (World Health Organization, 2012).

Adolescence is a sensitive developmental period that can greatly influence future well-being, where psychological and biological development and maturation can lead to new sets of behaviours and capacities that can both enable transitions in the family, peer and educational domains and modify childhood trajectories towards health in adulthood (Viner et al., 2012). In developing to their full potential and attain the best health outcomes in adulthood, adolescents should experience safe and supportive schools, families and peers during their adolescent development. In order to understand the behavioural and health outcomes of adolescents, there is a need to consider the health burden and influence associated with the social determinants of health and understand that improvements in adolescent health require assessing and modifying the daily living conditions that are most salient to an adolescent's development (World Health Organization, 2012).

*Family.* Adverse conditions within the family structure and environment can have negative consequences for the development and well-being of adolescents. A study by Sobotkova et al. (2012), which involved a nation-wide school survey of Czech Republic adolescents at the ages of

12, 14, and 16, detected a significant relationship between antisocial behaviour and the quality of family environments. Results reflected that, compared to the identified low antisocial behaviour group, adolescents with higher levels of antisocial behavioural tendencies were the only group to demonstrate a significant risk for psychiatric, health and social problems. Additionally, the higher antisocial behaviour group of adolescents reported poorer parenting aspects such as low parental involvement, low control and warmth, and less consistency in parenting practices compared to the low antisocial behaviour groups. Although this study was limited to an urban population and based only on self-report by adolescents, the comparison of the severity of antisocial behavioural tendencies between adolescents within a large sample provides insight into how the family context, including parenting practices and extent of parental attachment, can reinforce antisocial attitudes and behaviours in adolescents. Similar studies investigating adverse family conditions illustrate that inconsistent parenting increased delinquent-oriented attitudes and antisocial behaviour as well as decreased social competence with peers (Halgunseth et al., 2013).

Research has also demonstrated that the educational attainment of adolescents can be impaired if, as children, they experienced persistent family structure instability. Fomby (2013) examined data from the National Longitudinal Study of Adolescent Health illustrating that early family instability can have enduring consequences on status attainment and educational outcomes and found that family instability in childhood and adolescence reduced the likelihood of obtaining a college degree, which significantly predicted status attainment in adulthood, and impacted college enrolment and commitment. This study reported strong, negative correlations between family stability and a mother's self-reported health and adolescent reported health, which the researchers stated could influence both school attendance and educational attainment. Given that educational attainment provides numerous protective factors for adolescents in early

life to promote better health outcomes and strong determinant of vocational success, compromised conditions within the family domain could mitigate the likelihood of positive behaviour and outcomes for adolescents later in the lifespan (Viner et al., 2012; WHO, 2010).

Comparatively, positive family conditions can support adolescents experiencing challenging conditions or distressing events during their development and serve as a buffer to adverse consequences (Mikkonen & Raphael, 2010; WHO, 2012). Supportive parenting and family connectedness has been demonstrated in the literature to provide protection against poor health outcomes. In a sample of 203 adolescents from a single-site mainstream English high school, Oldfield et al. (2015) had adolescents complete several self-report measures of parental and peer attachment, school connectedness, conduct problems, emotional symptoms and prosocial behaviour. The researchers illustrated in their study that adolescents who self-reported more secure attachments with their parents displayed greater prosocial behaviour and better mental health outcomes, including lower levels of emotional difficulties and less engagement in conduct problems, compared to self-reported insecurely attached parent-adolescent relationships. Similarly, parental monitoring can mitigate the likelihood of engaging in antisocial behaviour and displaying externalizing problems from exposure to community violence (Slattery & Meyers, 2014; Viner et al., 2012). Overall, the conditions within the family context can impact present and future behavioural and health outcomes of adolescents.

*School***.** As a primary social setting within adolescence, the conditions and quality of the school domain should be carefully considered for its influence on the development and health outcomes of adolescents. Adverse school conditions can result in increasing mental health concerns and association with delinquent peers, which could increase the likelihood of school dropout and limit future educational attainment and negatively impact health outcomes (Viner et al., 2012).

In a study examining the relationship between adolescent violence, victimization and educational attainment, Wilczak (2014) found a significant relationship between a victim or perpetrator of violence in the school setting and the increasing likelihood of school dropout, thereby reducing future educational opportunities. Analyzing a stratified random sample of adolescents living in the United States from the first and third waves of the school-based National Longitudinal Study of Adolescent health, results indicated that adolescents who were victimized at school had a greater likelihood of immediate school dropout, while being a perpetrator of violence was also a risk factor for later school dropout. The results indicated that poor quality conditions and experiences within the school can inhibit future academic achievement and educational opportunities. Additional studies illustrate that poor conditions within the school context, such as poor peer or student-teacher relationships, can contribute to misconduct, delinquent behaviour and vandalism (Wissink et al., 2014).

To improve adolescent health outcomes, maintaining positive aspects or improving daily conditions within schools could improve the likelihood of educational attainment and act as a protective factor against stressful conditions. Fruiht and Wray-Lake (2013) investigated the interactions of mentor type and educational attainment for adolescents, results reflecting that a positive teacher-student mentor relationship was most predictive of educational attainment. Although results were based on student-parent interviews and despite a reliance on retrospective self-report and lack of teacher reports, the study effectively conveys that, consistent with other literature, safe and supportive schools are crucial to healthy adolescent development and attaining the best health outcomes as adults (Viner et al., 2012).

*Community***.** Community conditions and opportunities for engagement have also been reported to promote negative or positive health behaviours and outcomes depending on the social context. Kingsbury et al. (2015) investigated the association between the perception of

neighbourhood cohesion and prevailing adolescent mental health and behaviours. Using data from the National Longitudinal Survey of Children and Youth, the study demonstrated that, compared to highly cohesive neighbourhoods, adolescents from low cohesive neighbourhoods were more likely to experience mental health illnesses such as anxiety and depression, while adolescents from neighbourhoods with high social cohesion showed greater engagement in prosocial behaviour. Supportive community conditions promoting social cohesion, such as feeling you can depend on neighbours to assist in an emergency or having adults in the neighbourhood who are positive role models for the children, illustrate greater opportunities for healthy social development and moderate health outcomes as adolescents. Additional research illustrates that poor neighbourhood conditions, including exposure to community violence and neighbourhood disadvantage, can promote antisocial behaviour or emotional disorders in adolescence (Slattery & Meyers, 2014; Rudolph et al., 2010).

Although ample literature illustrates the health behaviours and outcomes of adolescents are influenced by the social contexts of family, school and community, the conditions or quality of these determinants of health are predetermined by income or wealth as the level of income impacts the material and social living standards (Mikkonen & Raphael, 2010; WHO, 2012). Given that socioeconomic status defines the quality of all other social and living conditions important to defining and modifying the health behaviours and outcomes, it is important to assess the social determinants of health in relation to poverty.

**Social Determinants of Health and Poverty**

In Canada, income can influence the quality of other social determinants of health that shape overall living conditions, affect development and influence health-related behaviours (Mikkonen & Raphael, 2010). For adolescents already experiencing the challenges of development related to compromised social determinants of health, the additional barriers of

poverty can accentuate marginalization and increase negative outcomes for them in their transition to adulthood. Although Canada is a recognized leader in health promotion, current public policies have failed to adequately address the growing concern of family poverty and homelessness (Raphael, Curry-Stevens, & Bryant, 2010). More specifically, research reviewing poverty in Canada over the last ten years reflects that 80% of Canadian incomes have remained stagnant, making it difficult to resolve concerns in secure housing and employment security for Canadian families (Raphael, 2008). Further concern arises when we consider the welfare of the children growing up in poverty, where the material and social deprivation youth experience is outside of their control.

*Poverty in Adolescence***.** Canadian statistics report that the current child poverty rate in Ontario is 15%, an indication that an alarming proportion of children in Ontario are growing up experiencing the challenges of material and social deprivation inherent in living below the poverty line (Mikkonen & Raphael, 2010; Poverty Free Ontario, 2014). Considering the wealth of research that reinforces adolescence as a developmentally sensitive period in an individual's life that shapes their psychological and biological maturation, it is important to consider how poverty impacts the development and future outcomes of youth (Viner et al., 2012).

Research illustrates that adolescents who experience persistent poverty are at a greater risk of engaging in risky behaviours and experience poor health outcomes. Najman et al. (2010) demonstrated in a longitudinal study that poverty predicted aggressive or delinquent behaviour and risky behaviour (such as earlier onset of alcohol consumption and smoking) among adolescents. More importantly, adolescents who experienced persistent poverty, defined as experiencing poverty three to four times during the adolescent period, were twice as likely to engage in persistent risk-taking and delinquent behaviour throughout adolescence compared to adolescents reporting limited or short term poverty. Although the sample was limited in selection

to participants in two hospital sites and self-reports only of risky behaviours, the study reflected how poverty can reinforce antisocial or unhealthy behaviours and highlights that persistent marginalization from poverty can increase the likelihood of engaging in unhealthy behaviours.

The challenges experienced by adolescents who live in poverty and create barriers to healthy development and positive outcomes are emphasized with the additional contribution of underprivileged conditions within their social contexts. Benner and Wang (2014) report in their diverse adolescent sample from the National Longitudinal Study of Adolescent Health that adolescents who experienced both socioeconomic and social marginalization had significant disadvantages in their school performance and engagement compared to youth who solely experienced poverty. Additionally, adolescents who had both a poor school environment and poor social support also had lower grades and educational attainment compared to their peers who only reported low socioeconomic status (Benner & Wang, 2014). This study was limited by its use of retrospective data, measures of socioeconomic status constrained to parental education and occupation, and the exclusion of data regarding frequency of school transfers as a contributing variable to social connectedness. Yet, this study reflected the educational risks posed by poverty and adverse conditions within the school context.

Similarly, adolescents experiencing economic disadvantage as well as a compromised family environment demonstrate additional risks to their health. A longitudinal study by Evans and Cassells (2014) indicated that persistent poverty in childhood poses elevated risks through exposure to psychosocial and physical risk factors during adolescence that can impact mental health and behaviour. Adolescents who experienced poverty coupled with adverse living conditions of crowding, substandard housing, and less structured family routines within the home environment demonstrated greater externalizing problems and were more susceptible to learned helplessness. Although limited to a rural population and a measure of mental health that did not

include diagnoses or symptoms of mental illness, the study highlights that adolescents who live in poverty have accumulated exposure to risk factors, including compromised social determinants of health, which can impact mental well-being and negatively reinforce externalizing behavioural problems. Further studies reinforce the coupling of compromised family life such as family structure, instability and family poverty to fewer opportunities for future successes such as college enrolment or completion compared to youth from stable family structures (Fomby, 2013).

Finally, impoverished communities introduce additional risk factors to the health and development of adolescents. Odgers et al. (2015) demonstrated in their longitudinal study that boys living in poverty alongside affluent neighbourhoods engaged in more antisocial and delinquent behaviour relative to their peers who lived in neighbourhoods of concentrated poverty. Although the results only reflected the behavioural outcomes of boys in disadvantaged neighbourhoods, and reports of antisocial behaviours were based on the subjectivity of teacher and parent self-reports, the results of the study conveyed that the awareness of one's recognition and comparison of relative deprivation to financially and socially affluent peers can have detrimental effects on the behavioural outcomes of youth. Overall, current research demonstrates that compromised social determinants of health can accentuate marginalization and negative outcomes for adolescents who already experience the barriers of poverty in their transition to adulthood.

*Poverty and Antisocial Attitudes and Behaviour.* The accumulation of risk factors for adolescents living in poverty, in addition to adverse living conditions, may reinforce unhealthy attitudes and behaviours in response to the inequalities and disparities in social contexts. In a recent study assessing adolescent goal-directed behaviours and perceptions of future success, Bennett et al. (2014) found that adolescents who reported the highest degree of

hopefulness, had more protective factors present in their social and educational environment compared to high-risk adolescents who identified relatively less opportunities for prosocial development and access to protective factors. Coincidentally, a lack of motivation and a lost sense of hope was correlated with protective factors being absent or more risk factors being present within these same environmental contexts. This study illustrated that experiencing challenges and the presence or absence of risk factors for adolescents have a direct influence on their motivation and engagement in healthy or unhealthy behaviours that define their developmental outcomes. This is important to consider, as a proportion of adolescents experiencing persistent poverty and compromised living or social conditions may be motivated as a result of accumulated exposure to risk factors to engage in antisocial or delinquent behaviour. Children marginalized by poverty and exposed to these challenging conditions are most susceptible to developing into violent offenders within the court system (Corrado, Leschied, & Lussier, 2015). However, minimal research has investigated how the social determinants of health and poverty can reinforce engagement in offending behaviour or recidivism for Canadian youth.

## Social Determinants of Health, Poverty, and Youthful Offending

*Youth Crime Rate.* In Canada, the overall youth crime rate in 2013 was reported to have declined by 13% from the previous year. However, these declines were seen across all crime types *except for violent youth crime*, which has steadily increased in recent years (Boyce, Cutter, & Perreault, 2014). Given the consistent prevalence in the violent crime rate among young offenders, attention should be directed at understanding the contributing factors and characteristics for adolescents choosing to engage in violent offending behaviour and are motivated to remain in the justice system.

Young offenders experience a range of risk factors that contribute to their likelihood of reoffending and engaging in delinquent behaviour. Canadian research cites that young offenders are typically characterized by having higher levels of conflict within their home environment and come from unstable families, including single-led mother, absent father, or abusive family homes (Corrado, Leschied, & Lussier, 2015). In the school context, Canadian young offenders have also been identified as having higher school dropout rates, negative relationships, or a lack of support from peers and teachers, as well as lower cognitive abilities relative to non-delinquent peers (Corrado, Leschied, & Lussier, 2015; Lipman & Boyle, 2008). A final noteworthy observation has been that offending youth who reside in disadvantaged neighbourhoods with limited opportunities for prosocial behaviour demonstrate a greater risk for recidivism and engagement in violent behaviour (Kurlychek et al., 2012; Wright et al., 2014). Although the results of the available research convey the consequences of marginalization by poverty and compromised social determinants of health, minimal incorporation of this knowledge has been considered in modifying and implementing effective intervention strategies to better rehabilitate Canadian offending youth.

*Youth Criminal Justice System***.** The Youth Criminal Justice System (YCJS) was established to govern the correctional services for youth within Canada (*YCJA*, 2015). More specifically, the Youth Criminal Justice System aims to desist reoffending of youth by rehabilitating offenders through the implementation of intervention programs (*YCJA*, 2015). The assessments provide pertinent information regarding the specific risks and needs of offending youth that can be taken into consideration when developing risk-reduction strategies to desist further offending.

The research available on the efficacy of intervention programs for offending youth is minimal. However, it has been suggested that intervention strategies be implemented from a

risk/needs framework and that rehabilitative success of offending youth will depend on focusing and responding to their individual criminogenic needs (Andrews & Bonta, 2006; Butler & Leschied, 2007). Additionally, effective interventions should be sensitive to the developmental stage of the offender to ensure services are responding to the prioritized needs of the young offender to promote timely and effective intervention (Butler & Leschied, 2007; Corrado, Leschied, & Lussier, 2015; Leschied, Chiodo, Nowicki, & Rodger, 2008).

*Efficacy of Current Intervention Programs.* The literature regarding effective intervention strategies for rehabilitating young offenders outlines that effective correctional treatment and interventions take into consideration the needs of the offender as characterized in a risk/needs framework, and provides specific intervention plans that target the values and beliefs that have the greatest effect in reducing adolescent difficulties and reoffending in general (Butler and Leschied, 2007; Public Safety Canada, 2012). This literature has suggested that the most promising interventions will target antisocial attitudes and behaviours of offenders, associations with delinquent peers, low familial affection and parental monitoring, and poor educational or vocational attainment (Vieira, Skilling, Peterson-Badali, 2009). According to the results of Vieira et al. (2009), attending to and directly servicing youth according to their individualized criminogenic needs can increase the likelihood of treatment effectiveness for the adolescent, thereby meeting the rehabilitative ideals of the juvenile justice system of both lowering the recidivism rate of young offenders and improving their psychological functioning.

Peterson-Badali, Skilling & Haqonee (2014) examined the efficacy of current case management plans within the youth justice system in identifying individual criminogenic needs of young offenders. Completed assessments on 148 young offenders were evaluated for their ability to make effective connections between a risk assessment, identified treatment approaches and recidivism rates. These results demonstrated that decreased reoffending significantly

occurred when individual needs were met within the treatment approaches that were recommended through the assessment. Although the study demonstrates effective identification of young offender needs in creating treatment approaches in response to those individualized needs in attaining the goal of reduced recidivism, the study failed to consider how linking young offender needs in receiving services assists with rehabilitation.

Wasserman et al. (2009) in their initiation of Project Connect, an intervention program to improve agency collaboration and screening procedures for assessing the severity of young offender needs, compared agency involvement and access to services before and after program implementation. The results indicated that intervention programs effectively linked required services and community agencies for young offender needs and improved the likelihood of effective rehabilitation by prioritizing services. However, their measure of successful linkage was limited to young offenders attending the first appointment with community agencies; no follow-up studies were conducted to evaluate long-term implications of agency involvement and prioritization of accessing services in response to the severity of risks or needs of the young offenders.

In order to improve intervention strategies of matching youth to services that meet their criminogenic needs to reduce recidivism and improve a youth's functioning, Vieira et al. (2009) recommends further research to understand the needs of offending Canadian youth. In order to meet the rehabilitation ideals of intervention strategies, further research is necessary given that the results of the current available literature reflects mostly the American context and is not necessarily generalizable in describing the criminogenic needs of Canadian youth given the differences in culture, public policy, and the goals of the judicial system.

## The Present Study

### Purpose of Study

The current study responded to the need to inform researchers, practitioners, and policy makers about the Canadian youth justice population who are marginalized by poverty and experience compromised conditions characterized as the social determinants of health. It is recognized that in order to resolve the prevalence of poverty and youth crime, there is an essential need to provide programs and services that provide adequate working and living conditions that support and promote the health and well-being of all Canadians, including offending youth (Raphael et al., 2010). Given that appropriate treatment delivery for offenders depends on effective assessment of the range of factors known to be predictive of recidivism, this study focused on providing an analysis of the social determinants of health to educate communities and the courts regarding how to ensure treatment approaches delivered beyond the court process can improve the likelihood of academic or vocational success and prosocial outcomes of these youth (Andrews & Bonta, 2006; Raphael et al., 2008). Furthermore, the study is pertinent in improving current and future efforts of the criminal justice system to desist youth re-offending and promote community safety. Acquiring knowledge of the prevalence, influence, and predictive utility of the social determinants of health in the outcomes of serious and violent young offenders can assist in refining current efforts to carefully assess the needs of these youth to encourage the prioritization and efficacy of service utilization and agency involvement.

A descriptive field study was used to report on young offenders who had been referred to an urban-based court clinic over the past seven years. Archival data reflecting the youths' criminal history, youth justice and service history, family history, education, and psychological information was withdrawn from assessment files and analyzed for the study.

For the purpose of this study, the following questions were addressed:

(1) What social determinants of health are most prevalent in describing a sample of young offenders referred by a youth court judge to complete assessment at a court related clinic?

Based on the current literature on the social determinants of health in relation to the adolescent population, the expected results of this study would illustrate findings related to the family, school, and community domains in their prevalence in determining health behaviours and outcomes of these youth. (Fomby, 2013; Fruiht & Wray-Lake, 2013; Halgunseth et al., 2013; Oldfield et al., 2015; Kingsbury et al., 2015; Sobotková, et al., 2012; Viner et al., 2012; Wilczak, 2014; WHO, 2012).

(2) To what extent are compromised social determinants of health predictive of young offender outcomes?

The current literature illustrates an accumulative effect of compromised social determinants of health contributing to poor health outcomes (Mikkonen & Raphael, 2012; Viner et al., 2012; WHO, 2012, 2010). This study proposes that serious and violent offenders with long-term criminal histories and numerous identified presenting problems will demonstrate more adverse conditions in their life history.

(3) How do social determinants of health mediate the likelihood of accessing services for effective intervention?

Based on the current literature regarding the efficacy of intervention programs linking offender needs to services (Peterson-Badali et al., 2014; Wasserman et al., 2009), the expected results would demonstrate that serious and violent young offenders with low quality social determinants of health exhibit the least opportunity in the past and present to agency involvement and access to services.

# Method

## Participants

The sample consisted of 281 young offenders (229 male, 48 female, 3 transgendered, 1 unidentified) ranging in age from to 12 to 23 years (M= 15.94, SD = 1.50) from the London and Middlesex County area (164 urban, 117 rural) who were referred by a youth court judge under section 34 of the *Youth Criminal Justice Act* (*YCJA*; 2002) to undergo psychological assessment by a qualified professional. The assessments were conducted by members of a multidisciplinary team of clinicians (i.e., psychiatrists, psychologists, and registered social workers). The results of the assessment were provided to the court in addressing the rehabilitative needs of the youth through a series of recommendations. The files reviewed must have been conducted in the previous 5 years (2010 – 2015) and have provided consent by both the offending youth and their parent/legal guardian to be accessed and reviewed for research purposes as outlined in the Letter of Understanding at the time of the assessment (see Appendix A).

## Procedure

**Archival Data Collection.** A descriptive field design was employed to collect archival data from review of available assessment files of young offenders attending the court clinic. Prior to data collection, ethical approval to conduct the study was obtained from the Western University Research Ethics Board (see Appendix B). All research team members obtained a Vulnerable Sector Police Record Check and agreed to the privacy and confidentiality conditions as outlined in the London Family Court Confidentiality Agreement (see Appendix C). Upon obtaining a file, all research team members ensured a consent form indicating both the youth and legal guardian provided consent to participate in research was enclosed before reviewing file information. From review of the Intake Questionnaire and Clinical Findings Report, data regarding the offending histories, social determinants of health, and recommended treatment

approaches for young offenders was encoded within a Data Retrieval Instrument (DRI). The DRI served as a guide for the extraction of data from all assessment files reviewed by each member of the research team. Collateral sources of information included copies of official school records, psychological testing, Risk Needs Assessments, and police reports were used to supplement the primary documents in coding detailed variables for analyses. File review and data transcription of each file took approximately 1.5 hours to complete. A corresponding data retrieving manual was developed to ensure accurate coding of information was conducted by the research team members (see Appendix D).

**Analysis.** Descriptive and regression analyses were conducted using variables within the DRI that defined a feature being present (Yes = 1) or absent (No = 0) for describing the offending youth, as well as using aggregates created from the cumulative score of associated variables and using created categorical variables for intensity of the feature describing the youth based on the tertile split of the range of scores from the aggregates. Data from each file was entered into the data analysis program, the *Statistical Package for the Social Sciences*(SPSS) – *Version 22*. In an effort to reduce the likelihood of an experimenter bias in coding, inter-rater reliability tests were conducted to ensure identical analysis of file assessments across multiple coders and a corresponding manual for the DRI was composed for reference so a consensus on data collection procedures was established.

## Materials

**File-based data.** Two documents within the young offenders' files at the urban-based court clinic were primarily considered for data collection: (1) Intake Questionnaire (see Appendix E), and (2) Clinical Findings Report. Prior to undergoing a clinical assessment, young offenders referred to the court clinic completed an intake process with their legal guardians

present where a clinician conducted an initial interview and requested a legal guardian to complete an Intake Questionnaire. The Intake Questionnaire gathers demographic information, history of criminal charges and court involvement, school history, developmental and medical history, mental health history, as well as information pertaining to social relationships, family life, agency involvement, leisure activities, and presenting problems pertaining to the youth as well as parental history of education, socioeconomic status, and mental health. The Clinical Findings report provided a summary of information collected within the Intake Questionnaire as well as supplementary information from police reports, school records, psychological assessments, social service and community agency reports, risk needs assessments and recommendations from the clinician of treatment approaches.

## Measures

**Poverty.** Youths' level of experienced poverty was defined in two ways: a cumulative index of poverty (ranging from 0 to 24) and an associated categorical label (i.e., low, moderate, and high level of poverty). The cumulative index of poverty was created using the range of weighted variables associated with poverty on the basis of a scale ranging from 1 to 4, where lower scores are indicative of lower poverty and higher scores more strongly associated to poverty. Nine associated variables of poverty were ranked and weighted by a research team with knowledge of the relevant poverty literature and who had experience reading related files at the court clinic. The associated variables and their values were as follows: Refugee status (weight = 2); marital status of primary caregiver (weight = 2); teenage pregnancy (weight = 2); primary caregiver level of education (weight = 2); housing conditions (weight = 2); primary caregiver employment (weight = 3); primary caregiver social assistance support (weight = 3), youth experienced living in a shelter (weight = 4), and youth experienced homelessness (weight = 4).

The refugee status score was added if the youth had ever identified with refugee status. Marital status of the primary caregiver was added to the total poverty score for any youth whose primary caregiver was single or separated, as this would indicate whether the child resided in a single or dual income household. The teenage pregnancy variable was added to the poverty score if the youth was born to a caregiver who was under the age of 18 at the time of birth. The level of completed education was the primary caregiver was added to the total poverty score when the youth's primary caregiver did not indicate completion of a high school education. The housing conditions score was added when family identified as living in poor housing conditions when asked for the reason for moving to be a result of poor housing or unsanitary housing conditions. The primary caregiver employment score was added in events where the caregiver indicated not having current employment. The primary caregiver social assistance support score was added when the caregiver indicated receiving social assistance support. If the youth had ever experienced residing in a shelter, a score for experience living in a shelter was added to the accumulated score. Last, if the youth had ever experienced homelessness a weighted score was added.

The weighted variables yielded a total score of poverty which ranged between 0 to 24 for each youth, and supported the categorical label for poverty applying a tertiary split of the cumulative index of poverty to identify three levels of experienced poverty. The results were: levels of Low Poverty (scores range 0 – 8), Moderate Poverty (9 – 16), and High Poverty (17 – 24). All associated variables were also examined as being present (Yes =1) or absent (No = 0) for the purpose of describing the population.

**Offense history.** To evaluate young offenders and the severity of their criminal history, several categorical variables were used in consideration of the data analysis. Categories for

offender type included persistent offender, where the youth had a criminal history starting at or before the age of twelve, and a limited offender, where the youth had a criminal history beginning after the age of twelve. Additionally, analyses identified youth as first-time offenders from reoffenders using a categorical variable (0 = No, 1 = Yes), where re-offenders would be defined in the current assessment that indicated the present charge was not their first offense. Additional offense history variables included offence type categories, which included weapons offences, disorderly conduct offenses, administration of justice offenses, violent offenses, sexual offenses, property offenses, and drug offenses. Weapons offenses were defined as the youth being in possession of a weapon with harmful intent or engaging in assault with a weapon. Disorderly conduct offenses were limited to loitering and causing a disturbance, while administration of justice offenses included failure to attend or comply, a breach of probation or recognizance or obstructing police. Violent offenses consisted of uttering a threat of bodily harm or death, general assault, robbery, manslaughter or murder. Sexual offenses included sexual interference, assault or prostitution, and property offenses included theft under and over $5,000, mischief, arson, fraud, attempted theft, breaking and entering, and possession under or over $5,000. Last, drug offenses were defined by possession of an illegal substance and substance trafficking.

The numerical total number of charges in the young offender's criminal history was considered in analyses to represent their extent of criminal history.

**Family Conditions.** An aggregate was constructed to measure the social determinants of health of family conditions by ranking and weighting the associated variables of risk of family instability by a team of experts who were knowledgeable of the relevant literature and read related files from the agency. The family aggregate consisted of the biological parent being the

legal guardian of the youth (weight = 1), the youth not living with at least one adult family member at the time of assessment (weight = 3), parents lacking concern for youth's offending behaviour (weight = 2), residential instability (weight = 3), lack of parental involvement (weight = 3), siblings demonstrate involvement with the law (weight = 2), half-siblings demonstrate involvement with the law (weight = 2), presence of family violence (weight = 4), involvement of child welfare services (weight = 3), youth having crown ward status (weight = 4), kinship agreement in effect for youth (weight = 3), child witnessed domestic violence (weight = 3), the youth is identified as a victim of familial sexual abuse (weight = 4), presence of neglect (weight = 4), child experienced physical abuse (weight = 4), lack of parental supervision (weight = 3), single-led parent home (weight = 2), and whether personal crises of the primary caregiver impacted the well-being of the youth (weight = 3). The weighed scores of each variable when present for the youth were added together to create an overall score of the family conditions.

If the biological parent was not the legal guardian of the youth, a weighted score of 1 was added to the family conditions score. If the youth was not residing with their legal guardian/parent or other adult family member such as a relative at the time of the assessment a weighted score of 3 was added to the family condition aggregate. A lack of concern from the guardian referred to their response to the criminal charges of the youth being dismissive, minimalizing the youth's actions or blaming others, or indicating no concern, and an additive score of 2 was added to the family condition aggregate. If the youth's history demonstrated relocating 5 or more times, a weighted score of 3 was added to reflect residential instability. If the youth's primary caregiver was rated to be minimally involved in their life, as demonstrated by a lack of attendance or participation in the youth's court involvement, service access, or as primary caregiver, the weighting for parental involvement was added to the overall family risk score. An equal weighted value of 2 was applied to the cumulative family conditions score if

either a full or half-sibling of the offending youth had an identified history of being involved in the criminal justice system. If there was presence of current family violence or a history of family violence within the home the youth was residing at the time of assessment, then a weighted value of 4 was added to the overall family conditions score. The involvement of child welfare services reflected whether the child's family had current or previous history with the involvement of the Children's Aid Society and their services including community supervision, counselling, or adoption. If the youth was involved in kinship care or had crowd ward status at present or in the past specifically, then that would also be considered in the cumulative family conditions score. If a child demonstrated present or past history of witnessing domestic violence of their primary caregiver or legal guardian a weighted value of 3 was added to the aggregate. If the youth was also a direct victim of physical abuse, neglect, or family sexual abuse, a weighted value of 4 was added to the overall family conditions score for each form of child maltreatment. The parental crisis impact weighting was added to the overall score if the youth's primary caregiver experienced a crisis that had an impact on the youth. Possible parental crises include the death of a loved one, family separation, emotional illness, physical illness, problems with nerves, substance use, financial strain, trouble with the law and personal or family mental health problems.

The levels of compromised family conditions were grouped using a tertiary split of the cumulative score for family conditions. The three categorical groups for the intensity of compromised family conditions were classified as Low Risk (scores range 0 – 15), Moderate Risk (16 – 30), and High Risk (31 – 45). All associated variables were also examined as being present (Yes =1) or absent (No = 0) for the purpose of describing the population.

**School Conditions.** A cumulative index of the social determinant of health - education - was created by ranking and weighing the associated variables of school risk by a team of experts who were knowledgeable of the relevant literature. The school aggregate consisted of the presence of learning disability (weight = 1), presence of developmental disability (weight = 1), special education assessment conducted (weight = 1), special education help provided (weight = 1), presence of behavioural difficulties (weight = 2), educational attainment defined by completing required course credits by the associated school grade (weight = 2), grade failure (weight = 2), perceiving school as difficult (weight = 2), lack of school attendance (weight = 3), history of difficulties with teachers (weight = 3), history of suspension (weight = 4), lack of school interest (weight = 3), change of schools due to victimization (weight = 3), change of schools due to problems with peers (weight = 3), change of schools due to family circumstances (weight = 3), change of schools due to experienced trauma (weight = 3), change of schools due to expulsion (weight = 4), and change of schools due to involvement with the law (weight = 4).

If there was the presence of a learning disability or developmental disability, the weights of those variables were added to the overall school risk score for either condition. If the youth was enrolled or recommended to enroll in a special education program, the weighted value of 1 was added to the overall education risk score. If special education supports were provided, such as the presence of individual education programs (IEPs), educational assistants (EAs), homework clubs and tutors, then a weighted value of 2 was added to the overall education risk score. If a school report or parents directly indicated the presence of behavioural problems an additional value was added to the education aggregate.

Educational attainment was determined using the Ministry of Education's outlined credit completion criteria by grade and compared the expected credits completed to the youth's current

credits completed. In the event the youth had failed to meet the number of credits expected to be achieved by their identified grade, the weighed value was added to the education risk aggregate to reflect not attaining educational outcomes expected. Similarly, if it was reported the youth had failed a grade in their school history this was added as a weighted value to the overall education risk score. School difficulty and teacher difficulty weighting was added based on parent and teacher reports as to whether the youth found schoolwork difficult and whether the student had conflict with their teacher. The school motivation weighting was added to the risk score if parents or youth reported that the youth had little to no interest in school. If the youth demonstrated truancy or a lack of school attendance as indicated in the school reports or intake form, a weighed value was added to the overall education risk score. History of suspension led to a weighed value of 4 being added to the cumulative score for education risk. A final consideration was the rationale for the youth relocating to different schools, where evidence of relational difficulties such as bullying, problems with peers, family moves or experiences of trauma would result in a score of 3 being added for each event to the overall education risk score. If, however, the student demonstrated their involvement with the criminal justice system interfered with their school attendance and educational attainment, a score of 4 as added to the cumulative score for education risk.

Similarly, a tertiary split of the weighted values was used to create three categorical groups based on priori cut off scores to help characterize the sample as being Low Risk (scores range 0-9), Moderate Risk (scores range 10-19), and High Risk (scores range 20-28) for the social determinant of education impacting the youth. All associated variables were also examined as being present (Yes =1) or absent (No = 0) for the purpose of describing the population.

**Community Conditions.** A cumulative index of the social determinant of neighbourhood or community engagement was created by ranking and weighing the associated variables by the research team using knowledge from relevant literature and from review of agency files. The community aggregate consisted of the no social ties outside the family home (weight = 2), having negative social ties (weight = 3), no leisure activities/hobbies (weight = 2), poor housing conditions in the community (weight = 2), the youth not having employment (weight = 2) and youth involved in community gang activity (weight = 4). The community aggregate can range in score from 0 -15, and similarly to other social determinants of health aggregates priori cut off scores were determined using a tertiary split to create categories of Low Risk (scores 0-4), Moderate Risk (scores 5-10), and High Risk (scores 11-15). All associated variables were also examined as being present (Yes =1) or absent (No = 0) for the purpose of describing the population.

**Mental Health.** Mental health was examined in its relation to the social determinants of health. Mental health was characterized by the presence of mental health diagnoses, psychological features, and engagement in behaviours that impacted the well-being of the youth such as substance abuse or self-harm. Youth were recorded as having a mental health diagnosis if a registered clinical psychologist or psychiatrist officially diagnosed them. The diagnoses considered were as follows: Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), Anxiety, Depression, Bipolar Disorder, Borderline Personality Disorder (BPD), Post-Traumatic Stress Disorder (PTSD), Antisocial Personality Disorder, Psychosis, Schizoaffective Disorder, Disruptive Mood Disorder, and Fetal Alcohol Syndrome Disorder (FASD).

Additional contexts that impact the mental health outcomes of youth were also considered, including substance use and suicidal ideation. Substance use was categorized as the use of alcohol and/or various prescriptive or recreational drugs including cannabis, hashish, cocaine, methamphetamine, lysergic acid diethylamide (LSD), ecstasy or MDMA, steroids, inhalants and oxycodone. To evaluate outcomes, the presence of alcohol or substance use was considered present if the legal guardians and/or youth indicated "current" or "prior and current" use in the assessment. The final mental health outcome consideration was whether the youth self-reported the presence of suicidal ideations at the time of the assessment.

**Social Well-Being.** To determine the social well-being outcome of the youths impacted by compromised social determinants of health, social well-being was defined as the presence of an existing support network and healthy relationships. Variables considered included how the youth evaluated their family time (positive, negative), whether youth self-reported the presence of friends (yes, no), and whether those friendships were supportive (positive, negative). A final variable considered was whether the youth was identified by the legal guardian or clinician as being at-risk of harm (harm to self, harm to others, harm to self and others).

**Agency involvement.** Agency involvement was investigated using the total agencies involved with the offender and categorical values for determining the type of agencies used, including outpatient and inpatient services (where 1 = service used, 0 = service not used).

## Results

Three sets of analyses were conducted to accomplish the aims of the study: descriptive analyses were conducted to characterize the sample of offending youth depending on their level of experienced poverty and compromised social determinants of health. Correlation and regression analyses were conducted to examine the relationship of the social determinants of health to poverty, patterns of criminality, family conditions, education risk, and community risk. Last, chi-squared analyses were conducted to identify patterns between outcomes of youth who experience compromised conditions in the family, school, and community contexts.

The first portion of the Results section describes the characteristics of participating youth by their level of poverty. The second section characterizes the social determinants of health and examines the relationships between poverty, criminal history, mental health, social well-being, and agency involvement. Given that multiple comparisons were examined, a Bonferroni correction was calculated to account for the probability of a Type I Error, resulting in the alpha value ($p = 0.05$) being divided by the total number of correlational analyses conducted resulting in the adjusted *p*-value of 0.006.

**Socioeconomic Status.** The majority of the sample was living in lower levels of poverty (80%; $n = 226$), with a moderate proportion experiencing moderate poverty (18%; $n = 50$), and a few youth identified living in concentrated, or deep end poverty (2%; $n = 5$). Descriptive statistics were conducted investigating what proportion of the offender population ($n = 281$) was impacted by factors associated by poverty. At the time of the assessments, 4 (1.40%) of the youth had refugee status, 89 (31.67%) of the youth were being raised in a single parent-led home, 26 (9.30%) were being raised by teen parents, 28 (10.00%) had parents with an elementary education or less, 7 (2.50%) were being raised in poor housing conditions, almost one in four youth (70; 24.90%) came from families with unemployed caregivers, 79 (28.10%) of

youth came from families relying on social assistance programs for financial support, 37 (13.20%) were in a shelter, and 28 (10.0%) of youth identified as homeless. The remaining demographic information of the sample is summarized by poverty level in Table 1.

**Offending Histories.** The number of offenses committed by these youths ranged from 1-24, with much of the sample demonstrating a persistent pattern of offending, such that their first offense occurred before or at the age of 12 years (60%, $n$ = 170). Consistent with this offending pattern, most young offenders had previous charges (60%, $n$ = 169), while the remaining offenders identified the current charge as their first formal charge (40%, $n$ = 112). Consistent with the trends found in offences committed by youth in the Canadian criminal justice system, the most common charge reported amongst the sample ($n$ = 142) was an administrative offense (i.e., failure to comply, failure to attend court, breach of probation, recognizance, and obstruction of police). Following administration of justice offenses, the most common type of offence was a property offence ($n$ = 120), followed by violent offence ($n$ = 119), weapons offence ($n$ = 50), sexual offence ($n$ = 30), disorderly conduct ($n$ = 15), and drug offence ($n$ = 15).

**Service Access.** At the time of referral, the majority of youth (75%, $n$ = 211) were accessing outpatient services (i.e., community counselling, CAS services, probation, outpatient mental health agencies, psychiatric services) while the remaining youth (25%, $n$ = 70) accessed inpatient services (i.e., residential treatment facilities, hospitalization, detention).

Table 1

*Demographics of Young Offender Sample Referred for Assessment in London, ON*

| | Group Membership by Level of Poverty | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Low (*n* = 226) | | | Moderate (*n* = 50) | | | High (*n* = 5) | | |
| Offense Features | *n* | SD | % | *n* | SD | % | *n* | SD | % |
| **Offense Identification** | | | | | | | | | |
| Limited Offender (first offense after the age of 12) | 94 | 0.49 | 41.6 | 13 | 0.44 | 26.0 | 3 | 0.55 | 60.0 |
| Persistent Offender (first offense before or at the age of 12) | 131 | 0.49 | 58.4 | 37 | 0.44 | 74.0 | 2 | 0.55 | 40.0 |
| **Offense by Type** | | | | | | | | | |
| Administration of Justice | 113 | 0.50 | 50.0 | 27 | 0.50 | 54.0 | 2 | 0.55 | 40.0 |
| Disorderly Conduct | 11 | 0.22 | 4.9 | 3 | 0.24 | 6.0 | 1 | 0.45 | 20.0 |
| Drug Offenses | 11 | 0.22 | 4.9 | 3 | 0.24 | 6.0 | 1 | 0.45 | 20.0 |
| Property Offenses | 96 | 0.50 | 42.5 | 21 | 0.50 | 42.0 | 3 | 0.55 | 60.0 |
| Weapons Offenses | 39 | 0.38 | 17.3 | 11 | 0.42 | 22.0 | 0 | 0.00 | 0.00 |
| Sexual Offenses | 25 | 0.31 | 11.1 | 5 | 0.30 | 10.0 | 0 | 0.00 | 0.00 |
| Violent Offenses | 99 | 0.50 | 43.8 | 16 | 0.47 | 32.0 | 4 | 0.45 | 80.0 |
| **Offense Pattern** | | | | | | | | | |
| First Charge (Yes) | 94 | 0.49 | 41.6 | 17 | 0.48 | 34.0 | 1 | 0.45 | 20.0 |
| Re-offender | 132 | 0.49 | 58.4 | 33 | 0.48 | 66.0 | 4 | 0.45 | 80.0 |
| Agency Involvement | | | | | | | | | |
| **Agencies Accessed by Severity** | | | | | | | | | |
| Accessing Outpatient Services | 163 | 0.90 | 72.1 | 43 | 0.70 | 86.0 | 5 | 0.00 | 100.0 |
| Accessing Inpatient Services | 70 | 1.85 | 31.0 | 23 | 2.01 | 46.0 | 3 | 2.19 | 60.0 |

## Young Offenders and Poverty

**Low poverty youth.** Offending youth identified as experiencing a low level of poverty demonstrated similar identification as limited or persistent offenders (41.6% and 58.4% respectively), whereby limited offenders engaged in their first offense after the age of 12, while persistent offenders first offended before the age of 12. In review of the presenting charges at the time of the assessment, low poverty offending youth engaged primarily in administration of justice offenses (50.0%), property offenses (42.5%), and violent offenses (43.8%). The target of the violent offenses were acquaintances (18.1%), family members (18.1%), or members of a group home (10.6%). As expected, low poverty offending youth were accessing outpatient

services (72.1%). Based on the agencies provided, low poverty offending youth demonstrated mental health needs that were being addressed by community counselling services (53.5%) and hospitals (49.0%). An overwhelming 57% were receiving support from a community psychiatrist. Offending youth experiencing low poverty were also characterized by moderate housing and familial needs, reflected in 39.4% were engaged in group home services, indicating a high level of residential instability and arising concerns with family dynamics. The concern for child welfare in relation to family dynamics is further emphasized by the prevalence of supervision orders in effect in almost a third of the cases (29.6%) and temporary care agreements in one out of five cases (20.8%) with the Children's Aid Society (CAS).

**Moderate poverty.** In comparison to those youths considered as living in low end poverty, offending youth who were considered as residing in moderate levels of poverty have distinctively different offending patterns and service needs compared to youth who are experiencing few features of poverty. Unlike the low poverty offending group, young offenders from moderate poverty are primarily identified as persistent offenders (74.0%), indicating that most offending youth from this group were engaging in delinquent behaviour prior to the age of 12 years. This is further supported by more than two-thirds of these youth displaying a reoffending pattern (66.0%), even though they demonstrated a similar offense type pattern reflected in property offenses (42.0%), violent offenses (32.0%) and administration of justice offenses (54.0%) as compared to offenders from low poverty. In consideration of the target of their offenses, youth moderately impacted by poverty engage in crimes primarily against family members (20.0%), followed by offenses against acquaintances (14.0%) and authority figures (12.0%).

To respond to the criminogenic needs of moderately impoverished youth, results indicated a need for access to a community psychiatrist (72.0%), hospitals (58.0%) and community counselling (52.0%) in response to mental health needs. Compared to the low poverty group, offending youth from moderate poverty reflected greater access to the use of family services, with one in every two youth requiring group home services (50.0%); 6% had a supervision order in effect, with equal engagement in temporary care agreements (32.0%). One third of this group had been referred to the Community Services Coordination Network (CSCN) for further consideration of their needs (CSCN; 32.0%). Interestingly, offenders from moderate poverty also reflected greater access to developmental services (6.0%) relative to the low poverty offender group (2.2%), which indicates that poverty may have a detrimental effect on a youth's development and behavioural outcomes.

**Deep end poverty**. The final consideration is of young offenders identified as highly marginalized by poverty, where 4 of the 5 youth in this category were identified as re-offenders and two of the five identified as persistent offenders. When comparing the offense type and target of offenses, the high poverty offender group demonstrated the most violent offenses and the most offenses against authority figures compared to youth offenders experiencing fewer features related to poverty. Although the trend for all offenders was engagement in administration of justice offenses, property offenses and violent crimes, the young offenders from high poverty reflected the greatest involvement in serious crimes.

When considering the criminogenic needs of high poverty offending youth and their access to services, results reflected the ongoing use of outpatient services (100.0%) while accessing more intensive support through inpatient services (60.0%). More specifically, offending youth from high poverty demonstrated greater use of a clinical supports programs

(40.0%) and addiction treatment facilities (20.0%) relative to the low and moderate poverty offenders for their mental health needs. Family needs show greatest concern as well among high poverty offending youth, where two in five of the youth (40.0%) had crown ward status and 60% demonstrated supervision orders in effect.

Youth regardless of their level of poverty demonstrated high involvement in justice-related services. As expected, all youth have a high engagement with police services (99.1% for low poverty group; 98.0% for moderate poverty group; 100.0% for high poverty group) as they begin or continue their involvement within the court. High poverty offending youth, however, show the greatest interaction with detention services (60.0%) compared to low poverty offending youth (41.2%) and moderate poverty offenders (56.0%) likely as a reflection of their re-offending behaviour and greater frequency of engagement in violent crimes.

**Young Offenders and the Social Determinants of Health by Level of Poverty**

Although poverty is linked to specific offense patterns and the severity of offense, it is also relevant to consider how the social determinants of health contribute to the prevalence of these youth within the judicial system.

**Family.** To identify the most prevalent family conditions as a social determinant of health characterizing the sample, descriptive statistics were conducted. As outlined in Table 2, there are varying degrees of missing data in each of the variables, and the descriptive statistics are shown with valid cases and organized by degree of experienced poverty.

For the social determinant of family conditions, results convey that significant differences in the condition and quality of the youth's experience can be recognized depending on the individual's level of poverty. It is important to note that at least 1 in 5 young offenders do not have their parent as their legal guardian, reflected in 22% of the moderate poverty group

compared to 24.8% of low poverty youth and 60% of high poverty youth. Further indication of unconventional family structure is reflected in the results that, regardless of their level of poverty, more than 1 in 4 offending youth do not currently live with their family (37.6% in low poverty; 40.0% in moderate and high poverty). A chi-square test of independence examined the relationship between level of compromised family conditions and the parent being the legal guardian of the child. The relationship between these variables was significant, $X^2$= (2, $N$ = 279) = 90.028, $p$ = .00, φcramers = 0.568, such that youth from higher levels of compromised family conditions had higher than expected counts of an absent caregiver as legal guardian than those youths from lower levels of compromised family conditions. A chi-square test of independence was also conducted to examine the relationship between level of compromised family conditions and whether the youth resided with an adult guardian at the time of the assessment. The relationship between these variables was significant, $X^2$= (2, $N$ = 281) = 61.652, $p$ = .00, φcramers = 0.468. Youth who were experiencing severely compromised conditions within the family context were significantly more likely to be alone or living with a non-familial adult than youth from more structured family dynamics. Ninety-two percent of youth in higher levels of compromised family conditions ($n$ = 25), 47.9% of youth in moderate levels of compromised family conditions ($n$ = 58), and 18.0% of youth in low levels of compromised family condition ($n$ = 24) reported being alone or living with a non-familial adult.

In further exploring the parent-child relationship, the results illustrated a lack of parental involvement especially for youth from high poverty (80.0%). A chi-square test of independence examined the relationship between level of compromised family conditions and degree of caregiver support for the youth. The relationship between these variables was significant, $X^2$= (2, $N$ = 263) = 69.960, $p$ = .00, φcramers = 0.516, such that youth from higher levels of compromised family conditions were more likely to experience less involvement and support

from their caregiver during their adolescence ($n$ = 22) than youth from less compromised conditions in the family environment ($n$ = 12). As well, parents reported allowing personal crises from their life to impact youth (65.0% in low poverty group, 92.0% in moderate poverty, 80.0% from high poverty). A chi-square test of independence examined the relationship between offender type and the personal crises of primary caregivers being involved with the law. The relationship between these variables, however, was not significant, $X^2$= (1, $N$ = 227) = 0.574, $p$ = .449.

Other family members under consideration were siblings, where sibling and half-siblings involved in the law were present among low poverty youth (8.0% and 3.5%) and moderate poverty youth (16.0% and 2.0%) but not among high poverty offending youth. A chi-square test of independence examined the relationship between offender type and siblings involved in the law. The relationship between these variables was significant, $X^2$= (1, $N$ = 270) = 2.813, $p$ = .093, phi = 0.102, such that persistent offenders were more likely to have full siblings demonstrating involvement in the criminal justice system ($n$ = 19) than limited offenders ($n$ = 6). The results were not significant, however, for the relationship between offender type and half siblings involved in the law, $X^2$= (1, $N$ = 268) = 1.217, $p$ = .270, phi = 0.067.

*Family violence*. Distinct features characterizing offending youth were determined through a review of the conditions and experiences within the family. Family violence was heavily represented for youth among all levels of poverty (58.4% Low; 70.0% Moderate; 60.0% High) and in witnessing domestic violence (52.7% Low; 60.0% Moderate; 60.0% High). The overall risk and occurrence of violence within the home is especially concerning given the reported proportion of youth who spend time with family (70.8% Low; 68.0% Moderate; 80.0% High), and that few identify the time spent with family as negative (7.5% Low; 1.23% Moderate;

20.0% High). A chi-square test of independence examined the relationship between level of compromised family conditions and family violence. The relationship between these variables was significant, $X^2$= (2, *N* = 277) = 95.073, *p* = .000, φcramers = 0.586, indicating that youth from severely compromised conditions within the family context are more likely to experience family violence (*n* = 41) than those from less compromised family conditions (*n* = 25). The outcomes for offending youth growing up in a violent home are also noteworthy. Rates of CAS involvement were high among all offending youth and was universally reported among high poverty young offenders (100.0%). High poverty offending youth were also characterized as having the highest occurrence of kinship agreements (100.0%), crown wardship status (40.0%), and being a victim of familial sexual abuse (40.0%) and physical abuse (80.0%). A chi-square test of independence examined the relationship between level of compromised family conditions and physical abuse. The relationship between these variables was significant, $X^2$= (2, *N* = 274) = 116.044, *p* = .000, φcramers = 0.651. Youth from compromised family conditions were more likely to experience physical abuse (*n* = 27) than youth from less compromised family conditions (*n* = 26).

Young offenders from moderate poverty experienced the greatest level of neglect (38.0%) and residential instability (68.0%). A chi-square test of independence examined the relationship between level of compromised family conditions and neglect. The relationship between these variables was significant, $X^2$= (2, *N* = 278) = 77.286, *p* = .000, φcramers = 0.527, indicating that youth from severely compromised conditions within the family context reported experiencing neglect (*n* = 23) more often than youth from less compromised family contexts (*n* = 9).

A final consideration was determining the extent of compromised family conditions experienced by the offending youth. Descriptive statistics demonstrated that of all associated family risk variables, almost half of the sample demonstrated low risk (47.3%, $n = 133$), followed by moderate risk (43.1%, $n = 121$), and about 1 in 10 offending youth experience high risk family conditions (9.6%, $n = 27$). Relative to poverty, youth from low poverty experienced mostly low risk family conditions (50.0%, $n = 113$), relative to moderate family risk conditions in the moderate poverty group (48.0%, $n = 24$), and offending youth from deep end poverty demonstrating the greatest risk in the family domain (40.0%, $n = 2$). Correlational analyses revealed a weak ($r = 0.183$) but significant ($p = 0.002$) correlation between the accumulated index of poverty and the social determinant of family conditions.

*Table 2*

*Descriptive Statistics of the Family Condition as a SDH for LFCC offender sample*

| | *Group Membership by Level of Poverty* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Low (n = 226)* | | | *Moderate (n = 50)* | | | *High (n = 5)* | | |
| Family Characteristics | *n* | % | % valid | *n* | % | % valid | *N* | % | % valid |
| Legal Guardian is Parent (No) | 56 | 24.8 | 24.9 | 11 | 22.0 | 22.4 | 3 | 60.0 | 60.0 |
| Youth Not Living with Family | 85 | 37.6 | 37.6 | 20 | 40.0 | 40.0 | 2 | 40.0 | 40.0 |
| Guardians Not Concerned with Youth's Offense History | 26 | 11.5 | 20.6 | 7 | 14.0 | 36.8 | 1 | 20.0 | 20.0 |
| Residential Instability | 98 | 43.4 | 47.6 | 34 | 68.0 | 70.8 | 2 | 40.0 | 40.0 |
| Guardians Demonstrate Minimal Involvement in Youth's Life | 57 | 25.2 | 27.0 | 18 | 36.0 | 38.3 | 4 | 80.0 | 80.0 |
| Siblings with Offense History | 18 | 8.0 | 8.2 | 8 | 16.0 | 17.0 | 0 | 0.0 | 0.0 |
| Half-Siblings with Offense History | 8 | 3.5 | 3.7 | 1 | 2.0 | 2.0 | 0 | 0.0 | 0.0 |
| Family Violence Present | 132 | 58.4 | 59.2 | 35 | 70.0 | 71.4 | 3 | 60.0 | 60.0 |
| CAS involvement | 173 | 76.5 | 76.5 | 47 | 94.0 | 94.0 | 5 | 100.0 | 100.0 |
| Kinship Agreement in Effect | 16 | 7.1 | 7.1 | 3 | 6.0 | 6.0 | 5 | 100.0 | 100.0 |
| Youth a Crown Ward | 34 | 15.0 | 15.0 | 9 | 18.0 | 18.0 | 2 | 40.0 | 40.0 |
| Youth witnessed Domestic Violence | 119 | 52.7 | 53.6 | 30 | 60.0 | 61.2 | 3 | 60.0 | 60.0 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Victim of Familial Sexual Abuse | 17 | 7.5 | 7.6 | 5 | 10.0 | 10.4 | 2 | 40.0 | 40.0 |
| Evidence of Neglect | 54 | 23.9 | 24.1 | 19 | 38.0 | 38.8 | 1 | 20.0 | 20.0 |
| Youth experienced Physical Abuse | 106 | 46.9 | 48.0 | 37 | 74.0 | 77.1 | 4 | 80.0 | 80.0 |
| Lack of Parental Supervision | 35 | 15.5 | 16.4 | 6 | 12.0 | 13.0 | 2 | 40.0 | 50.0 |
| Personal Crises of Parent Impacted Youth | 147 | 65.0 | 76.2 | 41 | 82.0 | 89.1 | 4 | 80.0 | 100.0 |
| Time Spent with Family (Yes) | 160 | 70.8 | 72.7 | 34 | 68.0 | 69.4 | 4 | 80.0 | 80.0 |

To determine the impact of factors consistent with compromised conditions within the family context, a series of chi squares were conducted to evaluate the relationship to negative life outcomes.

To evaluate mental health outcomes, a chi square test of independence determined that a significant relationship exists between level of compromised family conditions and an outcome of mental health diagnoses or features, $X^2$= (2, $N$ = 268) = 6.903, $p$ = .032, φcramers = 0.160. To determine the most contributing predictor variable to the outcome, a post-hoc analysis indicated that the overall relationship was significant but no one level contributed more to the relationship.

For the prevalence of addictions as an outcome of poor family conditions, a chi square test of independence determined that there was no significant relationship between the extent of compromised family conditions and the abuse of alcohol or substances, $X^2$= (2, $N$ = 268) = 0.058, $p$ = 0.638. Last, results of a chi square test of independence indicated no significant relationship between level of compromised family conditions and suicidal ideations, $X^2$= (2, $N$ = 280) = 2.574, $p$ = 0.276.

To evaluate social well-being, a chi square test of independence determined that no significant relationship existed between level of compromised family conditions and the outcome of perceiving time with family as positive, $X^2$= (2, $N$ = 280) = 3.788, $p$ = 0.150. Further evaluation of social outcomes for young offenders of dysfunctional family conditions were

suspended for the outcomes of presence of friends, presence of a positive support network, and harm to self or others due to violations to statistical assumptions.

To evaluate educational outcomes, a chi square test of independence was conducted to evaluate if a significant relationship was predictive from the level of compromised conditions within the family context. Results indicated that no significant relationship was present, $X^2$= (2, $N$ = 198) = 4.99, $p$ = .082.

**Education.** For the social determinant of education, results indicated that conditions within the school drive academic achievement and success. More specifically, descriptive statistics as shown in Table 3 illustrate that more than half of these youth have completed an education assessment (57.5% Low; 66.0% Moderate; 80.0% High). The results illustrate that offenders from low and moderate poverty had a greater likelihood of being identified with a developmental disability (7.5% and 14.0%) but not for young offenders from high poverty (0.0%). Comparatively, behavioural difficulties were identified in an assessment for young offenders from low poverty (16.4%), moderate poverty (22.0%) and high poverty (20.0%) and regardless of the identified needs from assessment, special education services were provided to offending youth regardless of their level of poverty (59.3% Low; 68.0% Moderate; 100.0% High). A chi square test of independence demonstrated a significant relationship between behavioural difficulties and criminality, $X^2$= (1, $N$ = 279) = 4.139, $p$ = 0.042, phi = 0.122, such that the presence of behavioural difficulties contributes to determining limited or persistent offenders.

In a review of school connectedness and commitment, all offending youth regardless of their level of poverty perceived school to be difficult (81.4% Low; 84.0% Moderate; 100.0% High). For offending youth from marginal poverty, youth were characterized by the lowest rate

of school attendance (31.4%), which directly impacted the frequency of grade failure (25.7%) and maintaining the expected level of educational attainment by their grade level (45.1%). In review of the reasons for school transfer, young offenders from low poverty indicated family circumstances (27.9%) as the primary contributor. In comparison, offenders from moderate poverty reflected the greatest identified behavioural difficulties following an assessment (22.0%) as well as the highest rate of school suspension (62.0%). Similar to offenders from low poverty, family circumstances were identified as the primary reason for school transfers, followed by involvement with the law (18.0%) and the highest rate of school expulsion (6.0%) among all offender groups. A final consideration for offenders heavily impacted by poverty indicated that offending youth from high poverty were characterized by the highest rate of a lack of motivation or interest in school (40.0%), which could assist in understanding their perception of school as being difficult (100.0%). High poverty offending youth also distinctively have difficult relationships with their teachers (80.0%) and demonstrate the lowest rate of educational attainment (20.0%) relative to other young offenders. In terms of reason for school transfers, family circumstances (60.0%) and involvement with the law (20.0%) accounted as the primary cause for this offender group.

To determine the extent of compromised conditions within the school domain, descriptive statistics demonstrated that of all associated school risk variables, most young offenders experienced moderate risk in the school domain (64.8%, $n = 182$), followed by low risk (27.0%, $n = 76$), and high risk conditions (8.2%, $n = 23$). Relative to poverty, youth from low poverty experienced the least risk in the school domain (29.6%, $n = 67$) compared to offenders from moderate poverty (16.0%, $n = 8$) and deep end poverty (20.0%, $n = 1$). Correlational analyses revealed a weak ($r = 0.117$) but significant ($p = 0.005$) correlation between the accumulated index of poverty and the social determinant of education.

To determine the impact of the education context on criminality and later life outcomes, a series of chi squares were conducted. Results of a chi square test of independence determined a significant relationship between level of compromised conditions within the educational context and offender type, $X^2$= (2, $N$ = 280) = 13.152, $p$ = 0.001, φcramers = 0.217, such that the criminal trajectory of a young offender can be reliably predicted from the extent of compromised conditions within the educational context.

To evaluate mental health outcomes, a chi square test of independence determined that a significant relationship exists between level of compromised education settings and an outcome of mental health diagnoses or features, $X^2$= (2, $N$ = 268) = 6.049, $p$ = .049, φcramers = 0.150. To determine the most contributing predictor variable to the outcome, a post-hoc analysis indicated that the overall relationship was significant but no one level contributed more to the relationship.

For the prevalence of addictions as an outcome of poor educational context, a chi square test of independence determined that compromised conditions within the education setting contribute directly to alcohol abuse, [$X^2$= (2, $N$ = 278) = 6.312, $p$ = 0.043, φcramers = 0.151] and substance abuse, [$X^2$= (2, $N$ = 277) = 5.763, $p$ = 0.056, φcramers= 0.144]. Last, results of a chi square test of independence indicated no significant relationship between level of education conditions and suicidal ideations, $X^2$= (2, $N$ = 0.036) = 0.982.

To evaluate social well-being, a chi square test of independence determined that no significant relationship existed between level of compromised education conditions and the outcomes of presence of friends, presence of a positive support network, and harm to self or others due to violations to statistical assumptions.

To evaluate educational outcomes, a chi square test of independence was conducted to evaluate if a significant relationship was predictive from the level of compromised conditions

*Table 3*
*Descriptive Statistics of Education as a SDH for LFCC offender sample*

within the education context. Results indicated that a significant relationship was present, $X^2$= (2, *N* = 198) = 17.345, *p* = .000, φcramers= 0.296. Post-hoc analysis indicated that the largest residual was in the cell of high level risk for compromised conditions within the education setting with not attaining educational expectations, indicating that the poorer experiences within the school context the more likely these youths do not have positive educational outcomes.

| Education Characteristics | *Group Membership by Level of Poverty* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Low* (*n* = 226) | | | *Moderate* (*n* = 50) | | | *High* (*n* = 5) | | |
| | *n* | % | Valid % | *N* | % | Valid % | *N* | % | Valid % |
| Special Education Assessment conducted (yes) | 138 | 61.1 | 61.9 | 36 | 72.0 | 73.5 | 4 | 80.0 | 80.0 |
| Developmental Disability | 17 | 7.5 | 7.5 | 7 | 14.0 | 14.0 | 0 | 0.00 | 0.00 |
| Behavioral Difficulties | 37 | 16.4 | 16.4 | 11 | 22.0 | 22.0 | 1 | 20.0 | 20.0 |
| Special Education Services Provided | 134 | 59.3 | 60.9 | 34 | 68.0 | 69.4 | 5 | 100.0 | 100.0 |
| Educational Attainment (no) | 61 | 27.0 | 37.4 | 12 | 24.0 | 35.3 | 0 | 0.0 | 0.0 |
| Lack of School Interest | 45 | 19.9 | 20.8 | 6 | 12.0 | 12.2 | 2 | 40.0 | 40.0 |
| Lack School Attendance | 71 | 31.4 | 31.6 | 12 | 24.0 | 24.5 | 1 | 20.0 | 20.0 |
| History of Grade Failure | 58 | 25.7 | 30.2 | 12 | 24.0 | 27.9 | 1 | 20.0 | 20.0 |
| History of Suspension | 125 | 55.3 | 61.0 | 31 | 62.0 | 64.5 | 1 | 20.0 | 25.0 |
| Perceive School as Difficult | 184 | 81.4 | 83.6 | 42 | 84.0 | 85.7 | 5 | 100.0 | 100.0 |
| Difficulty with Teachers | 142 | 62.8 | 66.0 | 37 | 74.0 | 77.1 | 4 | 80.0 | 80.0 |
| School Transfer due to Bullying | 1 | 0.4 | 0.5 | 1 | 2.0 | 2.2 | 0 | 0.0 | 0.0 |
| School Transfer due to Problems with Peers | 8 | 1.8 | 2.2 | 2 | 4.0 | 4.4 | 0 | 0.0 | 0.0 |
| School Transfer due to Family Circumstances | 63 | 27.9 | 33.9 | 18 | 36.0 | 40.0 | 3 | 60.0 | 60.0 |
| School Transfer due to Experienced Trauma | 0 | 0 | 0.0 | 0 | 0.0 | 0.0 | 0 | 0.0 | 0.0 |
| School Transfer due to Expulsion | 4 | 1.8 | 2.2 | 3 | 6.0 | 6.7 | 0 | 0.0 | 0.0 |
| School Transfer due to Involvement with the Law | 16 | 7.1 | 8.6 | 9 | 18.0 | 20.0 | 1 | 20.0 | 20.0 |

**Neighbourhood and community.** A final consideration is how the neighbourhood or community impacts the welfare of offending youth. Results illustrated in Table 4 indicate a high prevalence of no social ties to the community for all offenders regardless of their poverty level (40.4% Low; 44.0% Moderate; 80.0% High). A chi square test of independence demonstrated there was no significant association between level of community risk and offender type, $X^2$= (2, *N* = 280) = 2.980, *p* = 0.225. Young offenders from high poverty demonstrated the greatest likelihood of having negative relationships with people in the community and the highest prevalence in gang activity (80.0%). It is also noteworthy that a total absence of structured

activities or hobbies were demonstrated among offending youth regardless of their level of poverty group membership (65.9% Low; 78.0% Moderate; 80.0% High).

To determine the relative experience of compromised community conditions, descriptive statistics were conducted and determined that more than half of offending youth experienced moderate risk to their well-being in the community (51.2%, $n = 144$). By extent of experienced poverty, results indicated offending youth from deep end poverty had not experienced high risks within their community (0%, $n = 0$) compared to moderate poverty offending youth (6.0%, $n = 3$) and offenders from low poverty (4.9%, $n = 11$). There was no significant relationship found between level of poverty and level of risk associated with the social determinant of community ($r = 0.022$, $p > 0.05$).

To determine the impact of the community context on criminality and later life outcomes, a series of chi squares were conducted. To evaluate mental health outcomes, a chi square test of independence determined that no significant relationship exists between level of compromised community risk and an outcome of mental health diagnoses or features, $X^2 = (2, N = 268) = 0.597$, $p = 0.742$. Similarly, results demonstrated no significant relationship between level of community risk and suicidal ideations, $X^2 = (2, N = 280) = 0.887$, $p = 0.642$. Last, evaluating associations between level of community risk and substance abuse, results of a chi square test of independence indicated no significant relationship between level of education conditions and substance abuse, $X^2 = (2, N = 0.036) = 0.982$.

Table 4

*Descriptive Statistics of Community for LFCC Sample*

| Community Characteristics | *Group Membership by Level of Poverty* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Low* (*n* = 226) | | | *Moderate* (*n* = 50) | | | *High* (*n* = 5) | | |
| | *n* | % | % valid | *n* | % | % valid | *n* | % | % valid |
| No Social Ties outside the Family | 130 | 57.5 | 59.6 | 27 | 54.0 | 55.1 | 1 | 20.0 | 20.0 |
| Negative Social Ties Present | 22 | 9.7 | 10.2 | 3 | 6.0 | 6.1 | 1 | 20.0 | 20.0 |
| No organized leisure activities/hobbies | 149 | 65.9 | 69.3 | 39 | 78.0 | 79.6 | 4 | 80.0 | 80.0 |
| Poor Housing Conditions | 2 | 0.9 | 0.9 | 4 | 8.0 | 8.0 | 1 | 20.0 | 20.0 |
| Involved in Gang Activity | 10 | 4.4 | 4.6 | 4 | 8.0 | 8.7 | 0 | 0.0 | 0.0 |

To evaluate social well-being, a chi square test of independence determined that no significant relationship existed between level of compromised community and the outcomes of presence of friends, presence of a positive support network, and harm to self or others due to violations to statistical assumptions.

To evaluate educational outcomes, a chi square test of independence was conducted to evaluate if a significant relationship was predictive from the level of compromised conditions within the community context, however, analyses violated statistical assumptions and was rejected.

**SDH and Service Access.** Correlations were computed to determine if a significant relationship could be associated between agency involvement and the social determinants of health. There was a moderate significant correlation ($r = 0.244$, $p = 0.000$) between agency involvement and the social determinant of education. Similarly, a moderate significant correlation ($r = 0.374$, $p = 0.000$) was found between agency involvement and the social determinant of family dynamics. Finally, a weak but significant correlation ($r = 0.141$, $p = 0.018$)

was found between agency involvement and the social determinant of neighbourhood, however, results were no longer significant after account of adjusted *p* values ($p > 0.006$).

## Regression Analyses

**SDH and Offending Behaviour.** Based on the numerous significant correlations found between poverty and the social determinants of health, regression analyses were conducted to explore whether offending and agency involvement could be predicted from the social determinants of health and are summarized in Table 5. A regression was calculated to predict offending behaviour based on the risk associated with the social determinant of education. A significant regression equation was found [$F (1, 278) = 7.892$, $p < 0.005$], with an $R^2$ of 0.028. The results indicate that 2.8% of the variability in offending behaviour can be predicted by the social determinant of education. A similar regression analysis was conducted to predict offending behaviour from the social determinant of family dynamics and a significant regression equation was found [$F (1, 278) = 13.512$, $p < 0.000$], with an $R^2$ of 0.046. The results illustrate that 4.6% of the variability in offending behaviour can be predicted by the social determinant of family dynamics. Offending behaviour could not be predicted, however, from the social determinant of neighbourhood [$F (1,278) = 1.509$, $p > 0.005$].

*Table 5*

*Summary of Regression Analyses for SDH Variables predicting Offense History* (N = 280)

| Source | *B* | *SE B* | B | *T* | *P* |
|---|---|---|---|---|---|
| SchoolRisk | 0.223 | 0.079 | 0.166 | 2.809 | 0.005 |
| FamilyRisk | 0.159 | 0.043 | 0.215 | 3.674 | 0.000 |
| CommRisk | 0.225 | 0.183 | 0.073 | 1.229 | 0.220 |

Dependent Variable: Offense History

**SDH and Service Access.** Regression analyses were also conducted to determine if agency involvement could be predicted from the social determinants of health and are summarized in Table 6. A regression was calculated to predict agency involvement based on the risk associated with the social determinant of education. A significant regression equation was found [F (1,279) = 17.593, $p < 0.000$], with an $R^2$ of 0.059. The results illustrate that 5.9% of the variability in agency involvement can be predicted by the social determinant of education. A similar regression was calculated to predict agency involvement based on the risk associated with the social determinant of family dynamics. A significant regression equation was found [F (1, 279) = 45.411, $p < 0.000$], with an $R^2$ of 0.140. The results illustrate that 14.0% of the variability in agency involvement can be predicted by the social determinant of family dynamics.

*Table 6*

*Summary of Regression Analyses for SDH Variables predicting Service Access* (N = 281)

| Source | *B* | *SE B* | B | *T* | *p* |
|---|---|---|---|---|---|
| SchoolRisk | 0.191 | 0.058 | 0.185 | 3.316 | 0.001 |
| FamilyRisk | 0.201 | 0.031 | 0.356 | 6.566 | 0.000 |

Dependent Variable: Service Access

**The mediating effect of poverty.** To examine moderator and mediator effects, regression analyses were conducted to determine if poverty mediated the relationships between offending behaviour and the social determinants of health as well as the relationship between agency involvement and the social determinants of health. The results demonstrate that, as predicted, poverty was a mediator for the relationship between offending and the risks associated with the social determinants of health of education and family dynamics [F (4, 275) = 5.481, $p < 0.000$], with an $R^2$ of 0.074. For agency involvement, results demonstrated that, as predicted, poverty was a mediator for the relationship between agency involvement and the risks associated

with all the social determinants of health [$F (4, 276) = 16.522$, $p < 0.000$], with an $R^2$ of 0.193. The results suggest that 19.3% of the variability of agency involvement can be predicted by the extent of associated risk for each social determinant of health. Overall, results suggest that as the degree of poverty increases, so does the likelihood of re-offending and the extent of agency involvement.

## Discussion

This study examined the association of the social determinants of health and youth criminality in the context of poverty for serious and violent young offenders who were referred for psychological assessment by a youth court judge to an urban-based court clinic to support intervention outcomes. A descriptive examination of the participants revealed the extent of poverty differentiated offenders in their level of elevated risks within the social determinants of health and accessing services. More specifically, offenders demonstrated a significant elevation in their criminal engagement, use of intensive interventions and agency services, and risks for dysfunctionality within their living domains as experienced poverty became more concentrated. When evaluating the prevalence and extent of compromised conditions within the social determinants of health, limited but significant differences in life outcomes and access to services were demonstrated. Young offenders demonstrated that factors associated within the family and school domain were predictive of service access and the prevalence of adverse life outcomes. However, results were limited in demonstrating any predictive utility in understanding the community context of the young offender and its impact on later life consequences. Importantly, the context of poverty was significant in understanding the rehabilitative success of young offenders, where offenders from concentrated poverty showed more adverse conditions in the social determinants of health than youths from minimal or moderate poverty. Regardless of the psychosocial risk factors prevalent within each domain, poverty mediated the relationship between adverse life conditions and criminal trajectory for youths who were persistent offenders.

### Current Findings in Relation to Previous Literature

**Family Domain.** Consistent with the literature, results indicated a significant relationship between adverse conditions within the family context and the prevalence of antisocial or delinquency behaviour (Sobotkova, 2012). Unconventional family structure was prevalent

among all young offenders within the sample, reflected in more than one-in four were either not living within the family domain or experienced an absence in parental involvement, reliance, or commitment. Young offenders also demonstrated unconventional roles within the family from parents allowing personal crises to impact the well-being of their child. Consistent with the literature, low parental involvement or control and less consistent parenting practices had a predictive impact on the offending patterns of their youth (Alvi, 2012; Sobotkova, 2012). Although parents with a criminal history did not reflect on the offending patterns of their youth, results did indicate that youth with full siblings involved in the law demonstrated an earlier age of onset in criminal engagement and as persistent offenders compared to first charge or limited offenders. Although inconsistent findings with relevant literature, the influence of siblings demonstrates observational learning and values within the home promoting antisocial behaviour and criminal engagement as a response to adverse conditions. Predictive utility of this relationship could be supportive in family intervention practices. Consistent with the literature, persistent poverty elevated exposure to psychosocial and physical risk factors impacting the health outcomes of offending youth, as demonstrated by the high prevalence of exposure to domestic violence, experience of physical or sexual abuse, and neglect (Fomby, 2013).

Further consideration of the association between poverty and the social determinants of health is reinforced in the prevalence of intensive services and adverse life outcomes for youth experiencing severe risk in the family domain. Child welfare services were accessed and kinship agreements or crown ward status were implemented for young offenders demonstrating moderate and high levels of relative poverty. This is consistent with the literature that reflects that persistent poverty reinforces familial risks that create residential and emotional instability for youth (Evans & Cassells, 2014). In addition, research conveys that greater externalizing problems and a higher prevalence of mental health concerns are present when familial risk

factors are higher, as reflected in the link between elevated familial risk and prevalence of mental health disorders or psychological features (Evans & Cassells, 2014). These findings support the hypothesis that greater adverse conditions in the family are linked to unhealthy outcomes for young offenders.

Contrary to the literature, results did not convey that unstable family environments decrease social competency with peers and establishing a social network (Halgunset et al., 2013). Youth may seek out peers and rely more on peer relationships more strongly in the presence of family conflicts, allowing opportunities for social learning and competency in establishing and maintaining social relationships. The literature has illustrated that youth with antisocial or delinquent behaviours demonstrate greater propensity for association with delinquent peers and are more susceptible to gang affiliation in the absence of strong social connections to prosocial peers or family (Corrado, Leschied, & Lussier, 2015; Lipman & Boyle, 2008).

A final consideration was the impact adverse conditions within the family domain had on criminal engagement and in accessing resources. Consistent with the literature, findings demonstrate a relationship between family instability and delinquency, such that greater antisocial behaviour is associated with the psychological and social risks within the family (Sobotkova, 2012). Further demonstration of family influence with youth outcomes is reflected in the moderate correlation between level of risk within the family domain and agency involvement. These results are consistent with the literature that family instability impacts educational enrollment and completion; family circumstances were most frequently reported among the sample in contributing to school transfers (Fomby, 2013). Results also conveyed that access to services was moderately dependent on familial risk, and that poverty moderated this association such that greater prevalence of poverty resulted in additional barriers in accessing services in the past and present.

**School Domain.** Results illustrated that the school domain and its associated risks have the greatest predictive utility for life outcomes and criminal trajectories of both persistent and limited offenders. Consistent with the literature, poor school settings can contribute to presenting deficits in cognition and mental health, as demonstrated by more than half of the sample requiring an educational assessment. All offenders in the current sample were identified as having a learning or behavioural disability that interfered with their educational attainment (Corrado, Leschied, & Lussier, 2015; Lipman & Boyle, 2008; Viner et al., 2012). The presence of behaviour difficulties differentiated persistent from limited offenders. Previous literature has reported that ongoing poor school environments reinforces antisocial behaviour and association with delinquent peers (Benner & Wong, 2014; Wissink et al., 2014).

Consistent with the literature, young offenders perceived their school environment to be difficult and as a result they tended to demonstrate poor school attendance, grade failure, a history of suspension(s), and a lack of educational attainment relative to their peers (Wissink et al., 2014; Viner et al., 2012). The results of poor school engagement could reflect a lack of school connectedness, as demonstrated by youth having a higher incidence of poor relationships with peers and teachers. The literature suggests that increased risk of school dropout or grade failure can result from deficits in establishing relationships with teachers and peers in the school setting (Viner et al., 2012). Further consideration of the context of poverty illustrates that offenders categorized in the concentrated poverty group had the lowest prevalence of educational attainment and highest incidence of negative relationships with teachers. The presenting finding is consistent with the literature that high poverty youth immersed in unhealthy environments are more likely to demonstrate low educational attainment supplemented by poor relationships with teachers and peers which together, contribute to delinquent behaviour (Benner & Wong, 2014; Wissink et al., 2014).

Several unhealthy behaviours and adverse life outcomes were present for youth in compromised education settings. Results indicated a significant relationship between the level of risk in the school domain and the prevalence of mental health diagnoses or psychological features, as well as the presence of alcohol or substance abuse (Benner & Wong, 2014; Viner et al., 2012). Contrary to the literature, no relationship was found between education and the presence of friends, positive networks, or harm to self or others in defining the social well-being outcome of youth. The literature illustrates that the absence of friends and poor peer relations contribute to delinquent behaviour. However, data regarding the social opportunities for this population was limited (Benner & Wong, 2014; Lipman & Boyle, 2008; Wissink et al., 2014). As well, given the few positive relations within the school setting, analysis of the presence of positive relationships serving as a protective factor for educational outcomes was not possible. This is, despite the literature reporting the presence of positive peer or teacher relationships could serve as a protective factor in preserving educational attainment (Fruiht & Wray-Lake, 2013).

A final consideration is the evidence of a significant and predictive relationship between the relative quality of the educational context and educational attainment. Consistent with the literature, the level of risk within the school setting was predictive of whether youth successfully attained expected levels of education, with higher prevalence of associated risks further impeding academic progress (Benner & Wong, 2014; Viner et al., 2012).

**Community Domain.** The prevalence and extent of influence the community context had on the health behaviours and outcomes of offending youth was limited. Although there was a high prevalence of youth having no social ties to the community and an absence of structured hobbies or activities regardless of experienced poverty, neither associated risk contributed to criminal engagement. This was inconsistent with the literature that a lack of social cohesion and

absence of leisure activities provided limited opportunities for prosocial behaviour that reinforced greater recidivism than those who had more community opportunities (Kurlycheck et al., 2012; Wright et al., 2014).

In review of the influence of poverty, community as a social determinant of health demonstrated no reliable relationship with poverty. This was contrary to research conveying that poverty has a direct impact on exposure to antisocial behaviours in persistent poverty (Odgers et al., 2015). Consistent with previous literature, results reflected that youth from high poverty did have the greatest affiliation with gang membership and perceived negative relationships with the community. (Rudolph et al., 2010; Slattery & Meyers, 2014).

Inconsistent findings were detected when evaluating healthy behaviours and life outcomes. No direct impact of community risk to mental health conditions, suicidal ideations or substance abuse was found, which was contrary to the literature that reported low cohesive communities contributed to more anxiety, depression, and emotional dysregulation (Kingsbury et al., 2015; Rudolph et al., 2010). As well, despite previous literature reporting poorer neighbourhoods contribute to antisocial relationships, exposure to violence and risk-taking behaviours, limited opportunities for prosocial behaviour negative peer relationships, and harm to self and others, (Rudolph et al., 2010; Slattery & Meyers, 2014; Wright et al., 2014) these findings were not corroborated in the current study. There was a weak correlation identified between neighbourhood risk and agency involvement, which could illustrate that given the lack of exposure to opportunities for community engagement reflects only the prescribed involvement with community agencies through the criminal justice system.

The focus of the remaining discussion will relate the current findings to implications for clinical practice and policy.

**Relevance for Clinical Practice**

The findings of the present study suggest that the social determinants of health and the quality of the associated conditions within these broader determinants should be incorporated into developing effective intervention strategies for young offenders who are already marginalized by their experiences of living in poverty.

The research findings suggest the clinical relevance regarding the specific nature and needs of serious and violent young offenders in relation to the social determinants of health. This should influence treatment approaches for youth involved in the youth justice system. Service providers will want to be aware of the need to differentially interact with youth and their families in providing services depending on the level of poverty and the extent of compromised conditions in the social determinants of health. Sensitivity from service workers in evaluating how to respond can directly impact the outcomes of these youth and should be taken into consideration when recommending programs of service.

As well, consideration of the extent of poverty experienced by the young offender and exploring the influence on the associated social determinants of health can prove helpful in navigating, selecting and prioritizing service access. For example, young offenders who live in persistent poverty demonstrated greater adverse conditions within the family than low poverty young offenders, which was also linked to a youth's removal from the home into more intensive service such as through the child welfare system. The justice system should consider both the risk and protective factors available within the social determinants of health when composing individualized recommendations for interventions to reduce recidivism and promote rehabilitation.

**Relevance to Policy**

What remains less clear is the relevance of the social determinants of health and the domains of family, school, and community contexts in the recommendations for treatment for young offenders. As a leader in health promotion, current Canadian public policy fails to adequately address family poverty and the insufficient ability for Canadians to meet the needs in their living domains (Raphael, 2008; Raphael, Curry-Stevens, & Bryant, 2010). Canadian policies should incorporate the findings of the present research to better address the welfare of youth who rely on the macrosystems to respond to the material and social deprivation in these living domains. As results from the current study indicated, the failure to address the mediating effect of poverty and the prevalence of adverse conditions within the social determinants of health in various social policies can result in further recidivism and poor health outcomes for offending youth.

While research on policies regarding intervention practices in Canada are limited, the results of the current study are aligned with those few studies that suggest that support for youth should be based on a risks-need framework in responding to the criminogenic needs of youth, and that policies that target low familial affection or parental monitoring and that promote educational attainment are among the most relevant targets of service (Andrews & Bonta, 2006; Butler & Leschied, 2007; Vieira et al., 2009). Further consideration of policies that promote effective intervention for chronic offenders in achieving positive outcomes should be among the most salient for social policy.

**Future Directions and Research**

This study explored the social determinants of health of young offenders who had been referred for an assessment to an urban-based court clinic. The findings reflected that adverse conditions within the family, school, and community domains elevated concern with initial and

ongoing access to community services and agencies, as well as further contributing to the recidivism of violent and young offenders. Closer attention needs to be paid to how the extent of poverty experienced by young offenders creates the conditions for additional consequences in their broader life environments and can result in further negative consequences to the health status and behavioural outcomes of this population. As well, focus should be placed on inquiring how societal structures could be modified such that improved social organization and distribution of resources can promote the motivation in young offenders to utilize available interventions in promoting greater prosocial values and behaviours.

Although Canadian research has reflected concern for the social determinants of health, research has neglected to investigate the further impact of these compromised conditions on the health outcomes of Canadians (Raphael, 2008). The current study is the first to explore how adverse outcomes for young offenders reflects the influence of societal structures and the neglect of understanding how broader environments shape the behaviours of this population rather than focusing on the individualistic responsibility perspective. Future research should focus on expanding the knowledge of the relevance of the social determinants of health to the outcomes of Canadian youth by expanding the research methods from an ideological focus on the individual to the community's responsibility for change regarding how clinicians, policymakers, and the criminal justice system responds to the criminogenic needs of this population (Raphael, 2008; Raphael, Curry-Stevens, & Bryant, 2010). It is possible that the weak community to youth association is an accurate reflection of community disengagement given that participation within the judicial system facilitates isolation from connections with community members and the perception of a lack of social cohesion (Kingsbury et al., 2015). Alternatively, the poor association could reflect the discrepancy in viewing the criminal behaviour as a reflection of the individual and only collecting data on the individual agency in school and family. Future

research needs to take a greater systemic approach by evaluating all the variables involved in the community to identify where policy and clinical changes can be made to better services the needs of these youth.

The current study also found that poverty has direct predictive utility in life outcomes for young offenders and is mediated by the relationship between compromised conditions within the social determinants of health and engagement in offending behaviour. However, further research is necessary to understand the association between crime and poverty. Although an extensive degree of research has evaluated the health behaviours and outcomes of youth in concentrated poverty, further research is needed to understand the cycle of poverty and its influence on the experiences within the social determinants of health (Raphael, 2008; Vieira et al., 2009). Findings from the current study reflect that poverty was a mediating variable in youth accessing services while also linking its impact to the severity of adverse life conditions that are experienced by young offenders that is dependent on the level of their experience with poverty. Future research should further address the results of this study that suggest that persistent patterns are evident in the degree of experienced poverty and the life experiences of young offenders within the family, school, and community domains. Further understanding of how broader influences from the social determinants of health can reinforce or desist recidivism for certain youth who are entrenched in poverty and the support they need to prevent future offending. As well, further consideration of the positive conditions within these domains is needed, since protective factors such as consistent parenting, positive teacher relationships, and social cohesion within the community have demonstrated their influence in encouraging educational attainment, reducing recidivism, and promoting healthy behaviours (Fomby, 2013; Fruiht & Wray-Lake, 2013; Kingsbury et al., 2012; Viner et al., 2012). The incorporation of this

future research into reintegration practices and policy development for youth programming may further facilitate the rehabilitative goals of the criminal justice system.

A final consideration would be for future research to include case studies and other qualitative methodologies. Given the inconsistent and inconclusive results of the current study, further research using a qualitative or mixed methods research design would support the objectives of the present study to identify the nature and needs of the young offender population in a Canadian context. By incorporating research findings from various methodologies that can expand on the initial research presented in this quantitative study, further detailed knowledge of this population can be incorporated into initiatives to support rehabilitative goals and life outcomes of these youth.

**Limitations to Current Research Design**

The findings of the present study should be interpreted and generalized within specific limitations. It is important to consider that findings of the study were based on data collection and analysis limited to one urban-based court clinic that assessed young offenders from the London and Middlesex County region. Interpretation of the results should not be generalized to describe the nature and needs in the family, school, and community domains of the general young offender population of Canada.

As well, data collection and inferences from the results were confined to the available assessment files at the court clinic that met inclusion criteria. Although file-based information can provide valuable information to understand the criminal justice system and psychology of young offenders, some of the files were more comprehensive than others. Certain intake forms contained more detailed or supplementary documentation that was reflected in the clinical findings section of the court report. As well, the primary document under review and consideration for data collection was the intake form, which relied on the self-report of the legal

guardians and the young offend themselves. Given the variability of contribution to data collection, the reliability of the data and the inferences from the data presented in the study results may have been compromised. As well, the data retrieval instrument was constructed for the purpose of maximizing consideration of descriptive and explanatory variables of information pertaining to the nature and needs of this population, so its validity as an accurate measure must be considered.

A final consideration is that the study relied on retrospective data, leading to limitations in making inferences regarding the criminal trajectory and life outcomes of the young offenders. Many of the study variables were based on nominal data, indicating the presence or absence of risk factors or conditions within living domains and did not provide opportunity to relay information about the longevity of compromised conditions. Understanding the depth and the extent of the exposure to poverty and other compromised conditions was limited. A lack of chronological information and duration of events also compromised understanding service access and responsivity to the risks presented by the young offender in various contexts.

**Summary**

Despite the limitations of the present study, understanding regarding the nature of the social determinants of health for the offender population is relevant to understanding the contributing factors to later adverse life outcomes. This is encouraging given that the current literature is limited in understanding the relative psychosocial risks within these life domains for serious and violent young offenders within the Canadian criminal justice system. The findings of this study indicate that the severity of compromised conditions within the family, school, and community domains have predictive utility for future educational success and functionality in society. This highlights the importance of considering these social determinants of health in selecting and prioritizing services to reduce recidivism and promote rehabilitation. Further,

poverty mediates the likelihood of recidivism and access to relevant agencies and community services. Ongoing research should be conducted to determine to what extent knowledge of the current conditions within the social determinants of health with impoverished youth needs to be a part of future developing policies and practices in the context of a prevention framework in reducing the number of youth who engage in criminal activity.

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# Appendices

## Appendix A: Letter of Understanding [LOU]

London Family Court Clinic
Professional Services for Families in Court

LETTER OF UNDERSTANDING
REGARDING THE ASSESSMENT PROCESS
ASSESSMENT SERVICES FOR
YOUTH IN CONFLICT WITH THE LAW

Name: _____ _____

1. This assessment was ordered by the Court and the report we prepare will be given to the Court. The Court is our client. This means that:
   - This is not like therapy where things are kept private.
   - Whatever we discuss and learn about you is not confidential.
   - In Court, information may be discussed openly in front of you, and others who are present.
2. There are also times when other people may need to be involved and information must be shared, by law. For instance:
   - If you told us that you wanted to harm yourself or someone else.
   - If you told us that someone is abusing a minor or causing them harm.
   - If you told us that you have been sexually abused by a licensed health care professional in Ontario (such as a physician, chiropractor, psychologist, nurse); however, we can do this without using your name.
   - If your file is subpoenaed by Court, we must provide the Court with a copy of the file.
   - If the College of Psychologists asks for the file in order to investigate a psychologist or ensure a psychologist is maintaining the appropriate standards or practice, then we must provide the College with that file.
3. From this assessment, we make recommendations to the Court that are expected to help stop you from getting into further trouble with the law.
4. While completing the assessment, the assessors may consult with other professionals at the Centre.
5. You should understand that it is your responsibility to obtain legal advice.
6. Should you have any concern with respect to the assessment process, you can initially discuss the matter with the assessor and/or, when necessary, the Clinic's Director.
7. The Clinic maintains non-identifying information about all referred cases as it is a research and training based agency.
8. You may be contacted in the future as a follow-up so we can get your feedback on the services and the outcome of the court process.
9. All information related to your services here is kept in a locked file. We follow the guidelines of the Personal Health Information Protection Act (PHIPA) and the Personal Information Protection and Electronics Documents Act (PIPEDA)
10. Your personal information may be shared if your file is selected for review by an on-site team, as part of the CCA (Canadian Centre for Accreditation). You have the right to choose not to participate in having your personal information disclosed.
11. Your signature below indicates you understand the above and agree to this assessment.

DATED at _____, Ontario this ____ day of _____, 20____.

_____ _____ _____
*Signature of Witness* *Signature of Youth* *Signature of Parent/Guardian*

**Young person has agreed to participate in a file review by a team from the CCA. ☐**

**Appendix B: Research Ethics Board (REB) Ethics Approval Letter**

Western Research

Research Ethics

February 5, 2016

Dear Dr. Leschied,

RE: Youth Justice and Poverty: Making Sense of a Complex Relationship

Thank you for submitting your project, "Youth Justice and Poverty: Making Sense of a Complex Relationship" to our office for review. Please note that after review by the delegated board members and the chair it was decided that this project does not require research ethics approval.

The Tri-Council Policy Statement 2: Ethical Conduct of Research Involving Humans Article 2.4 indicates "REB review is not required for research that relies exclusively on secondary use of anonymous information, or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information". It is the chair's understanding that as the data will be de-identified when you receive it, your research falls under this guideline.

I wish you the best of luck with your work.

**Appendix C: London Family Court Clinic Confidentiality Agreement**

London Family Court Clinic
Policy/Training Signature Sheet

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# Confidentiality

Association with LFCC may require that you are privy to information that is of a personal and confidential nature.

This includes information about services users, donors and supporters, volunteers and staff of LFCC.

Information about individuals who are affiliated with LFCC may include such information as medical condition and/or treatment, finances, living arrangements, employment, sexual orientation, alcohol or drug use, and/or relationships with family members.

I understand the confidential nature of the work I will be doing with LFCC and with all individuals associated with the Clinic's services.

I am aware that there is a written policy that outlines in detail the terms and conditions of this confidentiality agreement. I have been advised by my supervisor regarding how to access this policy and I take responsibility for reading and understanding the policy.

I agree that I will not disclose information to any person who is not affiliated with LFCC and authorized by LFCC to have such information, without the specific written consent of the individual to whom such information pertains, regardless of the manner in which such information becomes available to me.

Should I come in contact with clients' names with whom I am acquainted or related, I agree to advise my supervisor and not proceed further with the task involving the client's file unless directed to do so by my supervisor or designate.

By signing this document I am confirming that I have read, understand and agree to follow the Policies and Procedures of LFCC. I also agree to review the Policies and Procedures of LFCC on a regular basis.

| Staff/Consultant/Student's Name (please print) | Signature | Date |
|---|---|---|
| Supervisor's Name (please print) | Supervisor's Signature | Date |

## Appendix D: Data Retrieval Instrument [DRI] Coding Manual

**Data Retrieval at the London Family Court Clinic:**
**Poverty Reduction Project**

AGENCY INFORMATION - A

**1.** ID – ID Number [Numerical] (Var: 0000000)
**2.** YrAss – Date Information was received:
[year] (Var: 2010; 2011; 2012; 2013; 2014; 2015; 2016; 2017; 2018; 2019; 2020)

IDENTIFYING INFORMATION - B

**3.** Age – Age at time of assessment [Numerical 00-99]
**4.** Gender - at the Time of the Assessment – Gender
[1= male; 2=female, 3=unidentified; 4=transsexual; 5=intersex; 6=Unsure]
**5.** SexOrien - Sexual Orientation at the Time of the Assessment– [1=Heterosexual; 2=Homosexual; 3=Bi-Sexual; 4=Queer; 5=Pan Sexual; 6=Asexual; 7=Questioning; 8=Unidentified; 9=Not Stated]
**6.** Preg - Pregnant? [1=Past; 2=Current; 3=No; 4=N/A]
**7.** Geo – Originates from Urban or Rural Area [1=Urban; 2=Rural]
**8.** Home – Currently living [1=Parents; 2=Group Home; 3=Foster Home; 4=Homeless; 5=Detention; 6=Independent; 7=Relative's Home; 8 =Shelter]
**9.** Lang – First Language [1=English; 2=French; 3=Spanish; 4=Arabic 5=Farsi; 6=Chinese; 7=Polish; 8=Portuguese; 9=German; 10=Italian; 11=Korean; 12=Dutch; 13=Greek; 14=Other]
**10.** Relig – Religion [1= Non-religious; 2=Roman Catholicism; 3=Christian; 4=Islam; 5=Hinduism; 6=Mennonite; 7=Buddhism; 8=Indigenous Faith 9=Other; 10=Not Stated]
**11.** Ethnicity – [1= Euro-Canadian (Caucasian); 2= Native-Canadian; 3= Black/African; 4= Asian-Canadian; 5= Hispanic-Canadian; 6= Mixed Ethnicity; 7= Other; 8= Not Stated]
**12.** Native – Native Heritage [1=Aboriginal; 2=Metis; 3=Inuit; 4=Other; 5=N/A; 6=Not Stated]
**13.** LegBio – Is legal guardian biological parent? [1 = Yes; 0 = No]
**14.** YEmploy - Youth employed? [1 = Yes; 0 = No]
**15.** YHomeless - Youth Ever Been Homeless? [1 = Yes; 0 = No]

CHARGES AND COURT INVOLVMENT - C

Present Charge (type) – Most serious offense at the time of referral:
16. PCtheftu - Theft under 5,000.00 [1 = Yes; 0 = No]
17. PCthefto - Theft Over 5,000.00 [1 = Yes; 0 = No]
18. PCfailtocom - Failure to Comply [1 = Yes; 0 = No]
19. PCfailAtt - Failure to Attend Court [1 = Yes; 0 = No]
20. PCbreach - Breach of Probation [1 = Yes; 0 = No]
21. PCdt - Uttering a Death/Harm Threat [1 = Yes; 0 = No]
22. PCSexA - Sexual Assault [1 = Yes; 0 = No]
23. PCSexInt – Sexual Interference [1 = Yes; 0 = No]
24. PCLoit - Loitering [1 = Yes; 0 = No]
25. PCAssBH - Assault Causing Bodily Harm [1 = Yes; 0 = No]
26. PCMisch - Mischief [1 = Yes; 0 = No]
27. PCAttThe - Attempt Theft [1 = Yes; 0 = No]
28. PCObstPol - Obstructing Police [1 = Yes; 0 = No]
29. PCPossWep - Possession of a Weapon for a Dangerous Purpose [1 = Yes; 0 = No]
30. PCCauDist- Causing Disturbance [1 = Yes; 0 = No]
31. PCUttThr - Uttering a Threat to Cause Bodily Harm [1 = Yes; 0 = No]

32. PCPossIS - Possession of an Illegal substance [1 = Yes; 0 = No]
33. PCSubAbT - Sub Ab Trafficking [1 = Yes; 0 = No]
34. PCProst - Prostitution [1 = Yes; 0 = No]
35. PCGenAss - General Assault [1 = Yes; 0 = No]
36. PCFirstMur - First Degree Murder [1 = Yes; 0 = No]
37. PCSecoMur - Second Degree Murder [1 = Yes; 0 = No]
38. PCAssWea - Assault with a Weapon [1 = Yes; 0 = No]
39. PCTruanc - Truancy [1 = Yes; 0 = No]
40. PCFireSett - Fire Setting [1 = Yes; 0 = No]
41. PCStalking - Stalking [1 = Yes; 0 = No]
42. PCRobbery - Robbery [1 = Yes; 0 = No]
43. PCFraud - Fraud [1 = Yes; 0 = No]
44. PCPosUn – Possession Under $5000 [1 = Yes; 0 = No]
45. PCPosOv – Possession Over $5000 [1 = Yes; 0 = No]
46. PCBreak – Breaking and Entering [1 = Yes; 0 = No]
47. PCOther – Other charge [1 = Yes; 0 = No]

Aggressive Offense against (Hands-on offenses only):
48. OffFam- family member [1 = Yes; 0 = No]
49. OffFriend – friend [1 = Yes; 0 = No]
50. OffAcqu – acquaintance [1 = Yes; 0 = No]
51. OffStran – stranger [1 = Yes; 0 = No]
52. OffAuth- Authority [1 = Yes; 0 = No]
53. OffFos-Foster family member [1 = Yes; 0 = No]
54. OffGroup - Group Home resident [1 = Yes; 0 = No]

**55.** CoOrLone - Co-offender or Lone offender for Current charge
[1=Co-offender; 2=Lone Offender]
**56.** YouthResp - Youth's response to charge
[1=Evidence of Remorse; 2=Indifferent; 3=Defensive; 4=Denying Culpability; 5=Pride; 6=Blame the Victim; 7=No Response]
**57.** ParResp - Parents response to charge [1=Disappointed; 2=Indifferent; 3= Blame others; 4=Defensive; 5=Minimizing; 6=Threatened; 7= No Response]
**58.** FirstChar - First charge [1 = Yes; 0 = No]
**59.** NumChar - How many previous and current charges? [Numerical - 00-999]
**60.** NumGuilt - Number of Previous and Current findings of guilt?
[Numerical - 00-999]
**61.** PrevCoLone – Previous and current pattern of CJH suggests
[1=Co-offender; 2= Lone offender; 3=Both Co and Lone Offender; 4=N/A]
**62.** InvolPol – Number of involvements with police [Numerical 00-999]
**63.** YrsYJS – Length of time involved in the YJS?
[1= <1 year; 2= >1 Year; 3= >2 years; 4= >3 years]

Previous Experience in YJS:
64. PrevAltMes - Alternative Measures [1 = Yes; 0 = No]
65. PrevComServ - Community Service Order [1 = Yes; 0 = No]
66. PrevProb - Probation [1 = Yes; 0 = No]
67. PrevCus - Custody [1 = Yes; 0 = No]
68. YTC - Mental Health Court [1 = Yes; 0 = No]
69. Det - Detention [1 = Yes; 0 = No]

Previous Placement in YJS:

70. PrevOpenD - Open Detention [1 = Yes; 0 = No]
71. PrevSecD - Secure Detention [1 = Yes; 0 = No]
72. PrevOpenC - Open Custody [1 = Yes; 0 = No]
73. PrevSecC - Secure Custody [1 = Yes; 0 = No]
74. YrsDet – Months spent in detention [Numerical 0 -99]

SCHOOL HISTORY - D

75. School – Registered in school [1 = Yes; 0 = No]
**76.** Grade – Present grade [Numerical 00-12]
**77.** CredsCom – High school, how many credits completed [Numerical 00-99]
**78.** AttSchool – Does youth attend school [1 = Yes; 0 = No]
**79.** AbSchool – If no, why?
[1=Negative attitudes towards school; 2= Family Circumstances; 3= Suspended; 4=Family Not Encouraged 5= Psychological issues; 6= Other; 7=N/A]
**80.** FailGr – Failed a grade [1 = Yes; 0 = No]
**81.** ReasFail – Reasons why failed? [1= Not attending school; 2= Intellectual Disability; 3=Incomplete Work; 4=Transition; 5= Other; 6=N/A]
**82.** AcadAss – Ever formally assessed academically [1 = Yes; 0 = No]
**83.** Excep – Identified as exceptional [1 = Yes; 0 = No]
If yes to above was it:
84. Gifted - Giftedness [1 = Yes; 0 = No]
85. LearnDis - Learning Disability [1 = Yes; 0 = No]
86. DevDis - Developmental [1 = Yes; 0 = No]
87. Behav - Behavioural [1 = Yes; 0 = No]
**88.** SpecEd – Special education program or specialized help? [1 = Yes; 0 = No]
**89.** SpecHelp – If so, describe (homework group, etc.)
[1= IEP; 2= homework group; 3= tutor; 4= EA; 5= N/A]
**90.** SchoDif – Do you find school difficult [1=Yes; 2 =No; 3 = Sometimes]
**91.** WhySchoDif – If so, why?
[1= Intellectual Disability; 2= Trouble with Peers; 3= Difficulty with authority; 4=No Interest; 5= History of being Bullied; 6= Other; 7= School Hard; 8= N/A]
**92.** NumSchAtt – Number of schools attended since kindergarten? [Numerical 00-99]
**93.** WhyNumSch – Primary reason for school changes?
[1= Family Moves; 2=Expelled; 3= Problems with Peers; 4=Victim of Bullying; 5=Involvement in Justice System, 6=Trauma; 7=N/A]
**94.** DifTeach – Difficulty with teachers? [1 = Yes; 0 = No]
**95.** Suspend – Ever been suspended [1 = Yes; 0 = No]

SOCIAL BEHAVIOURS / PEER RELATIONSHIPS – E

**96.** Friend – Do you have friends? [1 = Yes; 0 = No]
**97.** Older - Older friends [1=yes; 2=no; 3 = N/A]
**98.** Younger – Younger friends [1=yes; 2=no; 3 = N/A]
**99.** SameAge - Same age friends [1=yes; 2=no; 3 = N/A]
**100.** SameSex - Same sex friends [1=yes; 2=no; 3 = N/A]
**101.** OppSex - Opposite sex friends [1=yes; 2=no; 3 = N/A]
**102.** GoodInf- Good influence friends [1=yes; 2=no; 3 = N/A]
**103.** PoorInf- Poor influence friends [1=yes; 2=no; 3 = N/A]
**104.** IntPartner – Do they have an intimate partner [1 = Yes; 0 = No]
**105.** LeadOrFoll – Youth a leader or follower? [1=leader; 2=follower]
**106.** SexConc – Concerns about sexual behaviour/attitudes? [1 = Yes; 0 = No]

**107.** DesSexConc – Describe sexual concerns: [1=Prostitution; 2=Unprotected Sex; 3=Exposure to Pornography; 4=Inappropriate Sexualized Comments; 5=Sexual Preoccupation and Distress; 6=Promiscuity; 7= Other; 8= N/A]
**108.** OrganActi – Youth participates in organized activities? [1 = Yes; 0 = No]
**109.** DesActNum – Describe activities: [Number of Activities] [00-99]
**110.** Hobbies – Hobbies or Interests? [1 = Yes; 0 = No]
**111.** DesHobb – Describe Hobbies or Interests? [1= Alone; 2= With Peers; 3=Family; 4=N/A]
**112.** FamTime – Spend time with family? [1 = Yes; 0 = No]
**113.** DesFamTim – Describe family time? [1= positive; 2=negative; 3=neutral; 4= N/A]
**114.** SocOfTies – Social ties outside family? [1 = Yes; 0 = No]
**115.** KindOfTie – Social ties? [1= positive; 2= negative; 3= both; 4= N/A]
**116.** SibStatus - Sibling Status [1= Youngest; 2= Eldest; 3= Middle Child; 4=Only Child]
**117.** SibAndLaw - Has sibling(s) been involved in the law [1=yes; 2=no; 3= N/A]
**118.** HalfSibLaw - Has half sibling(s) been involved in the law [1=yes; 2=no; 3= N/A]

AGENCY INVOLVMENT – F

Ever involved with:
119. AgOut - Child/Youth Mental Health Agency (Outpatient) [1 = Yes; 0 = No]
120. AgIn - Child/Youth Mental Health Agency (Inpatient) [1 = Yes; 0 = No]
121. AgBoth- Child/Youth Mental Health Agency (In and Outpatient) [1 = Yes; 0 = No]
122. AgProbatio - Previous Probation [1 = Yes; 0 = No]
123. AgDare - Project DARE [1 = Yes; 0 = No]
124. AgClinical - Clinical Supports Program [1 = Yes; 0 = No]
125. AgHosp - Hospital for mental health [1 = Yes; 0 = No]
126. AgGroup - Group Home [1 = Yes; 0 = No]
127. AgPolice - Police [1 = Yes; 0 = No]
128. AgChildWel – Child Welfare [1 = Yes; 0 = No]
129. AgAddict - Addiction Treatment Facility [1 = Yes; 0 = No]
130. AgDetent - Detention [1 = Yes; 0 = No]
131. AgComPsych – Community Psychiatrist [1 = Yes; 0 = No]
132. AgCommCouns – Community Counselling [1 = Yes; 0 = No]
133. AgDevDisabil – Developmental Disability Agency [1 = Yes; 0 = No]
134. AgResTSexD – Residential Treatment Sexual Disorder [1 = Yes; 0 = No]
135. Youth Treatment Court [1 = Yes; 0 = No]
136. CSCN – Community Services Coordination Network [1 = Yes; 0 = No]
137. AgTotalN [Numerical 00-99]

CHILD WELFARE SYSTEM INVOLVMENT – G

138. ChildWel - Child Welfare [1 = Yes; 0 = No]
If yes to Child welfare was it:
139. CWelCouns – Counselling [1=Yes; 2=No; 3=N/A]
140. CWelComm - Community Supervision [1=Yes; 2=No; 3=N/A]
141. CWelTemp - Temporary Care Agreement [1=Yes; 2=No; 3=N/A]
142. CWelCrown - Crown Ward Status [1=Yes; 2=No; 3=N/A]
143. CWelKin - Kinship Care Arrangement [1=Yes; 2=No; 3=N/A]
144. AdoptCAS- Adoption through CAS [1=Yes; 2=No; 3=N/A]

FAMILY LIFE - H

**145.** FamCurLiv – Currently living with
[1 = mother; 2=father; 3=both; 4=common-law; 5=step mother; 6=step father; 7=Alone; 8=Extended Family Member; 9=Sibling; 10=N/A]

146. Moves – How many family moves since birth?
[1=1; 2=2; 3=3; 4=4; 5=5-9; 6=10>]

**147.** MoveThem – If more than 5, indicate theme?
[1= Occupation; 2= Economic; 3=Social Service transfer; 4= Removed from home; 5= Criminal Charges; 6=Evicted/Unsanitary; 7=Poor Housing Conditions; 8=Gang Influence; 9=Relationship Conflicts; 10=CAS Inter; 11=N/A]

**148.** Adopt – Adopted [1=Yes; 2=No]

**149.** Refugees - Refugee Status [1=Yes; 2=No]

**150.** FamVio - History of or current family violence [1=Yes; 2=No]

**151.** Shelter - Did family ever reside in a shelter [1=Yes; 2=No]

**152.** SeeViolen - Evidence of child being present at the time of partner violence [1=Yes; 2=No]

**153.** SexAbasPerp / Youth as Perpetrator - History of sexual abuse? [1= yes; 2=no]

**154.** SexAbasVict / Youth as Victim - History of sexual abuse? [1= yes; 2=no]

**155.** SexAbFam - sexual abuse intra- or extra-familial where youth is victim
[1= intra; 2=extra; 3=both]

**156.** SexEx – Evidence of ever being sexually exploited/sex trade [1=Yes; 2=No]

**157.** Neglect - Evidence of neglect? [1=-yes; 2=no]

**158.** EmotTra - Evidence of emotional trauma [1=yes; 2=no]

**159.** PhysAbuse – Evidence of physical abuse? [1=yes; 2=no]

**160.** AgeConcern - Age at which parents first identified concern
[Numerical 00-18]

**161.** PerOrLimOff - Persistent or limited offending (when did offending-like behaviours begin?)
[1=persistent equal to or <12 age; 2=limited>age 12]

DEVELOPMENTAL HISTORY - I

**162.** DevStatus – Cognitive / Developmental Status [1= Low; 2= Moderate; 3= Severe; 4=Average Range; 5=Above Average; 6=N/A]

**163.** SerChIll – Serious Childhood Illness [1= yes; 2=no]

**164.** SerChAcci – Serious Childhood Accidents [1= yes; 2=no]

**165.** HeadInj – Head Trauma / Injuries [1= yes; 2=no]

**166.** Hospital – Any Hospitalization [1= yes; 2=no]

If hospitalized, what for?

167. HospMental - Mental health reasons [1=Yes; 2=No]

168. HospPhys – Physical health reasons [1=Yes; 2=No]

169. HospBothMP – Both mental and physical health reasons [1=Yes; 2=No]

170. ComPregBir – Complications during pregnancy/birth of youth [1=Yes; 2=No]

MENTAL HEALTH STATUS INFORMATION - J

171. DiaFASD - Diagnosis of FASD [1=Yes; 2=No]

172. AgeFASD - If yes to FASD, at what age [Numerical 00-18]

Formal Psychiatric diagnoses:

173. ADHD [1=Yes; 2=No]

174. ODD [1=Yes; 2=No]

175. CD - Conduct Disorder [1=Yes; 2=No]

176. DiaAnxiety - Anxiety [1=Yes; 2=No]

177. DiaDepress - Depression [1=Yes; 2=No]

178. BPD - Bi Polar Disorder [1=Yes; 2=No]

179. PTSD [1=Yes; 2=No]
180. APD - Antisocial Personality Disorder [1=Yes; 2=No]
181. NARCISS - Narcissism [1=Yes; 2=No]
182. Psychosis [1=Yes; 2=No]
183. SleepCompl - Sleep Complaints [1=Yes; 2=No]
184. SchizoAff - Schizoaffective Disorder [1=Yes; 2=No]
185. DisrupMoodD - Disruptive Mood Dysregulation Disorder [1=Yes; 2=No]
186. TotDia - Total number of different diagnoses [Numerical 00-99]

Findings from Psychological Testing (Check as many as applicable – elevation noted in clinical report)
187. SocIn – Socially Inhibited [1=Yes; 2=No]
188. EmoIn – Emotionally Insecure [1=Yes; 2=No]
189. PWP – Problems with Peers [1=Yes; 2=No]
190. PsychAnx – Anxiety [1=Yes; 2=No]
191. PsychDep – Depression [1=Yes; 2=No]
192. SocAnx – Social Anxiety [1=Yes; 2=No]
193. PoorSE – Poor Self Esteem [1=Yes; 2=No]
194. Suicide – Suicidal [1=Yes; 2=No]
195. Agg_Peers – Aggression towards peers [1=Yes; 2=No]
196. Agg_Adults – Aggression towards adults [1=Yes; 2=No]
197. Agg_Fam - Aggression towards family members [1=Yes; 2=No]
198. Agg_PA – Aggression towards peers and adults [1=Yes; 2=No]
199. Autism – Autism [1 = Low, 2 = Medium, 3 = High, 4 = None]
200. PsycPTSD – PTSD [1=Yes; 2=No]
201. Somatic – Somatic Complaints [1=Yes; 2=No]
202. CDTraum – Complex Developmental Trauma [1=Yes; 2=No]
203. PsychSubA - Substance Abuse [1=Yes; 2=No]
204. PreoccSexTh - Preoccupation with Sexual Thoughts [1=Yes; 2=No]
205. SocialInsens - Socially Insensitive [1=Yes; 2=No]
206. HomicIdea - Homicidal Ideation [1=Yes; 2=No]
207. PsychAPD - Antisocial Personality Disorder [1=Yes; 2=No]
208. PersonDis - Personality Disorder [1=Yes; 2=No]
209. SocioPTend - Sociopathic Tendencies [1=Yes; 2=No]
210. EatDisorder - Eating Disorder [1=Yes; 2=No]
211. NSSI-Non Suicidal Self Injury [1=Yes; 2=No]
212. Dysthymia - Dysthymia [1=Yes; 2=No]
213. SubInPsychD - Substance Induced Psychiatric Disorder [1 =Yes; 2=No]
214. AttachD - Attachment Disorder [1=Yes; 2=No]
215. AvoidPersD - APD-Avoidant Personality Disorder [1=Yes; 2=No]
216. BodyImageC - Body Image Concerns [1=Yes; 2=No]
217. Hypervigil – Hypervigilance [1=Yes; 2=No]
218. Apathy – Apathy [1=Yes; 2=No]
219. PsychTTotal – Total number of different psychological areas of concern [Numerical 00-99]
220. MoodMed – Ever Prescribed Mood Alterant Medication [1=Yes; 2=No; 3=N/A]
If yes to mood alterant medication (current or past}, was it for:
221. MedADHD – ADHD [1=Yes; 2=No]
222. MedDep – Depression [1=Yes; 2=No]
223. MedAnx – Anxiety [1=Yes; 2=No]
224. MedBPD – Bi Polar Disorder [1=Yes; 2=No]
225. MedSD – Sleep Disorder [1=Yes; 2=No]
226. MedPsych – Psychosis [1=Yes; 2=No]
**227.** AgeofSym – Age when mental health symptoms were first identified [Numerical 00-99]

**228.** AgeofDia – Age when first diagnosed with mental health disorder [Numerical 00-99]

CAREGIVER HISTORY – J (Parent #1 – Most involved caregiver)

**229.** A_Relation – Relationship to youth
[1 = mother, 2= father, 3= Stepmother, 4 = Stepfather, 5 = foster mother, 6 = foster father, 7= grandparent, 8 = other family member, 9= other]
**230.** A_TeenPar – Teen Parent of the Child being Assessed
[1 = Yes, 2 = No, 3 = N/A]
**231.** A_TimeWCh – Length of time living with child (Years) [Numerical 00-99]
**232.** A_MarStat – Marital status [1 = Married, 2 = Cohabiting 2 = Single]
**233.** A_Divorce – Ever divorced [1 = Yes, 2 = No]
**234.** A_CEdu – Caregiver Education Completed [1= None; 2= Elementary; 3= Highschool; 4 = Undergraduate; 5 = Above; 6= College]
**235.** A_Employ – Caregiver Employed [1=Yes; 2=No]
**236.** A_Finance – Financial Support [1 = EI, 2= OW, 3= ODSP, 4= Child Support]
**237.** A_Youth - Financial support received by youth
[1 = EI, 2= OW, 3= ODSP, 4= Child Support]
**238.** A_FreqInv – Frequency of Parental Involvement (Rated on scale of 1-5: 1=no-little involvement; 5= very involved) [Numerical 1-5]
**239.** A_DomVio – Domestic Violence [1 = Yes, 2 = No]
**240.** A_PhyAg – Physical Aggression [1 = Yes 2 = No]
**241.** A_VerbAg – Verbal aggression [1 = Yes, 2= No]
**242.** A_PolCall – Police being called [1 = Yes, 2 = No]
**243.** A_Crisis – Caregiver Personal Crises [1 = Yes, 2 = No]
Was crisis a:
244. A_Death - Death [1 = Yes, 2 = No]
245. A_Sep - Separation [1 = Yes, 2 = No]
246. A_EmoIll - Emotional illness [1 = Yes, 2 = No]
247. A_PhysIll - Physical illness [1 = Yes, 2 = No]
248. A_Nerves - Problems with "nerves" [1 = Yes, 2 = No]
249. A_SubUse - Issues with drugs/alcohol [1 = Yes, 2 = No]
250. A_FinStra - Financial strain [1 = Yes, 2 = No]
251. A_Law - Conflict with the law [1 = Yes, 2 = No]
252. A_FamSep - Separation from family [1 = Yes, 2 = No]
**253.** A_MentalH – Presence of Mental Health History [1 = Yes, 2 = No]
**254.** A_FamMenH – Extended family mental health present [1 = Yes, 2 = No]
**255.** A_Med – Medications [1 = Yes, 2 = No]
**256.** A_Impact – Is it thought that crises has impacted youth?
[1 = Yes, 2 = No]

CAREGIVER HISTORY – K (#2 – Second most involved caregiver)

**257.** B_Relation - Relationship to youth [1 = mother, 2= father, 3= Stepmother, 4 = Stepfather, 5 = foster mother, 6 = foster father, 7= grandparent, 8 = other family member, 9= other]
**258.** B_TeenPar – Teen Parent of the Child being Assessed
[1 = Yes, 2 = No, 3 = NA]
**259.** B_TimeWCh – Length of time living with child (Years) [Numerical 00-99]
**260.** B_MarStat – Marital status [1 = Married, 2 = Cohabiting 3 = Single]
**261.** B_Divorce – Ever divorced [1 = Yes, 2 = No]
**262.** B_CEdu – Caregiver Education Completed [1 = None 2= Elementary, 3= Highschool 4 = Undergraduate 5 = Above; 6= College]

**263.** B_Employ – Caregiver Employmed [1=Yes; 2=No]
**264.** B_Finance – Financial Support [1 = EI, 2= OW, 3= ODSP, 4= Child Support]
**265.** B_Youth - Financial support received by youth [1 = EI, 2= OW, 3= ODSP, 4= Child Support]
**266.** B_FreqInv – Frequency of Parental Involvement - Rated on scale of 1-5: 1= no-little involvement; 5= very involved) [Numerical 1-5]
**267.** B_DomVio – Domestic Violence [1 = Yes, 2 = No]
**268.** B_PhyAg – Physical Aggression [1 = Yes 2 = No]
**269.** B_VerbAg – Verbal aggression [1 = Yes, 2= No]
**270.** B_PolCall – Police being called [1 = Yes, 2 = No]

Caregiver Personal Crises:

271. B_Death - Death [1 = Yes, 2 = No]
272. B_Sep - Separation [1 = Yes, 2 = No]
273. B_EmoIll - Emotional illness [1 = Yes, 2 = No]
274. B_PhysIll - Physical illness [1 = Yes, 2 = No]
275. B_Nerves - Problems with "nerves" [1 = Yes, 2 = No]
276. B_SubUse - Issues with drugs/alcohol [1 = Yes, 2 = No]
277. B_FinStra - Financial strain [1 = Yes, 2 = No]
278. B_Law - Conflict with the law [1 = Yes, 2 = No]
279. B_FamSep - Separation from family [1 = Yes, 2 = No]
280. B_MentalH –History of Mental Health Issues [1 = Yes, 2 = No]
281. B_FamMenH – Extended family mental health issues present [1 = Yes, 2 = No]
282. B_Med – Medications [1 = Yes, 2 = No]
283. B_Impact – Is it thought that caregiver crises have impacted youth? [1 = Yes, 2 = No]

CAREGIVER HISTORY – L (*Absent or Noncustodial Parent*)

**284.** C_Relation – Relationship to youth [1 = mother, 2= father, 3= Stepmother, 4 = Stepfather, 5 = foster mother, 6 = foster father, 7= grandparent, 8 = other family member, 9= other, 10 = deceased parent]
**285.** C_TeenP – Teen Parent of the Child being Assessed [1 = Yes, 2 = No]
**286.** C_MarStat – Marital status [1 = Married, 2 = Cohabiting, 3 = Single]
**287.** C_Edu – Caregiver Education Completed [1 = None; 2= Elementary; 3= Highschool; 4 = Undergraduate; 5 = Above; 6= College]
**288.** C_Employ – Caregiver Employment [1 = Yes, 2 = No]
**289.** C_Finance – Financial Support [1 = EI, 2= OW, 3= ODSP, 4= Child Support]
**290.** C_Impact – Crises of this parent thought to impact youth [1 = Yes, 2 = No]
**291.** C_MentalH – Presence or history of mental health issues [1 = Yes, 2 = No]
**292.** C_ConStop – Has contact stopped? [1 = Yes, 2 = No]

PRESENTING PROBLEM LEADING TO THE LEGAL SYSTEM - M

Cause of Problem [Parent Perspective]:

293: MH – Mental health issues [1 = Yes, 2 = No]
294. Impuls - Impulsivity [1 = Yes, 2 = No]
295. DrugAlch - Drug and Alcohol [1 = Yes, 2 = No]
296. SexBeh - Inappropriate Sexual Behaviour [1 = Yes, 2 = No]
297. SchoInt - No interest in school [1 = Yes, 2 = No]
298. Neg_Peer - Negative Peers [1 = Yes, 2 = No]
299. GangAct- Gang Activity [1 = Yes, 2 = No]
300. Account - Lack of Accountability [1 = Yes, 2 = No]
301. PSuper - Lack of Parental Supervision [1 = Yes, 2 = No]

What help parent(s) believe youth need:

302. Limits – Setting of limits (consequences) [1 = Yes, 2 = No]
303. Bound – Setting of boundaries [1 = Yes, 2 = No]
304. LawUnder - Clear understanding of the law [1 = Yes, 2 = No]
305. AggCons - Consequences for aggression [1 = Yes, 2 = No]
306. MH_Res - MH Residential Treatment [1 = Yes, 2 = No]
307. SubInter - Substance abuse interventions [1 = Yes, 2 = No]
308. Counsel - Ongoing Counselling [1 = Yes, 2 = No]
309. Mentor - Mentor [1 = Yes, 2 = No]
310. AppMed - Appropriate Medication [1 = Yes, 2 = No]
311. IDK - Doesn't know [1 = Yes, 2 = No]

Previous Unsuccessful Efforts:

312. PUEbadpeer - Staying Away from bad peers [1 = Yes, 2 = No]
313. PUEdrugs - Staying Away from Drugs [1 = Yes, 2 = No]
314. PUEcouns - Counselling [1 = Yes, 2 = No]

**315.** Drug – Drug Use [1 = Yes, 2 = No, 3=N/A]
**316.** Alch – Alcohol Use [1 = Yes, 2 = No]
**317.** Pyro – Fire Setting [1 = Yes, 2 = No]
**318.** Gang – Gang Activity [1 = Yes, 2 = No]
**319.** SexVict – Sexual Victimization [1 = Yes, 2 = No]
**320.** Bully – Bullying [1 = Yes, 2 = No]
**321.** EmoDist - Emotional Distress [1 = Yes, 2 = No]
**322.** Harm – Thoughts of Harming Self or Others
[1 = Self; 2 = Others; 3 = Self and Others; 4 = No]

YOUNG OFFENDERS STRENGTHS - N

323. StrenPhys - Physical [1 = Yes, 2 = No]
324. StrenSoc - Social /Interpersonal [1 = Yes, 2 = No]
325. StrenCog - Cognitive [1 = Yes, 2 = No]
326. StrenEmo - Emotional [1 = Yes, 2 = No]
327. StrenAcad - Academic [1 = Yes, 2 = No]
328. StrenProsoc - Prosocial Attitude/Behaviour [1 = Yes, 2 = No]
329. StrenPosAtt - Positive Attitude Towards Help Seeking [1 = Yes, 2 = No]
330. StrenOther - Other [1 = Yes, 2 = No]
331. NumStren - Number of strength areas [Numerical 0-7]

ALCOHOL / SUBSTANCE USE INFORMATION - O

**332.** AlcAb – Is there the presence of alcohol abuse? [1= Prior Use; 2= Current Use; 3= Prior and Current Use; 4= No evidence of alcohol use]
**333.** SubA - Substance Use [1= Prior Use; 2= Current Use; 3= Prior and Current Use; 4= No evidence of substance use]

Drugs used:

334. Cannabis - Cannabis [1=Yes; 2=No]
335. Hash - Hashish [1=Yes; 2=No]
336. Cocaine - Cocaine [1=Yes; 2=No]
337. Meth - Methamphetamine [1=Yes; 2=No]
338. LSD - LSD [1=Yes; 2=No]
339. Heroine - Heroine [1=Yes; 2=No]
340. MDMA - MDMA [1=Yes; 2=No]
341. Steroids - Steroids [1=Yes; 2=No]

342. PresAbuse - Prescription Abuse [1=Yes; 2=No]
343. IntoxInhal - Intoxicative Inhalant [1=Yes; 2=No]
344. Oxy – Oxycodone(Oxtcontin) [1=Yes; 2=No]
345. TotDrugs - Total number of drugs used [Numerical 1-100]

RISK / NEED ASSESSMENT INFORMATION - P

346. RNA - Was there a RNA on file? [1=Yes; 2=No]
If yes to RNA complete the following:
347. RNAFam - Family Circumstance and Parenting
[1= low; 2= med; 3=high; 4 = N/A]
**348.** RNAEd - Education [1= low; 2= med; 3=high; 4 = N/A]
**349.** RNAPRel - Peer Relations [1= low; 2= med; 3=high; 4 = N/A]
**350.** RNASubA - Substance abuse [1= low; 2= med; 3=high; 4 = N/A]
**351.** RNARec - Leisure / recreation [1= low; 2= med; 3=high; 4 = N/A]
**352.** RNAPer - Personality [1= low; 2= med; 3=high; 4 = N/A]
**353.** RNAAtt - Attitudes [1= low; 2= med; 3=high; 4 = N/A]
**354.** RNASum - Summary of RNA [1= low; 2= med; 3=high; 4 = N/A]
**355.** RNATotS – Total Risk Score [1= low; 2= med; 3=high; 4 = N/A]
Assessment of Other Needs from the RNA:
356. RNASigFamT - Significant family trauma [1=Yes; 2=No; 3=N/A]
357. RNALearnD - Presence of a Learning disability [1=Yes; 2=No; 3=N/A]
358. RNAVicNeg - Victim of Neglect [1=Yes; 2=No; 3=N/A]
359. RNADepress - Depression [1=Yes; 2=No; 3=N/A]
360. RNAPSocSk - Poor Social Skills [1=Yes; 2=No; 3=N/A]
361. RNAHisSPAs - History of Sexual/Physical Assault [1=Yes; 2=No; 3=N/A]
362. RNAAsAuth - History of assault on authority figures [1=Yes; 2=No; 3=N/A]
363. RNAHisWeap - History of use of weapons [1=Yes; 2=No; 3=N/A]
364. CaseMAs - Case managers assessment of Overall Risk
[1 = Low, 2 = Moderate, 3 = High, 4 = Very High]
365. ClinOver - Was clinical override used [1=Yes; 2=No]
366. ClinOverRisk - If yes to clinical override was it
[1=Lower Risk; 2= Higher Risk; 3=N/A]

RECOMMENDATIONS FROM ASSESSMENT - Q

**367.** Custody - Custody [1=Yes; 2=No]
**368.** CustType - If Custody was it.. [1= Secure; 2 = Open; 3 = No Custody]
**369.** CustDur - If Custody, how long? [1 = less than one week; 2 = one month; 3 = 2-6 months; 4 = 7-12 months; 5 = 12+ months; 6 = N/A]
**370.** Probation - Probation [1=Yes; 2=No]
**371.** ComServOrd - Community Service Order [1-Yes; 2= No]
**372.** OutPCoun - Outpatient Counselling [1=Yes; 2=No]
**373.** ResTreat – MH Residential Treatment [1=Yes; 2=No]
**374.** AddictTreat - Treatment for Addictions [1=outpatient; 2=residential; 3=No]
**375.** SexOffTreat-Treatment for Sex Offending [1=outpatient; 2=residential; 3=No]
**376.** PsychInt- Psychiatric Intervention [1=Yes; 2=No]
**377.** AttendCen- Attendance Centre [1=Yes; 2=No]
**378.** IIS - Intensive Intervention Service [IIS] [1=Yes; 2=No]
**379.** IRS – Intensive Reintegration Service [IRS] [1=Yes; 2=No]
**380.** IntHom- Intensive Home Based Intervention [1=Yes; 2=No]
**381.** AltSchProg- Alternative School Programming [1=Yes; 2=No]

**382.** ReinPlan - Reintegration Planning [1=Yes; 2=No]
**383.** IndigInt- Indigenous Based Intervention [1=Yes; 2=No]
**384.** MHCourt- Mental Health Court [1=Yes; 2=No]
**385.** FurtherAss-Further Specific Assessment [1=Yes; 2=No]
**386.** EquineT - Equine Therapy [1=Yes; 2=No]
**387.** FamCouns - Family Counselling [1=Yes; 2=No]
**388.** SupEmpOpp - Supporting Employment Opportunities [1=Yes; 2=No]

MENTAL HEALTH COURT INVOLVEMENT - R

389. MHCrt - Was youth's case heard in the Mental Health / Youth Treatment Court? [1=Yes; 2=No]
Relevance of Mental Health in the Committal of the Offense(s):

**390.** MHrelate - In the opinion of the assessor was the presence of a mental health disorder related to the committal of any of the youth's offenses? [1=Directly Related; 2=Indirectly Related; 3=Not related]
**391.** DirectRel - If directly related is it [1=Medication; 2=Psychoses; 3=Intoxication at the time of the offense; 4=Offense linked to the specific nature of the Psychiatric Diagnoses; 5=Offense Pattern linked to Abuse History/Obtain Drugs; 6=N/A]
**392.** HistLFCC - History with London Family Court Clinic Number of Assessments [Numerical 00-99]

**Appendix E: The London Family Court Clinic (LFCC) Intake Form**

# Intake Form for Accompanying Adult (Caregiver)

Section 1 – ** *filled out by Agency Staff* **

Intake Worker: _____

Intake Date: _____ Date Information was received: _____

File Number: _____

Names of Person(s) filling out information: _____

Relationship(s) to youth: _____

## Instructions:

Please answer the following questions to the best of your ability. Please feel free to write on the back of the sheets if necessary. The assessment process involves gathering information that will help us to formulate a recommendation to the Youth Court around sentencing. It is important for us to better understand this youth's life circumstances, challenges, and strengths. Thank you for taking the time to be here to assist us with this task.

## Section 2 – Identifying Information:

2a. Youth

Youth's Name: _____

DOB (day/month/year): _____ Age: _____

Address: _____

Phone Number: _____

Where is youth currently living? _____

With whom are they living? _____

If currently in detention, date youth entered detention: _____

City of Birth: _____ Language (spoken at home): _____

Religion: _____ _____ Practising (yes/no) : _____

Lawyer's Name: _____ Phone Number: _____

Native Heritage: yes: _____ no: _____

2b. Parent(s)/Guardian

Legal Guardian(s): _____

Address: _____

Phone Number: _____ Cell #: _____

*if different than above*

Mother: _____

Address: _____

Phone Number: _____ Cell #: _____

Can you be contacted at work? YES NO Work Phone #: _____

Father: _____

Address: _____

Phone Number: _____ Cell #: _____

Can you be contacted at work? YES NO Work Phone #: _____

## Section 3 – Charges/Court Involvement:

3a. Present Charges:

Please list all present charges, any details about charges (eg. events that led up to charge, whether youth committed charge alone or with others, youth's response to charges, your response to charges:

_____

_____

_____

_____

_____

3b. Previous Charges:

Please list all previous charges, circumstances that led to charges, outcome of court in relations to charges:

_____

_____

_____

_____

_____

_____

3c. Previous Police Involvement:

Please list any contact this youth may have had with the police or police family consultants in the past that did not result in any charges:

3d. Is there a Probation Officer (PO) involved at present: YES NO *If yes ...*

Name of PO: _____ City: _____

Length of order: _____ Date of termination: _____

3e. Has probation been involved in the past: YES NO *If yes ...*

Name of PO: _____ City: _____

Length of order: _____ Date of termination: _____

## Section 4 – School History:

4a. Is the youth registered in school? YES NO

Present grade: _____ If in High School, how many credits does student have: _____

4b. Present School: _____ Previous School: _____

School Board : _____ Previous Board: _____

4c. Does the Youth attend school? YES NO

If no, please state reason: _____

4d. Has the youth ever failed a grade? YES NO

If yes, please explain: _____

_____

_____

_____

4e. Has youth been in a specialized education program or received special help? YES NO

If yes, please describe: _____

_____

_____

_____

4f. Does youth find school difficult? YES NO

If yes, please describe: _____

_____

_____

_____

4g. How many schools has this youth attended, since Kindergarten?

1 2 3 4 5 or more

If more than 5, please indicate reason for the many changes: _____

_____

_____

_____

4h. Does youth have difficulty getting along with teachers? YES NO

If yes, please describe: _____

_____

_____

_____

## Section 5 – Social Behaviours / Peer Relationships

5a. Does the youth have friends: YES NO

If yes, please circle all that apply:

older younger same age same sex opposite sex
good influence poor influence

Is this youth seen as a leader or a follower in a group of peers? _____

5b. Are you concerned about sexual behaviour / attitude? YES NO

If yes, please describe your concerns: _____

5c. Does the youth participate in organized activities? YES NO

Please list: _____

5d. Does the youth have any interests or hobbies? YES NO

Please list: _____

5e. Does the youth spend time with family? YES NO

Please describe: _____

5f. Does the youth have any significant social ties to other adults outside immediate family? YES NO

Please describe: _____

## Section 6 – Agency Involvement

Please list any agency / organization that has had involvement with this youth.

*(for example include: Psychiatrists, Psychologists, Children's Aid Society - CAS, Child Mental Health Agencies, Police, Hospital, Detention Facility, Doctor, Educational Institutions, Probation, Group Homes, etc.)*

| Agency / Organization | Time of Involvement | Contact Person / Worker |
|---|---|---|
| | | |
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| | | |

6a. Has your family been involved with CAS? YES NO

If yes, is your family still involved with CAS? YES NO

Length of Involvement: _____

Name of Worker: _____

Location: _____ Phone Number: _____

6b. Has your family been involved in Family Court? *(eg. For custody and access, separation / divorce reasons)* YES NO

_____

_____

_____

6c. Has your son / daughter been caught in the middle of the court issue? YES NO

Please describe: _____

_____

_____

_____

_____

## Section 7 – Family Life:

7a. Does the youth reside with? *(please circle)*

| | | | |
|---|---|---|---|
| Mother | Father | Both | Common-law Partner |
| Step-mother | Step-father | other: _____ | |

7b. How many times has the youth moved since birth?

1 2 3 4 5 or more 10 or more

If more than 5, please indicate reason for so many changes: _____

_____

_____

_____

7c. Does this youth have a Brother(s) or Sister(s)? YES NO

If yes, please list

| Name | Age | Gender | Full / half / step sibling | Are they in conflict with the law? | Relationship with youth *(eg. close, good, average, fight)* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

7d. Please describe youth's relationship with family members: _____

_____

_____

_____

_____

## Section 8 – Developmental History

8a. At what age did the child begin to walk? _____

At what age did the child begin to talk? _____

At what age was the child toilet trained? _____

Has the youth had a serious illnesses? YES NO

Has the youth had any serious accidents? YES NO

Any head injuries? YES NO

Were there any complications during pregnancy/birth with youth? YES NO

Were there family problems at the time of birth? YES NO

Has the youth ever been hospitalized? YES NO

If yes, what hospital(s): _____

_____

_____

_____

If you answered yes to any of the above questions, please explain: _____

8b. Has youth ever had a psychiatric/psychological assessment? YES NO

If yes, please describe reason for this assessment and name of the assessor(s): _____

8c. Is the youth currently taking any medication? YES NO

If yes, specify type, amount, when and reason for medication: _____

8d. Has youth previously taken medication? YES NO

If yes, specify type and length of time: _____

## Section 9 – Parental History

9a. Parent:

Your relationship to the youth (eg. biological mom, step-father etc.): _____

Name: _____

D.O.B.: _____ Age: _____ Place of Birth: _____

Length of time living with child: _____

Current Marital Status:

| Married | Single | Separated | Divorced | Common-law |
|---|---|---|---|---|

Dates of Marriages/Separations/Divorces/Common-law unions: _____

_____

Date(s) of changes in parent's custody of child: _____

_____

Religion: _____ Language: _____

Education Completed:

| 1-8 | 9-10 | 11-13 | College | University |
|---|---|---|---|---|

Current occupation: _____

Employer: _____

Other means of Financial Support:

| EI | OW | ODSP | Child Support |
|---|---|---|---|

9b. How many partners have you been involved with since the youth's birth?

| 1 | 2 | 3 | 4 | 5 or more |
|---|---|---|---|---|

9c. Have any of these relationships involved:

Domestic violence YES NO

Aggression YES NO

Verbal aggression YES NO

Police being called YES NO

If yes to any of these, please explain: _____

_____

_____

_____

_____

9d. Please describe any significant personal crisis in your life:

*(include things such as death, separation, emotional illness, physical illness, problems with "nerves", issues with drugs/alcohol, financial strain, conflict with the law, separation from family etc.)*

9e. Any mental health issues, presently or in the past:

9f. Are there members of your extended family with mental health problems?

9g. Medications for above:

9h. How do you think these crisis may have impacted this youth?

9i. What do you like best about this youth:

## Section 10 – Parental History

*(Please fill out the following for the second parent/parent figure living in the home with the youth.)*

10a. Biological Parent or Step-Parent

Their relationship to the youth (eg. biological mom, step-father etc.): _____

Name: _____

Age: _____ Place of Birth: _____

Length of time living with child: _____

Marital Status:

| Married | Single | Separated | Divorced | Common-law |
|---|---|---|---|---|

Religion: _____ Language: _____

Education Completed:

| 1-8 | 9-10 | 11-13 | College | University |
|---|---|---|---|---|

Current occupation: _____

Employer: _____

Other means of Financial Support:

| EI | OW | ODSP | Child Support |
|---|---|---|---|

10b. Please describe any significant personal crisis in this person's life:

*(include things such as death, separation, emotional illness, physical illness, problems with "nerves", issues with drugs/alcohol, financial strain, conflict with the law, separation from family etc.)*

_____

_____

_____

_____

_____

_____

_____

10c. Any mental health issues, presently or in the past: _____

_____

_____

10d. Medications for above: _____

_____

_____

10e. How do you think these crisis may have impacted this youth? _____

_____

_____

_____

10f. What do you like best about this youth: _____

_____

_____

_____

_____

_____

## Section 11 – Parental History

*(Please fill out the following for a Biological or Step-Parent that no longer lives with the youth.)*

11a. Non-custodial or Absent Parent

Their relationship to the youth (eg. biological mom, step-father etc.): _____

Name: _____

Age: _____ Place of Birth: _____

Current address (City, town, Province etc.): _____

Marital Status:

| Married | Single | Separated | Divorced | Common-law |
|---|---|---|---|---|

Religion: _____ Language: _____

Education Completed:

| 1-8 | 9-10 | 11-13 | College | University |
|---|---|---|---|---|

Current occupation: _____

Employer: _____

Other means of Financial Support:

| EI | OW | ODSP | Child Support |
|---|---|---|---|

11b. Please describe any significant personal crisis in this person's life:

*(include things such as death, separation, emotional illness, physical illness, problems with "nerves", issues with drugs/alcohol, financial strain, conflict with the law, separation from family etc.)*

_____

_____

_____

_____

_____

_____

11c. Any mental health issues: _____

_____

_____

11d. Please describe youth's current contact and relationship with this person: _____

_____

_____

_____

11e. If youth no longer sees this parent, when was the last contact? _____

_____

_____

11f. Why did contact stop? _____

## Section 12 – Presenting Problem

*(Leading to youth's involvement with the legal system)*

12a. What do you see as this youth's major problem? _____

12b. When did this youth's problems begin? _____

12c. In your opinion, what sort of help does this youth need? _____

12d. What has not worked in the past, please describe why you think it has not been successful? _____

12e. Do you have a reason to believe this youth is involved in or experiencing any of the following?

| | | |
|---|---|---|
| Drug use | YES | NO |
| Alcohol use | YES | NO |
| Fire setting | YES | NO |
| Gang activity | YES | NO |
| Sexual victimization | YES | NO |
| Bullying | YES | NO |
| Emotional distress | YES | NO |
| Thoughts of harming self or others | YES | NO |

Please explain: _____

## Section 13

13a. Is there anything else that is important for us to know about the family and/or the youth?

## Section 14

14a. Please tell us what you see as this youth's strengths: _____

## Curriculum Vitae

**Name:** Orla Tyrrell

**Post-Secondary Education and Degrees:**

M.A. Counselling Psychology
Western University
London, ON, Canada
2015 – 2017

B.Sc. (Honours) Psychology, Neuroscience & Behaviour
McMaster University
Hamilton, Ontario, Canada
2009 – 2014

**Honours and Awards:**

Social Science and Humanities Research Council (SSHRC)
Masters Research Scholarship
2016 – 2017

Western Graduate Research Scholarship
Western University
2015 – 2016

**Related Counselling Experience:**

Counselling Intern
Humber College Institute of Technology & Advanced Learning
2016 – 2017

Group Therapy Co-facilitator with Paul Libeau
Wellspring London
2016

Group Therapy Co-Facilitator with Angela Geddes
London Family Court Clinic
2016

Group Therapy Co-Facilitator with Tara Peterson
Big Brothers Big Sisters of Peel
2016

**Publications:**

Tyrrell, O., Leschied, A. DW., Webb, J., Sabo, V., & MacLellan, A. S. (*in preparation*). *Social Determinants of Health and Criminal Youth Justice: Understanding the Nature and Needs of Serious and Violent Youth Offenders*

MacLellan, A. S., Leschied, A. DW., Tyrrell, O., Webb, J., & Sabo, V. (*in preparation*). *Exploring Mental Health in a Sample of Justice Involved Youth.*

Sabo, V., Leschied, A. DW., MacLellan, A. S., Tyrrell, O., & Webb, J. (*in preparation*). *Understanding Antisocial Friendships: Correlates of Antisocial Peer Association and Co Offending.*

Webb, J., Leschied, A. DW., Sabo, V., MacLellan, A. S., & Tyrrell, O. (*in preparation*). *An Exploration of Gender Differences Within Higher Risk Young Offenders.*