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Juvenile Justice

A System Divided

W. Jeff Hinton
Patricia L. Sims
Mary Ann Adams
Charles West
University of Southern Mississippi, Hattiesburg

An increasing public focus on the effects of juvenile crime on society has dramatically impacted juvenile justice policy decisions in recent years. Historically, juvenile justice policy makers have attempted to address juvenile crime by promoting policies that address the rehabilitative needs of the offender. However, throughout the last 20 years of the 20th century, policy makers have advocated more punitive offense-based policies to address juvenile crime. This article examines the differences between these two approaches and the implications associated with the continued emergence of a more offense-based approach compared to the offender-based approach, which historically has been the foundation of the American juvenile justice system. The authors hope to stimulate discussion among stakeholders in the juvenile justice system to promote sound policy decisions based on scientific evidence.

Keywords: *juvenile; treatment; policy*

Introduction

Historically, juvenile justice professionals, researchers, and policy makers have oscillated between rehabilitative and punitive strategies for reducing juvenile crime. The approach to dealing with juvenile delinquents has changed over time as society's view of children and crime has evolved. During colonial times, children were seen as miniature adults and were considered property of the parents who (along with adult courts if necessary) administered severe punishment to misbehaving children. Today, children have rights and protections but may still be treated as adults depending on state legislative mandates.

The juvenile justice system of the United States has evolved over the past 100 years, beginning with the emergence of the first juvenile court in Cook County, Illinois, in 1899. The system was established to provide dispositions targeting the rehabilitative needs of the offender rather than issuing punitive sentences based on the seriousness of the offense. This stance was based on evidence suggesting that

Authors' Note: Please address correspondence to W. Jeff Hinton, University of Southern Mississippi, Department of Child and Family Studies, 118 College Drive #5035, Hattiesburg, MS 39406-0001; e-mail: jeff.hinton@usm.edu.

delinquent youth were developmentally and cognitively distinct from adult offenders and that the traditional adult sentences resulted in cruel and inhumane treatment for juvenile offenders.

Unfortunately, juvenile justice researchers failed to produce credible scientific studies documenting the effectiveness of many of the therapeutic interventions for juveniles that were developed over the past 100 years. In part this occurred because the approaches used did not address the multiple factors that contributed to the development of delinquency. Also, many of the early juvenile justice studies examining the effectiveness of emerging interventions were fraught with methodological problems.

As juvenile crime rates continued to climb throughout the 1970s, 1980s, and early 1990s, society began to seek other options for addressing juvenile crime. The trend of rising juvenile crime rates, especially violent crime rates, combined with the lack of well-designed scientific studies documenting the effectiveness of juvenile justice interventions left public policy makers with little choice but to conclude that more punitive sanctions based on the offense committed rather than offender characteristics, including age, was the answer. Whereas 1,736 juveniles were incarcerated in adult jails in 1983, by 1998 more than 8,000 juveniles were incarcerated in adult jails, representing an increase of 366% (Austin, Johnson, & Gregoriou, 2000). This approach appears to have been no more and perhaps less effective than the early therapeutic attempts to deter future criminal behavior by the adolescent (Redding, 2000). Specifically, incarceration has been shown to increase the risk of physical and sexual abuse of the youth and to increase the rate of recidivism upon release (Redding, 2000). So what needs to be done to address this serious social problem in our society? At no time in history has the juvenile justice system's response appeared more fragmented than it appears today.

The purpose of this article is to clarify the distinct differences between two current philosophies that seem to be dividing the juvenile justice system in America. The authors will discuss the implications associated with the continued emergence of a more offense-based approach compared to the offender-based approach on which the juvenile justice system was founded. The authors hope to stimulate discussion among stakeholders in the juvenile justice system to promote sound policy decisions based on scientific evidence. Because juvenile crime is a formidable and complex social problem, policy makers should consider the multitude of existing and emerging scientific findings to formulate multifaceted approaches that protect the rights of juvenile offenders and promote rehabilitation while also protecting the public from the fiscal and social costs associated with delinquency (Hinton, Sheperis, & Sims, 2003).

Historical Overview

1700 to 1899

To understand the current state of the juvenile justice system in America, it is necessary to examine the evolution of the public response to juvenile crime and the

impact of this response on juvenile justice trends. The response to juvenile crime in the United States has changed as society's beliefs about both children and crime have changed. Until the 1700s children were viewed as nonpersons. They did not receive special treatment from the justice system, and neither were they recognized as having needs that were different from adults. During Colonial America children were perceived to be miniature adults who needed education and a trade to become "righteous" adults (Hawes, 1973). Punishment for misbehavior was determined by the courts but meted out by the parents and frequently consisted of a court-observed whipping (Mennel, 1973). The Massachusetts Stubborn Child Law of 1646 allowed parents to classify their child as stubborn and seek state punishment, including capital punishment (Ventrell, 1998). In addition, if authorities believed that parents were not providing good breeding or teaching a trade, the state was authorized to remove children and apprentice them for the common good, a frequent result in poor families (Ventrell, 1998).

As society moved from a primarily agrarian to an industrialized basis, youth who had once worked on farms were displaced when the economic centers moved to the urban areas and factories replaced farms as work centers for families. This movement toward industrialization marked the emergence of the modern age of juvenile delinquency (Thomas & Penn, 2002). During this time, adolescents experienced a number of factors that contributed to their increased risk for delinquent behavior. Parents moved from family-centered farming to industrialized jobs, leaving their children with little or no supervision. Children who had previously worked on family farms now found themselves displaced from the labor force with far too much free time and diminished supervision. Also, poverty levels increased during this period of history, resulting in many children being abandoned by parents who could not afford to raise them (Tanenhaus, 2004). These factors and others contributed to antisocial and delinquent behavior among youth.

Society was confronted with the task of developing strategies in response to these changes. An initial attempt came in the House of Refuge movement initiated in New York by reformers who were interested in promoting the rehabilitation of children. The first reformatory, built in 1824, housed juveniles who earlier would have been placed in adult jails with the goal of "saving" them (Ventrell, 1998). As the concept of reforming troubled youth became more prominent, a number of similar reformatories were established throughout the nation. Unfortunately, most of these reformatories housed poor rather than delinquent youth. Because most reformatories still treated juveniles harshly, providing a more punitive than rehabilitative environment, it could be argued that they failed to meet their goals of providing assistance to youth (Tanenhaus, 2004).

In 1899, Cook County, Illinois, established the first juvenile court, marking the beginning of the modern juvenile justice system in America (Thomas & Penn, 2002). This child-friendly court no longer tried youth as adult offenders. The juvenile justice system exercised its authority using a parens patriae (state as parent or guardian) role and assumed the responsibility of parenting children until positive changes

occurred or they became adults (Juvenile Justice FYI, n.d.). Juvenile courts differed from the existing criminal courts because juvenile courts rendered dispositions based on the needs of the offender as opposed to sentences based on the seriousness of the offense (Bilchik, 1999).

1900 to 1980s

The Progressive Era in the United States was a time of extensive social reform. During this period, which spanned approximately two decades, the concept of childhood as a separate developmental stage emerged. Children were viewed as having needs that were different from adults, and policy makers began to attempt to address these needs (Jimenez, 1990; Trattner, 1994). Child welfare reformers believed children and youth were to be protected from the worst extremes of urban-industrial life (Wolcott, 2003). The women's suffrage movement also emerged at this time, and these activists joined in the campaign against child labor (Garrison, 1983; Juvenile Justice FYI, n.d.). Child welfare advocates also provided for the movement of children from almshouses to private homes, establishing the concept of foster care (Trattner, 1994).

As formal youth courts developed to address issues of delinquency, a concurrent movement to address children's mental health began to emerge (Lourie & Hernandez, 2003). In 1909, the Juvenile Psychopathic Institute was established in Chicago to provide assistance to the Chicago Juvenile Court (Tanenhaus, 2004). This marked the beginning of the child guidance movement and recognition that juvenile delinquents were frequently in need of mental health services. It was during this period that researchers began to publish studies documenting the correlation between mental health problems and delinquent behavior.

As the modern view of children and crime emerged, society oscillated in its support between punitive and rehabilitative efforts to reduce juvenile crime rates in America. Interventions used in the juvenile justice system over the past 60 years focused on both punishment and rehabilitation. These approaches included juvenile boot camps, incarceration, probation and parole monitoring services, wilderness programs, intensive supervision programs, individual therapy, group therapy, family therapy, and family systems multimodal/multisystemic ecological interventions (Henggeler & Sheidow, 2003; MacKenzie, 1997).

1990 to Present

The 1990s perhaps more than any other decade in history yielded unprecedented challenges to and changes in the juvenile justice system in America. These challenges are likely the result of at least two factors. First, juvenile arrest rates in America rose substantially throughout the 1980s and early 1990s (Henggeler & Sheidow, 2003; Snyder, 1997). Second, the number of credible scientific studies documenting the effectiveness of juvenile justice interventions was sparse at best.

Although many social factors contributing to delinquency in youth had been acknowledged by juvenile justice researchers, researchers had not developed and adequately tested interventional strategies capable of addressing the complex relationships that exist between multiple risk factors associated with juvenile delinquency (Henggeler & Sheidow, 2003).

Juvenile arrest rates in virtually all categories rose substantially throughout the 1980s and early 1990s. According to a 1999 report from the Federal Bureau of Investigation, 23% of all arrests in 1998 involved juveniles. In excess of 1.6 million youth younger than the age of 18 were arrested by law enforcement personnel in 2000 (FBI, 2001). In addition, arrests for drug violations increased by 36% between 1990 and 1998 (FBI, 1999). Since the mid-1990s, overall arrest rates for both juveniles and adults have decreased. However, the nearly 1.6 million juvenile arrests reported in 2000 was still substantially higher than the less than 1.1 million reported in 1984 (Snyder & Sickmund, 1999).

The increase in juvenile crime throughout the 1980s and early 1990s did not go unnoticed by juvenile justice professionals, public policy makers, or the public at large. As a result of increased public concern regarding the rise in juvenile crime, juvenile justice professionals and stakeholders began to question their ability to address the problem. Some professionals advocated conducting sound methodological studies and rigorous clinical trials designed to test the effectiveness of some promising interventional strategies, although others, including many legislative bodies, argued that the rehabilitative efforts of the system had failed and advocated for harsher sentencing laws and the transfer of more juveniles to the adult court system.

To address the problem of increasing juvenile crime rates in America, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) dispersed funds in excess of $500 million per year between 1998 and 2001 (Flores, 2003), yielding rich data identifying effective strategies for conceptualizing and treating juvenile delinquency. In recent years, researchers have compiled impressive empirical evidence documenting the success of several interventional models for reducing the recidivism rates of juvenile offenders. Although a comprehensive examination of these models is beyond the scope of this article, a brief overview is included in a later section.

Brief Overview of Research in the 1990s

While public policy makers were busy legislating stricter and more punitive sentencing options for juvenile delinquents, proponents of developing more effective intervention strategies for treating delinquent youth focused their attention on understanding the existing body of knowledge regarding juvenile rehabilitation efforts. This section provides a brief examination of the research literature on the numerous programs instituted to rehabilitate juvenile offenders.

MacKenzie (1997) compared four random assignment studies examining the effectiveness of four different juvenile boot camp programs attempting to reduce

recidivism rates among referrals. MacKenzie concluded that "In general, findings indicate no difference between the offenders who participated [in boot camp programs] and those who did not" (p. 24). Specifically, MacKenzie reported that there was no statistically significant difference in recidivism rates for three of the programs examined. However, statistically significant differences were found in one study. These results indicated that youth participating in the boot camp program were significantly more likely to be reincarcerated than youth from the control group who received usual court sanctions, including incarceration in non–boot camp facilities.

Incarcerating juvenile offenders in correctional facilities has been only minimally successful in preventing future criminal activity (Altschuler & Armstrong, 1991; Baird, Storrs, & Connelly, 1984; Whittaker, 1979). In fact, MacKenzie (1997) reported that institutionalization and/or incarceration only resulted in a 10% reduction in recidivism rates when compared to no intervention. Considering the expense associated with institutionalizing/incarcerating youth, the minimal reduction in recidivism seems to be a poor investment of public funds. Furthermore, Cottle, Lee, and Heilbrun (2003) found that an increasing number of out-of-home placements (institutionalization/incarceration) was a significant predictor of future criminal activity by juveniles.

The 1970s and 1980s saw wilderness programs gain popularity, with more than 100 programs in North America established to treat delinquent youth (Winterdyk & Roesch, 1981). Wilderness programs generally emphasize physical challenge and encourage participants to do more than what they believe they can do. In spite of the popularity of these programs, few outcome evaluation studies measuring their effectiveness existed prior to 1987 (Gendreau & Ross, 1987). Altschuler, Armstrong, and MacKenzie (1999) reported that a recent study of four popular wilderness programs produced mixed results, and the authors concluded that overall, "Wilderness and challenge programs do not provide evidence that they are effective in reducing future criminal behavior" (p. 34).

The ineffectiveness of individual and group therapy programs with juvenile offenders for reducing recidivism rates has been well documented (Borduin, 1994; Henggeler, 1989; Henggeler & Sheidow, 2003; Lipsey, 1992; Ulrici, 1983). Lipsey (1992) found that individual and group counseling interventions only produced 4% and 3% reductions in recidivism rates, respectively. Henggeler and Sheidow (2003) concluded that these treatment modalities are largely ineffective because they often focus on individual risk factors in isolation and fail to recognize the reciprocal relationships that exist among various risk factors within multiple system levels.

Probation and parole services, including intensive supervision programs, are the most common intervention used in the juvenile justice system (Altschuler et al., 1999). Probation and parole services generally value increased monitoring and surveillance of juvenile offenders. However, a meta-analytic study of the effectiveness of delinquency outcome research found these interventions only resulted in a 4% decrease in recidivism (Lipsey, 1992). Altschuler et al. (1999) also found probation

and parole services, including intensive supervision programs, were unable to produce significant differences in the recidivism rates of participants when compared to control groups.

This information appears to increase the credibility of Martinson's (1974) conclusion that "with few and isolated exceptions the rehabilitative efforts that have been reported so far have had no appreciable effect on recidivism" (p. 25). Critics of Martinson's report argued that inadequate research methods used in these studies and poor program implementation were at fault for the poor results rather than the treatment approaches. Martinson's report however had a tremendous impact on how justice system officials would later manage offenders in this country (MacKenzie, 1997). Political leaders, judges, and other correctional policy makers began to abandon many rehabilitative efforts in favor of supporting harsher sentencing laws, resulting in longer periods of confinement and more punitive actions against juvenile offenders (MacKenzie, 1997).

Public opinion also shifted during the late 1980s and 1990s from support of treatment and rehabilitation to support of management and control strategies aimed at protecting the public and holding the delinquent youth accountable for his or her actions. This shift in public response has dramatically influenced changes in the juvenile justice system in the United States.

Bilchik (1999) stated, "The 1990s have been a time of unprecedented change as state legislatures crack down on juvenile crime" (p. 5). These changes included 45 states making it easier for juveniles to be transferred to the adult system, 31 states expanding the sentencing options for juvenile courts, and 47 states modifying or removing confidentiality provisions designed to protect juveniles. In addition, 43 state legislatures and the District of Columbia revised their laws related to serious or violent juvenile offenses, 24 states added crimes to the list of offenses to be handled by the criminal court system, and 36 states excluded certain categories of youth from juvenile court jurisdiction (Austin et al., 2000). These changes represent a dramatic shift in the focus of the juvenile justice system that was originally created to address the needs of the offender rather than to punish based on the severity of the offense (Bilchik, 1999).

The recent trend toward more punitive sanctions for juvenile offenders has occurred in spite of mounting evidence suggesting that harsher sentencing practices and placing juveniles in the adult system increases the likelihood of both physical and psychological harm for the youthful offender (Austin et al., 2000; Bilchik, 1999; Redding, 2000). Indeed, research shows that the futures for youth transferred to the adult system and subsequently incarcerated with adult offenders are bleak. Juveniles in adult correctional facilities are at greater risk for suicide and physical and sexual abuse. According to Beyer (1997), juveniles confined in secure adult settings are 8 times more likely to commit suicide, 200 times more likely to be physically assaulted by staff, and 5 times more likely to be sexually assaulted than juveniles detained in juvenile facilities. Not only are juveniles in adult facilities more likely to be physically and psychologically harmed than juveniles housed in juvenile facilities,

but they are also more likely to be denied participation in rehabilitative programs. Adult facilities are much less likely to emphasize rehabilitative programming than juvenile correctional facilities.

Bishop and Frazier (2000) interviewed 95 serious and chronic juvenile offenders and found that these juveniles described their experiences with the juvenile court system as fair and generally positive. This same group of juvenile offenders described their experience with the criminal court system much more negatively. Most of the juveniles incarcerated in juvenile facilities felt confident they would not reoffend after release, but only one third of juveniles incarcerated in adult facilities felt they would not reoffend. Juveniles housed in juvenile facilities frequently credited staff for evoking positive changes in their lives, whereas juveniles in adult facilities reported spending most of their time learning criminal behaviors from the adult inmates (Bishop & Frazier, 2000).

Current Status of Juvenile Justice Research

Because of the substantial changes that occurred in the juvenile justice system, including practice, research, and policy decisions during the 1990s, it seems important that juvenile justice stakeholders carefully examine the current state of the system. In response to societal pressure, juvenile justice professionals advanced two distinctly different positions to address the growing problems associated with the rising rates of juvenile crime that occurred throughout the 1980s and early 1990s. As noted earlier, juvenile justice professionals and policy makers advocating harsher sentencing laws and more transfers to the adult system have sought and obtained significant legislation in all but a few states. This has resulted in more youth, and increasingly younger youth, being placed within the adult criminal justice system.

The second trend in the juvenile justice system involved a renewed focus on rehabilitative methods. The OJJDP funded research on the implementation and evaluation of interventional strategies for treating juvenile delinquency that also met strict methodological requirements (Flores, 2003). The result of this effort has been the emergence of a substantial body of science-based juvenile justice literature regarding the effectiveness of interventional programs for reducing the recidivism rates for juvenile offenders (Henggeler & Sheidow, 2003).

Understanding that multiple factors contribute to juvenile delinquency was the first step in the development of effective interventions. Juveniles who commit criminal offenses experience numerous psychosocial and educational problems (Kazdin, 1987), including aggressiveness, poor social/interpersonal skills, low levels of concern for others (Tolan, 1990), attention deficit hyperactivity disorder (Hinshaw, 1997), and learning disabilities (Leone, Rutherford, & Nelson, 1991). Other factors such as temperament, genetic vulnerability, gender (e.g., males have higher risk), and cognitive abilities influence delinquent behavior (Loeber & Hay, 1994). Alcohol and drug abuse are also strongly correlated with delinquent behaviors in youth (Robertson, 2000).

These individual risk factors usually exist in combination with other social and environmental risk factors, particularly family characteristics. Poor parental monitoring and supervision, family history of criminal behavior, harsh parental discipline, family conflict, parental psychopathology, and exposure to abusive family interactions have been consistently linked with juvenile delinquency (Fagan & Wexler, 1987; Gorman-Smith, Tolan, Loeber, & Henry, 1998; Loeber, 1990; Tolan, 1990; Wright & Cullen, 2001). A lack of family cohesiveness, or parental attachment to their children, has also been found to increase the risk of delinquency (Anderson & Holmes, 1999; Brook, Nomura, & Cohen, 1989; Henggeler, Melton, & Smith, 1992; Henry, 2001; Leflore, 1988). Shields and Clark (1995) found a relationship between the number of delinquent acts committed by an adolescent and how disengaged he or she perceived his or her family to be. Other social factors influencing delinquency but mediated by family environment are association with deviant peers and poverty (Tolan & Guerra, 1998).

Throughout the 1990s, study after study indicated the importance of family and extended system risk factors associated with delinquency. The vast majority of youth committing crimes come from seriously dysfunctional families (Elliott, 1994; Loeber et al., 1993; Roberts, 1995; Snyder, 1997; Tolan & Guerra, 1998; Tolan, Guerra, & Kendall, 1995), but most interventions have targeted one specific risk factor or another, usually an individual risk factor rather than family or environmental characteristics. As noted earlier, previous studies have reported that traditional psychotherapeutic counseling strategies, including group therapy and individual therapy targeting just the adolescent, are not effective treatments for reducing the recidivism rates of juvenile offenders (Borduin, 1994; Ulrici, 1983).

It is clear that child and adolescent development is influenced by multiple systems (e.g., individual, familial, peer, and societal risk factors) that exert direct and indirect influences on the emergence of delinquent behaviors (Tolan & Guerra, 1998), and effective interventions must address the complex interrelationships that exist among these various risk factors (Henngeler & Sheidow, 2003). In *Blueprints for Violence Prevention*, Mihalic, Irwin, Elliott, Fagan, and Hansen (2001) reviewed more than 500 programs designed to reduce criminal behaviors in youth and found only 3 that met modestly stringent criteria for effectiveness. The models identified (functional family therapy [FFT], multisystemic therapy [MST], and Oregon treatment foster care) all used aspects of family systems theory and conceptualized delinquency ecologically.

These models are grounded in family systems theory, which views all behavior as being contextual (Becvar & Becvar, 1988). Systems theorists examine behaviors holistically in the relational and environmental context of mutual interaction and influence in which they occur. Behavior can only be understood within the social patterns of interaction one has with others. Because informal socialization occurs primarily in families and schools, examining the impact of family and extended system relationships on delinquency seems preferable to the more narrowly focused view of many other rehabilitative models, including individual counseling, group

counseling, boot camps, wilderness programs, community monitoring, and others (Hinton et al., 2003). Both FFT and MST not only attempt to target causative factors within the juvenile offender's family, peer, and school networks (Henggeler et al., 1992), but they also identify the strengths of various systems to encourage change (Henggeler & Borduin, 1995).

The Oregon treatment foster care targets juvenile delinquents who have already been removed from home, whereas functional family therapy and multisystemic therapy work with families whose adolescent is still in the home. FFT and MST have received praise for their effectiveness from the U.S. Surgeon General (U.S. Public Health Service, 1999, 2001) and the National Advisory Mental Health Council of National Institute of Mental Health (National Advisory Mental Health Council, 2001). Furthermore, FFT and MST have been described as exemplary models by numerous agencies and organizations largely due to their effectiveness in reducing recidivism rates for juvenile offenders (Henggeler & Sheidow, 2003). These two programs will be further described next.

Functional Family Therapy

Based on research that demonstrates that punitive approaches such as incarceration are largely ineffective and costly, FFT was developed to treat troubled youth and their families within the communities in which they live (Sexton & Alexander, 2000). The developers of FFT strongly believe that "by removing adolescents from their families and communities, punitive programs inadvertently make adolescents' problems more difficult to solve in the long run" (Sexton & Alexander, 2000, p. 3). The major goal of FFT is to improve family communication and support while decreasing negativity within the family system of the juvenile offender (Sexton & Alexander, 2000). Other program goals include the promotion of family problem-solving skills, the development of positive parenting strategies, and the encouragement of family members to access community-based resources already in existence (Sexton & Alexander, 2000).

Although FFT was originally designed for use with middle-class families with delinquent youth, over the past 30 years the program has evolved into a comprehensive treatment strategy that has been effective in improving family dynamics and reducing recidivism rates for poor and multiethnic populations. In addition, the program has demonstrated success with drug-abusing youth, violent youth, and serious juvenile offenders (Alexander, Robbins, & Sexton, 1999). Sites using FFT serve delinquent youth between 11 and 18 years of age and provide treatment to the siblings of referred youth (Sexton & Alexander, 2000).

Designed as a brief intervention with sessions usually spread over a 3-month period, FFT treatment averages 8 to 12 sessions for mild cases and up to 30 hours of direct service for more difficult cases. The FFT clinical model is delivered in three distinct phases (early, middle, and late), each having its own assessment foci, goals, and interventional strategies. Empirically validated risk and protective factors associated

with delinquency are targeted for change at each stage of intervention. FFT clinicians begin by engaging and motivating families to change, leading to the establishment of a strong therapeutic relationship. Next, FFT clinicians help the family to identify strengths and use these strengths to promote behavior change as needed. Specific behavior change plans are collaboratively developed for each family receiving FFT services. Prior to the conclusion of treatment, families are challenged to engage community support systems and modify family relationships to increase the likelihood of recent changes being sustained posttreatment (Sexton & Alexander, 2000).

To maintain treatment fidelity across sites for replication purposes, FFT has developed and implemented a sophisticated computer client assessment, tracking, and monitoring system (Functional Family Therapy–Clinical Services Systems; Functional Family Therapy, Inc., 1999). To increase outcome accountability and facilitate supervision of cases, FFT sites are required to use this computerized database. FFT clinicians are typically master's-level professionals with degrees in marriage and family therapy, clinical psychology, counseling, probation services, criminology, or recreation therapy.

FFT incorporates specific implementation and training criteria for all proposed service sites (Alexander et al., 1999). FFT training costs currently exceed $46,000 per working group, not including travel expenses (National Center for Mental Health Promotion and Youth Violence Prevention, n.d.). FFT has a systematic training and implementation protocol that consists of three phases that include clinical training for staff, advanced clinical training for team leaders, follow-up visits, and ongoing supervision. Each training phase can typically be completed in 1 year.

From 1973 to present, researchers publishing studies have documented the effectiveness of FFT for reducing the recidivism rates of program participants (Alexander et al., 1999; Sexton & Alexander, 2000). FFT has demonstrated success in comparison to no treatment and alternative therapeutic approaches in randomized trials and nonrandomized comparison group studies (Alexander, Sexton, & Robbins, 2000). Researchers have concluded that FFT has been successful in reducing adolescent rearrests by 20% to 60% when compared with no treatment, other family therapy interventions, and traditional juvenile court services (e.g., incarceration and probation services) (Alexander et al., 2000). Klein, Alexander, and Parsons (1977) reported that FFT also significantly reduced the likelihood that siblings of the referred youth would participate in future criminal activity.

FFT is a cost-effective, outcome-driven intervention program. The average costs range from $1,350 to $3,750 per referred youth (Alexander et al., 1998) compared to the average cost of detaining a juvenile, approximately $33,000 (Levitt, 1998). Although over the past 30 years a wealth of scientifically sound studies have documented the effectiveness of FFT for reducing the recidivism rates of juvenile offenders, only 50 FFT sites existed in 15 states (Alexander et al., 2000). Given the program's success, one must question why FFT programs have not been implemented in thousands of communities across America.

Multisystemic Therapy

MST is an intensive family-based treatment approach that targets known risk factors associated with antisocial behavior in delinquent youth and their families (Henggeler, 1999). Typically, interventions target individual factors (e.g., poor problem-solving skills), family factors (e.g., poor discipline and monitoring strategies), peer-related factors (e.g., association with deviant peers), and school factors (e.g., academic difficulties) (Henggeler, 1999). The primary goals of MST are to reduce rates of antisocial behavior for referred adolescents (including recidivism), reduce the number of out-of-home placements for referred youth, and empower families to resolve future potential problems (Henggeler, 1999). Goals are accomplished by empowering parents through the teaching of parenting skills and linkage with community resources and by empowering youth to cope with family, peer, school, and neighborhood problems (Henggeler, Mihalic, Rone, Thomas, & Timmons-Mitchell, 1998).

As a comprehensive community-based treatment approach, MST sites provide home-based services to families of referred youth between the ages of 12 and 17, removing barriers that often hinder access to services (Mihalic et al., 2001). MST services are usually provided by a team of (4 to 6) clinicians representing a variety of mental health disciplines and an on-site supervisor with a master's degree and exceptional skills or a doctoral degree in a mental health discipline (Henggeler, 1999). MST team members are assigned a small number of cases, four to six each, and work together as a unit to support the 24 hours a day, 7 days a week on-call needs of client families. MST treatment typically involves 60 hours of client contact over approximately 4 months but varies depending on the needs of the client families (Henggeler et al., 1998). Henggeler et al. (1998) reported that MST is very cost efficient (less than $3,500 per referral) when compared to incarceration ($33,000 average cost per juvenile detained) (Levitt, 1998).

The effectiveness of MST for reducing recidivism rates of chronic, violent, and drug-abusing adolescents has been well documented (Henggeler & Sheidow, 2003; Mihalic et al., 2001). Three major randomized clinical trials (Simpsonville Project, Columbia Project, and Charleston Project) have all yielded support for MST's effectiveness in reducing recidivism rates and are frequently cited within the juvenile justice literature.

Even though MST researchers have produced consistent results indicating that it is an effective model for treating chronic, violent, and drug-abusing adolescents and their families, only about 90 licensed MST programs exist across the United States (Multisystemic Therapy Services, 2002). Implementing an MST treatment program within an existing community agency presents a formidable challenge. More so than FFT, the implementation of MST requires radical shifts in service delivery systems (Leschied & Cunningham, 2001). According to Henggeler (1999), MST training costs range between $15,000 and $24,000 per team. These figures do not include travel expenses for trainers. MST training consists of an initial 5-day on-site orientation, 1.5-day quarterly booster trainings, and weekly telephone supervision from MST

training personnel (Henggeler, 1999). In addition to training costs, implementation costs for agencies using the MST approach can be quite extensive. Additional implementation costs associated with MST include budgeting for cell phone and pager costs as MST clinicians are on call 24 hours a day, 7 days a week; mileage expenses for clinicians because services are home based (12,000 miles per year per clinician) (Henggeler, 1999); and the addition of numerous clinicians as MST clinicians only carry caseloads of four to six client families at any given time.

Discussion and Conclusions

The United States Supreme Court made key rulings in the late 1980s—*Stanford v. Kentucky* (1989) and *Thompson v. Oklahoma* (1988)—that supported the constitutionality of the death penalty for youth 16 years of age and older. These rulings were likely influenced and buttressed by this rapidly progressing movement of public opinion toward more punitive sanctions for juvenile offenses, as evidenced by changing legislation in 47 states during the 1990s (Bilchik, 1999). However, the majority of states (21 of 38) still rejected the death penalty for juveniles younger than the age of 18 (Streib, 2005).

In contrast to its previous rulings regarding the constitutionality of the death penalty for juvenile offenders, in *Roper v. Simmons* (2005) the court held that the Eighth and Fourteenth Amendments forbid the execution of offenders who are younger than the age of 18 when their crimes are committed. In delivering the majority opinion, Justice Kennedy stated that since *Stanford v. Kentucky* (1989), a national consensus against the execution of juvenile offenders had formed and that this practice now violated society's evolving standards of decency. Justice Kennedy used as evidence for this new national consensus the Federal Death Penalty Act (1994), which stated that no one younger than the age of 18 may be sentenced to death. Justice Kennedy also cited the trend of state refusal to use capital punishment for juvenile offenders as evidence. Specifically, Justice Kennedy wrote regarding the use of capital punishment for juveniles, "A state cannot extinguish his life and his potential to attain a mature understanding of his own humanity" (543 U.S. at 573). He further wrote that "Retribution is not proportional if the law's most severe penalty is imposed on one whose culpability or blameworthiness is diminished, to a substantial degree, by reason of youth and immaturity" (543 U.S. at 571). Justice O'Connor however wrote a dissenting opinion arguing that "The difference in maturity between adults and juveniles was neither universal nor significant enough to justify a rule excluding juveniles from the death penalty" (543 U.S. at 601). Justice Scalia's dissent, which was joined by Justice Thomas and Chief Justice Rehnquist, argued that the court improperly substituted its own judgment for that of the people outlawing juvenile executions. Scalia stated, "Acknowledgment of foreign approval has no place in the legal opinion of this court," referring to the fact that the United States is the only country that has not ratified the international agreement of article 37(a) of the United Nations Convention on the Rights of the Child (543 U.S. at 628).

The decisions in *Stanford v. Kentucky* (1989) and *Roper v. Simmons* (2005) demonstrate the impact of public concern on juvenile justice practice in America. Even though shifting public opinion influenced the Supreme Court to rule against the execution of juvenile offenders, the issue of how juvenile offenders are to be treated is still a divisive issue.

Proponents of harsher sentencing laws have been successful in advancing their movement nationally in spite of a rather large body of evidence indicating that juveniles in adult facilities are at much greater risk of harm than youth housed in juvenile facilities and counter to the strong research supporting the effectiveness of systemic treatment models (Austin et al., 2000; Henggeler & Sheidow, 2003; Redding, 2000). Correctional administrators continue to be faced with the formidable challenge of protecting this growing number of juveniles housed in adult facilities. In addition to the likelihood of experiencing physical and psychological abuse, juveniles housed in adult correctional facilities are less likely to participate in rehabilitative programs than youth housed in juvenile facilities (Bishop & Frazier, 2000; Feld, 1984).

Even though the Supreme Court's ruling in *Roper v. Simmons* (2005) ended the practice of executing juvenile offenders, the trend toward more punitive sanctions for juvenile offenders is still influencing juvenile justice policy and practice. This is occurring despite the emergence of significant data that indicate that rehabilitative intervention models can greatly reduce recidivism rates for juvenile offenders, thus reducing juvenile crime and its associated costs. The people of the United States often demand quick responses to formidable problems, and public officials feel pressured to urgently respond to public safety issues. However, the vast majority of juvenile justice research indicates that juvenile delinquency is a complex and multifaceted problem that cannot be resolved by simplistic solutions that fail to address the multitude of individual, familial, and community risk factors associated with delinquent behavior in youth (Hinton et al., 2003).

Although it may be the case that early in our history juvenile justice researchers failed to use sound scientific practices to evaluate the success of their efforts, this is no longer true. There is strong research evidence that several rehabilitative models are effective for reducing juvenile crime. These models have been evaluated in numerous clinical trials and have used sound scientific methodology, providing a credible foundation for the successful treatment of juvenile offenders.

Juvenile justice professionals and policy makers must now decide the value of the application of these efforts to current juvenile justice practice. Will professionals choose to advocate for today's youth by promoting and implementing these effective rehabilitative models nationally, or will they continue to attempt to address juvenile crime by advocating for harsher sentencing practices based on the nature of the offense rather than the characteristics of the offender? Future research should examine how evidenced-based juvenile justice interventions (i.e., MST and FFT) have been successfully implemented within communities and barriers to implementation of these programs in additional communities. Studies of this nature will facilitate the integration of research into practice.

Although *Roper v. Simmons* (2005) has changed the fate of the 72 juvenile offenders currently on death row, it does not require that these juveniles be given appropriate, research-driven rehabilitative treatment while incarcerated. Perhaps in the future, juvenile justice professionals will collaborate with researchers and other stakeholders to provide treatment for juvenile offenders that goes beyond the removal of the death penalty.

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W. Jeff Hinton, PhD, is an assistant professor of family therapy and the director of the Marriage and Family Therapy Program at the University of Southern Mississippi. His research interests include juvenile justice treatment issues and the impact of family dynamics on delinquency in youth.

Patricia L. Sims, EdD, is a retired associate professor of family therapy. She previously served as the Marriage and Family Therapy Program director at the University of Southern Mississippi.

Mary Ann Adams, PhD, is an associate professor of family therapy at the University of Southern Mississippi in the College of Education and Psychology. She has worked extensively with gender-specific treatment for female juvenile offenders.

Charles West, PhD, is an assistant professor in the Department of Child and Family Studies at the University of Southern Mississippi. His research interests include justice issues related to children and families.