How transition between an age-differentiated mental health system creates strain and criminological risk: A scoping review

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Abstract

Youth with mental health problems face a multitude of problems and barriers when they
transition from a youth to an adult mental health system, including: displacement form treatment
or services, issues with health care coverage, trouble qualifying or accessing continued care upon
transition, and disengagement from mental health services altogether. However, how transition is
a strain itself, and how it impacts help-seeking and increases criminological risk has rarely been
conceptualized. A scoping review was conducted to collect and synthesize the effects of this
process. Seven articles were identified as relevant and the transition process was found to
produce strain and criminological risk through two key areas of the transition process:
administrative transitions and developmental transitions.

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Introduction

Making the transition from an adolescent to adult is filled with many developmental and personal challenges. For youth with mental health needs, extra challenges and risks are involved when making the transition from a youth to an adult mental health system, as few service systems address the challenges individuals living with mental illness may face throughout maturation in the "life course" (Sampson & Laub, 1992). The current available care and treatment services for people living with mental illness across the life course are often categorized and separated by life or developmental stages which assume that there is a distinct age in which certain services are required to begin and end. In fact, Elder in Sampson and Laub (1992) describe the navigation of the life course as "pathways through the age differentiated life span" (p. 65). In this sense, age differentiation refers to expectations of interpersonal behavior patterns, activities, attitudes, prohibitions, and obligations ascribed to age-based role differentiations (Eisenstadt, 1956) which "impinge on decision processes and the course of events that give shape to life stages, transitions, and turning points" (Elder in Sampson & Laub, 1992, p. 65). The administrative transition from a youth to adult mental health system— and concurrent developmental transition from youth to adult— can thus be conceptualized through this lens in order to understand how youth may encounter challenges leading to unmet mental health needs, and possible justice system involvement.

Elder in Sampson and Laub (1992) argues that "age-graded transitions are embedded in social institutions" (p. 66). This is congruent with how most health care systems— and specifically the mental health system— categorize everyone under the age of 18 as a child. The exact age of transition varies between the literature, with Cappelli et al. (2014) claiming the age of transition as from 14 through 25 years, while Davis & Sondheimer (2005) identify the age of

transition as being between 16 and 25 years, both being age ranges which fall directly in between child and adult-based services. Styron et al. (2006) assert that once an individual has "reached legal age, [they] are no longer mandated or committed to care" (p. 1100) which was once supported through the youth mental health system. Cappelli et al. (2014) argue that youth who require continued care in the adult mental health system are not well supported in preparation for the transition, and are, instead, thrust into the adult mental health system and expected to manage their own care and treatment within the community (Cappelli et al., 2014).

In an effort to distinguish how the transition between the age-differentiated youth and adult mental health systems is a strain in-and-of-itself resulting in emerging criminological risks and subsequent criminal justice involvement, a scoping review was conducted to extract and synthesize data from articles that studied the transition processes for youth with mental illness. The first section of this thesis reviews the literature pertaining to youth transitions and mental health needs. Then, the theoretical framework of this thesis--general strain theory--is discussed. Next, the scoping review methods and procedures used to synthesize research in this area are described. Finally, the results of the scoping review are explained, discussed, and interpreted.

Literature Review

Conceptualizing Transition

Seemingly straight-forward, 'transition' is a word often used to describe a process of change or maturation between one phase to another. Transition in the context of mental health care is defined by Coleman and Berenson (2004) as a process preparing an individual to leave one level of mental health care, which ends when the individual is received in the next care setting. However, Paul et al. (2013) states that this definition refers more closely to transfer than

transition. Under the scope of youth mental health care, Paul et al. (2013) defines transfer as an event between services characterized by the "termination of care by a children's healthcare provider and its re-establishment with an adult provider" (p. s36). This concept also aligns closely with the concept of administrative transition, which is characterized by an abrupt shift similar to a "transaction" (Paul et al., 2013, p. s36) from a youth-centered to adult-centered service system that occurs when a youth reaches the age of majority in the eyes of the law (Cappelli et al., 2014). Paul et al. (2013) asserts that, while the terms transfer and transition have long been conflated by scholars, they should be conceptualized separately.

Paul et al. (2013) furthers this distinction, describing the main difference between transfer and transition being that transition is a "process requiring therapeutic intent" (p. s36), or rather, requiring the intention to guide youth through the transition between mental health systems. Therapeutic intent may be expressed by a youth's preparation for transition, transition planning meetings, transfer of medical histories and case notes, and a period of joint care from both the youth and adult mental health systems (p. s36). If done correctly, it should result in "established engagement of the young person with adult services" (p. s36). However, it should be noted that despite there being therapeutic intent, it does not necessarily mean that transition was optimal. For this reason, Paul et al. (2013) sought to explore what characterizes optimal transition.

Conceptualizing Optimal Transition. Paul et al.'s (2013) conducted a retrospective case-note survey of youth soon reaching the age of majority in the youth mental health system to evaluate optimal transition. Paul et al. (2013) identified the four criteria which characterizes optimal transition for youth as: continuity of care, a period of joint care between youth and adult based services, minimum of one transition planning meeting, and information transfers including previous referrals, youth mental health system notes, and a current risk assessment. Co-

ordination and continuity of care throughout transition planning and management of mental

health services emerged as a key element in ensuring optimal transitions. As well, for transitions

to be successful, they must be considered optimal by all involved parties. However, the authors

found that less than 5% of those transferred to adult mental health services actually fulfilled all

four criteria for optimal transition (p. s39). Moreover, there was significant variance among the

distribution of participants throughout the criterion for "optimal transition" (p. s37),

demonstrating that a significant portion of youth transitioning between youth and adult mental

health services had a variety of mental health needs which were not addressed.

Unmet Needs of Transition

Although the "transition from youth to adulthood offers a unique opportunity to impact the

lifetime trajectory of mental illness" (Cappelli et al., 2014, p. 598), mental health services that

are designed for either youth and adults have been determined by many as being incapable of

addressing the variety of problems associated with transition-aged youth living with mental

illness (Cappelli et al., 2014; Davis, Peterson-Badali & Skilling, 2016; Liebenberg & Ungar,

2014; Maschi et al., 2008; McElvaney & Tatlow-Golden, 2016; O'Brien, Fahmy & Singh, 2009;

Peterson-Badali, Skilling & Haqanee, 2015; Steele & Dewa, 2007). Scholars commonly note that

current services and programs are inappropriate for meeting the needs of youth in transition to

adulthood, and that adolescents, parents, and professionals feel unprepared when youth are

transferred to the adult mental health system (Cappelli et al., 2014; Davis, 2003; McElvaney &

Tatlow-Golden, 2016; Paul et al., 2015; Peterson-Badali & Skilling, 2016; Riosa, Preyde &

Porto, 2015; Zajac, Sheidow & Davis, 2015). The inability to accommodate or appropriately

address youth's mental health problems can often leave youth without mental health care when

they or their current service providers share a perceived need for treatment, leading to what is

known as unmet mental health needs.

Much of the literature regarding youth mental health needs throughout transitions argues that youth are often "fraught with obstacles" (Maschi et al., 2008, p. 1377; Embrett et al., 2016; Kim, Munson, & McKay, 2012) which affect "successful service engagement" (Davis in Kim, Munson, & McKay, 2012, p. 242). As previously noted, this is because the separation of youth and adult mental health services can result in a disconnect from the service environment, or limited and restricted opportunities to access necessary services upon transition. This suggests that the transition itself poses a unique set of challenges and needs for youth, potentially leading to a range of unmet needs, or leading to youth not wanting or unable to seek help for their mental illness. If mental health needs go unaddressed, this could in turn create increased criminological risks which could draw youth into the justice system. Unmet mental health needs could manifest based on a number of factors such as forensic or clinical histories, which may not be prioritized as the same risk they once posed under the scope of youth mental health services (O'Brien, Fahmy, & Singh, 2009). Additionally, inadequate screening processes which do not fully assess for risks or need (Rogers et al., 2001), rigid referrals, and differences in eligibility for services and treatment programs (Davis & Sondheimer, 2005, Jack & Ogloff, 1997) could also be factors which influence an individual's ability to engage, or remain engaged, with treatment or services, affecting the overall transition from a youth to an adult system.

Embrett et al. (2016) identifies that other issues affecting the overall transition between youth and adult mental health services— which can be understood as possibly having an effect on youth's mental health needs— are the logistics associated with costs and communication, and experience between mental health systems. These logistical issues can result in limited understandings of the purpose and operation of transition itself, as well as the expectations both

youth and clinicians have about these transitions (p. 265). Additionally, they highlight the

cultural and clinical governance barriers, identifying that the youth and adult mental health

system is segregated in "the beliefs, approaches, attitudes, and language toward treating people

with mental illnesses" (McLaren in Embrett et al., 2016, p. 265). McLaren in Embrett et al.

(2016) characterizes the youth mental health system as providing a "proactive, family-oriented,

inclusive, and holistic approach to treatment" (p. 265), whereas the adult mental health system

has been described as "focusing exclusively on the individual and intervening with medication or

crisis management" (p. 265). Subsequently, this shift in service delivery philosophies may be

viewed as intimidating for someone unfamiliar with adult services, and could unintentionally

isolate youth who are still trying to understand how to assume the adult-based roles that

accompany coming of age.

As previously suggested, after reaching a certain age, youth are considered to be too old for

certain mental health services, and undergo an administrative transition process by being phased

into the adult mental health system (Cappelli et al., 2014). However, such a system fails to

recognize the fluidity of lifespan development, making the assumption that there are only two

developmental stages that require mental health services, and that these stages are governed by

age rather than developmental/ emotional maturity and readiness. In fact, the transition process at

a systems level is viewed by some scholars solely as an administrative event guided by legalities

regarding the eligibility and provision of services, which may lead to disengagement or

displacement from mental health services—a process also known as "aging out" (Cappelli et al.,

2014, p. 598). Aging out of youth-centered services can often leave youth in the care of adult

services which do not completely satisfy the administrative transition requirements, or meet the

youth's developmental mental health needs. The previously described unmet needs often operate

concurrently within the mental health system, unintentionally segregating, isolating and discriminating against people. Subsequently, this disengagement, discontinuity of services, and dissolution of a cohesive system of support could leave youth in a position where their goals and aspirations are also inhibited from the declining state of their mental health. Youth's inability to access adult-based services in an appropriate amount of time could also ultimately impact possible justice system involvement and future help-seeking behaviours.

Issues Affecting Help-seeking

Youth are in an extremely vulnerable position when transitioning to the adult mental health system, as their navigation of the administrative process is not easy and their developmental transitions are ongoing (Kim, Munson & McKay, 2012, p. 242). Developmentally, youth may be unable to satisfy the expectations of being an adult, or as is stated by Cappelli et al. (2014) they may not have the "emotional, physiological, psychosocial and personal growth efforts to assume adult-based competencies" (p. 598). When making this transition to the adult mental health system, a number of barriers and variables affect the help-seeking behavior of youth. Help-seeking in terms of youth mental health can be understood as an individual's attempt to find help to improve their overall mental health and well-being. This is distinguished from engagement or continuity, which is the established and active usage of mental health services over an extended period of time. Some variables identified in the literature as affecting help seeking are sociodemographic factors, stigma, fear and mistrust, as well as the administrative issues mentioned above.

Sociodemographic factors. Sociodemographic factors that exacerbate marginalization of youth, such as gender, minority status, socioeconomic status, and age, also affect youth's willingness to seek mental health services during the transition to adult-based mental health

services (Espinosa, Sorensen & Lopez, 2013; Jack & Ogloff, 1997; Kaushik et al., 2016;

O'Biren, Fahmy & Singh, 2009; Steele & Dewa, 2007). Although gender has not been shown to

consistently be a factor related to help-seeking engagement, males are statistically far less likely

than females to attend or remain engaged with services (O'Brien, Fahmy, & Singh, 2009,

Espinosa, Sorensen & Lopez, 2013). This finding was especially relevant if they were young

males from a visible minority (O'Brien, Fahmy, & Singh, 2009), as overall, ethnic minorities

were found to be more likely to discontinue services because there was "a spiral of worsening

engagement and mistrust" (p. 561). The lack of help-seeking initiated by minority youth can thus

be understood through what O'Brien, Fahmy, and Singh (2009) identify as "coercive hospital

treatment" (p. 561) and often times an overrepresentation in forensic services. Although not

addressed in the research, coercive treatment and overrepresentation may not be an ethnically-

limited phenomenon, and may also be consistent with certain socioeconomic factors.

     Socioeconomic factors which could impact help-seeking and "may reflect a more general

alienation from society as well as services" (p. 562) include poor social networks, education,

unemployment, marital status, and homelessness. For transitioning youth with mental health

issues, factors such as social connections may be limited, and they may experience challenges

with education because of symptoms which prevent them from learning at a regular pace, or their

diagnosis may prevent them from obtaining consistent employment and earning a means to

attend treatment. Another factor found to impact help-seeking was age, as young people are

statistically more likely to miss appointments and drop out of services altogether (O'Brian,

Fahmy, & Singh, 2009).

     Stigma. Mental illness is surrounded by a lot of stigma which, as a developing young

adult, may be difficult to come to understand and cope with. Perceptions of mental illness are

often intertwined with stereotypes that that people with mental illnesses are violent, dangerous, or criminal. Stigma can manifest in a variety of forms, from social, institutional or structural, to internalized or self-relevant stigma through the demoralizing, stigmatizing and disempowering effects of self-labeling (Livingston & Boyd, 2010; Corrigan & Shapiro, 2010; Moses, 2009). Stigma, and specifically how it is internalized within the individual, referred to as self-stigma (Livingston & Boyd, 2010; Corrigan, Kerr, & Knudsen, 2005; Corrigan & Shapiro, 2010; Moses, 2009), can play a key role in one's ability to access or seek treatment. Elkington et al. (2012) identifies stigma is a significant barrier to seeking mental health treatment. When factors such as one's self esteem and self-efficacy, feelings of empowerment or social support, and overall quality of life and hope are compromised, young people may feel ostracized or excluded from mainstream society. Livingston and Boyd (2010) highlight how this could in turn make people afraid of or unable to effectively pursue or manage their mental health care needs. This could prove especially relevant in terms of youth, who may doubt the usefulness of professional help and want to distance themselves from the negative stereotypes attached to mental illness (O'Brien, Fahmy & Singh, 2009).

Fear and Mistrust. Munson et al. (2011) identifies how many youths admitted that they experienced fear and mistrust with mental health services. Fear, as Munson et al. (2011) highlights, played a dual relationship in the lives of the participants. For some, it acted as both a motivating facilitator to seek care, while, for others, it served as a barrier to help-seeking and engagement in mental health services (p. 2265). Meanwhile, mistrust went hand in hand with fear, as many individuals expressed their unwillingness to engage in services when they were forced to change providers or case workers, which ultimately led to their disengagement from services altogether. Feelings of fear and mistrust in mental health services and providers are

common for many people with mental illness, however, as youth transitioning to adult mental health services, this experience is often "exacerbated by their daily experiences in broader cultural contexts" (Whaley in Munson et al., 2011, p. 2265).

Keeping the difficult circumstances, the tumultuous time of adolescence, and the stringent age-graded transitions between youth and adult in mind, it is easy to see how challenges with meeting the expectations of mental health needs and seeking help throughout the transition may be affected. Any disconnect in the provision of services— at a time where youth are trying to figure out who they are and where they belong— may result in disengagement of services due to unmet needs, issues in accessing the limited services available, and confusion over identity and belonging. Additionally, as Agnew's (1985, p. 151) general strain theory helps us to understand, this disconnect from systems of support and treatment throughout the transition from youth to adult can contribute to feelings of resentment and anger towards a failing system and unachieved mental health and personal goals, which may in turn result in "aggression, crime and other deviant behaviours" (Agnew in Froggio, p. 388) as a response to this failure, or in an attempt to get help or cope with their circumstances.

Theoretical Perspective

Origins of Strain Theory

Durkheim, in Hagan (2013), argued that crime and deviance is a normal phenomenon which assists groups of people in defining their moral boundaries. Feelings of anomie— or normlessness— may emerge from the failure of an individual to adapt to or internalize the norms of society into their identity and daily life, which may in turn lead to criminal acts. Merton (in Hagan, 2013) expands on the Theory of Anomie, conceptualizing anomie as a "condition that

occurs when discrepancies exist between societal goals" (Merton in Hagan, 2013, p. 159) and the means available to achieve them. These discrepancies between goals and achievement used to conceptualize structural and psychological explanations for crime, subsequently created conflict with societal norms, resulted in Merton's (in Hagan, 2013) ideas being referred to as strain theory. Common assumptions posit larger strains between aspirations and expectations create the greatest likelihood for offending, however it was found that this was not the case (Hagan, 2013, p. 161). Classical strain theory makes a good effort at trying to explain the emergence of crime and deviance, but it primarily explains "monetary or materialistically oriented crime" (p. 161), and neglects other types of crime and possible origins.

General Strain Theory

In an effort to create a more diverse and generalized theory of strain, Agnew conceptualizes strain as due to negative relationships "in which others are not treating the individual as he or she would like to be treated" (Agnew in Agnew, 2001, p. 319; Agnew in Hagan, 2013). These negative relationships may take on a variety of forms such as the loss of something valuable in one's life, unfavourable life events or conditions, the failure to achieve desired goals, or the negative treatment of others towards the individual (Agnew, 2006, p. 4; Agnew in Hagan, 2013, p. 161). These ideas improved upon Merton's work and eventually became known as general strain theory.

General strain theory (GST) posits that strains increase the possibility of negative emotions such as frustration, anger, depression, and hopelessness (Agnew, 2006, p. 13, Agnew in Agnew, 2001) "creat[ing] pressure for corrective action, [with] crime is one possible response" (Agnew in Agnew, 2001, p. 319). Agnew (2001) provides a comprehensive look at the different type of strains which can impact deviance and criminal behavior. To deconstruct the meaning of

strain, Agnew (2001) provides an overview of the different types of strains, including objective

and subjective strains. Objective strains are defined by Agnew (2001) as "events or conditions

that are disliked by most members of a given group" (p. 320), whereas subjective strains refer to

"events or conditions that are disliked by the people who are experiencing (or have experienced)

them" (p. 321). Due to this type of strain being open for interpretation, one must consider the

severity, duration and frequency of the strain (Agnew, 2011, pp. 333-334), as well as centrality

of the strain (p. 334).

Agnew (2001) asserts that most strains are unlikely to lead to crime, but it can under

certain conditions, such as if the strain is seen as unjust, viewed as high in magnitude or

significance, associated with low social control or autonomy, and creates some pressure or

incentive for criminal coping (p. 343). In the context of youth transitioning between mental

health systems, some of the strains which are likely to be strongly related to crime could include

the failure to achieve core goals (p. 343), adverse negative experiences (p. 344), criminal

victimization, or experiences with prejudice (p. 346). Conceptualizing the transition process as a

strain in-and-of-itself , which encompasses the strains identified by Agnew (2001), will allow us

to further understand how unmet mental health needs and help-seeking behaviours manifest and

may be impacted. This allows for a dynamic understanding how these forces impact justice

system involvement.

Transition as Strain

Although Agnew (2001) highlights some important factors pertaining to youth which

may create strain and involvement in crime, he and other scholars have yet to conceptualize and

define the dual relationship the strain of transition plays in the lives of youth living with mental

illness. In this context, transition as strain can, therefore, come to be understood as the

simultaneous administrative and developmental transition between mental health services and youth and adulthood, which creates stressful conditions and experiences, exposing youth to the possibility of criminal justice involvement. This process will be conceptualized in detail below.

There is a disconnect and lack of public education on the signs of a mental health crisis or episodes of psychosis. These common misconceptions and stigmas feed stereotypes of people with mental illness as being inherently dangerous or criminal. In the absence of an appropriate response team for mentally ill behavior, the criminal justice system has often taken responsibility as the means of first response for this population. Some argue "the current policies and practices in the juvenile justice system are not well suited to meet the multiple needs of these youth and, at times, can exacerbate existing problems" (Zajac, Sheidow & Davis, 2015, p. 146; Maschi et al., 2008). Nonetheless, individuals having a mental health crisis, experiencing delusions, or episodes of psychosis fall under the jurisdiction of law enforcement. As such, people living with mental illness have become increasingly stigmatized and associated with criminal activity and criminogenic behaviours. For this reason, many young people are unnecessarily and unwantedly drawn into the justice system for actions and behavior which does not conform to societal expectations, and for which they may not be able to appreciate.

As previously explored, people living with mental illness have a variety of mental health needs which are usually addressed through the provision of treatment and services. However, throughout the process of transitioning from youth to adult mental health services, youth are often disconnected from mental health services for a variety of reasons, in which they may never regain contact. During the transition from youth to adult mental health services, as the relationship with mental health services becomes strained and unmet mental health needs increase, youth may become increasingly vulnerable to justice system involvement. Disconnect

from services could ultimately lead to youth with mental illness unintentionally following a path of criminality because, without the proper care being delivered to them, they are incapable of recognizing their behaviours as criminal or socially unacceptable. Others may use criminal activity as a way of coping with the strains imposed by the transition process as a way to "regain what one has lost or been prevented from obtaining" (Hagan, 2013, p. 162). Likewise, youth with mental illness may become involved with the juvenile or criminal justice systems intentionally as an avenue to accessing faster, more reliable, and often more mandatory or compulsory treatment services they would not have access to otherwise (Representative for Children and Youth, 2016).

The rising numbers of youth with mental health problems involved with the justice system indicates the desperate need for mental health system reform, and, more importantly, the development of more diverse, accessible, and consistent system services for those in transition from a youth to adult. It also indicates that a relationship between strain and transition exist, which helps to support the foundation of the research question.

Research Question

Although the current literature provides some insight on what risk factors youth face in the transition from youth to adult mental health services, a large majority of research fails to formally recognize how the administrative and developmental transitions could potentially create risk factors which could place strain on youth and create an increased risk for criminal justice system involvement. I aim to address this knowledge gap by applying a theoretical lens of general strain theory and reviewing available literature to answer the following research question: How have youth-to-adult mental health system transitions been framed as strains or risks for criminal justice involvement for youth with mental health needs?

Methods

Given there is not currently a synthesis of information regarding how the transition from a youth-to-adult mental health system is a strain for youth with mental health needs which can perpetuate risks for criminal justice involvement, a scoping review of available literature seemed to be an appropriate addition to the field. Arskey and O'Malley (2005) outline steps involved in a scoping review which are: (a) identify research questions, (b) find relevant studies through researching, (c) select relevant studies, (d) chart the data, (e) collate and summarize the results, and optionally, (f) consult key players within relevant fields (clinicians, patients, policy makers, etc.) for more insight on what the literature may fail to highlight, and new references (pp. 8-9). A scoping review by nature, does not aim to make clear conclusions, but rather, it highlights the current available literature as well as knowledge gaps that could be addressed in future research. Although these steps are in place, Arksey and O'Malley (2005) emphasize that a scoping review involves a flexible, non-linear process allowing for constant reinterpretations, new findings, and new insights.

Search Strategy

Due to time limitations of this research project, and for ease of navigating a large amount of literature, four databases were selected. The databases included PubMed, Sociological Abstracts, WebofScience, and JSTOR which were used between September 2016 and February 2017. The search strategy involved a multi-step process of developing search terms and reworking them to yield better results. The search terms spanned three categories of information: population, event, and outcome variable. The terms used to distinguish the population were: (youth OR adolescent OR emerging adult). These search terms yielded many results, so further adjustment to the search terms was applied to distinguish what population of people I was

looking for, including: (child and adolescent mental health system OR youth mental health system). The event search term used was (AND transition OR system transition OR transition strain). Additionally, other terms used to search the outcome was (AND criminal justice system involvement OR criminal risk OR justice system involvement). No publication date restraints were used. After relevant articles were identified, a review of their reference lists was conducted to identify other relevant articles.

The screening process of articles involved the use of two forms of software. An Excel spreadsheet was created to keep track of the number of hits per database for the different combinations of search terms used. Additionally, the online program Refworks was used to manage and remove duplicate articles. After the initial search was completed and potential records were identified through a quick title review, irrelevant records were excluded from further analysis. A loose title/abstract screening on the remaining articles was conducted and any remaining duplicate articles were excluded from consideration. At this point, a strict title/abstract screening was conducted to see if the information available met the inclusion criteria. Records were excluded if the inclusion criteria did not appropriately apply to them. The last stages of the screening process involved a loose text screening, followed by an in-depth text screening. References lists of remaining articles were then hand searched to identify any other applicable literature.

Inclusion criteria

Studies were considered if they addressed at least two of the following areas: (a) involved youth with mental illness, (b) involved the transition from a youth mental health system to an adult mental health system, or (c) addressed involvement in the criminal or juvenile justice system or criminological risks. Both qualitative and quantitative studies were eligible for

inclusion. Only studies that were published in English were eligible.

      Data extraction and analysis

      Following determination of inclusion, data was extracted from each article and managed using Microsoft Word to generate a source grid table. Information that was extracted included: citation, location, institutional setting, sample size, research objective, methods, as well as findings and important contextual information.

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Results

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      The database and reference list searching produced 71,374 records. Removing duplicates and screening the abstracts and titles for eligibility reduced the records to 123 articles (Figure 1). After reading the full text articles and hand searching reference lists, seven articles were included in the scoping review. Of the included articles, none of the studies directly conceptualized the transition process itself as a strain which increased the likelihood of criminal justice system involvement.

Setting and study methodology

      Of the seven identified studies, five were conducted in the United States (Davis, Banks, Fisher, & Grudzinskas, 2004; Davis, Banks, Fisher, Gershenson & Gruzinskas, 2007; Munson et al., 2011; Pullman, 2010; Styron et al., 2006), one in the United Kingdom (Paul, Street, Wheeler, & Singh, 2015), and one in Canada (Cappelli et al., 2014). All seven of the articles addressed persons of mental illness who were currently or previously involved in the transitions between youth-to-adult mental health systems. In total, data was extracted about 1,970 individuals. Four studies used quantitative methods, two used qualitative methods, and one used a mixed method design. All of the quantitative articles used a longitudinal design. One article used a longitudinal

design that involved data collection at three points: referral to the Youth Transition Project,

intake with the transitions coordinator, and transition to adult mental health services (Cappelli et

al., 2014) to determine the effectiveness of a treatment program aimed at facilitating service

involvement for youth in transition between service systems.

The second of the quantitative articles used a longitudinal study that used statewide

administrative databases such as the Massachusetts Department of Mental Health (DMH) and

Criminal Offender Record Information (CORI) to examine involvement in the justice system of

individuals between ages 7 and 24 who were users of public mental health services for

adolescents (Davis, Banks, Fisher, Gershenson & Grudzinskas, 2007). The third expanded on the

previous study to examine the relationship of mental health services and receipt of those services

throughout the transition to adulthood (Pullman, 2010). The fourth article looked at clinical

records and criminal justice histories using a developmental trajectory method to examine the

patterns of criminal justice involvement for people who received public mental health services

between ages 8 and 25 years (Davis, Banks, Fisher & Grudzinskas, 2004). The last quantitative

study used a longitudinal design in six National Health Service (NHS) organizations across

Greater London ($n = 3$) and West Midlands ($n = 3$) with a series of case-note surveys (Paul et al.,

2013).

Of the qualitative studies, one used in-depth interviews and a multi-phase analysis to

explore the experiences of former mental health service users ($n = 60$) which included constant

comparison, concept matrices, crystallization and immersion techniques (Munson, et al., 2011).

The second qualitative study used a systematic review ($n = 19$) to conceptualize the effectiveness

of different models of care for those in transition from CAMHS to AMHS through service user

and staff perspectives. The mixed method study combined structured face-to-face interviews

with participants and face-to-face qualitative interviews with a subset of participants, a survey of

clinicians, and chart reviews (Styron et al. 2006).

Quantitative Results

Mentioned above, Cappelli et al. (2014) conducted a longitudinal study throughout referral

to the Youth Transition Project (YTP) which was designed to "assist youth with mental health

issues as they transitioned" (p. 606) from a youth to adult mental health system. The study

sought to measure whether the YTP was effective in maintaining continued care for youth in

transition between the youth and adult mental health system. Cappelli et al. (2014) identify

successfully transitioned youth as those who "continued services and completed engagement" (p.

606) to adult mental health services. They found that over an 18-month period, of the 215 youth

who met with a transitions coordinator, close to 60% ($n = 127$) had completed their transition

and were being seen by an adult mental health service provider. Nearly 20% ($n = 41$) had yet to

make the transition and remained on a waitlist for adult mental health services, while 22% ($n = 47$) had cancelled services by either moving away, not returning phone calls, or declining further

services. Furthermore, 7% (n=16) of youth cancelled services after meeting with a transition

coordinator, and nearly 15% ($n = 31$) of youth cancelled after being referred to adult mental

health services. Cappelli et al. (2014) found that the average length of transition was around 110

days (p. 602). At the point of intake with the transitions coordinator, two self-report

questionnaires (GAIN-SS, OCAN-Self) were completed by youth. The scores from these self-

report measures revealed that there were a variety of unmet needs of youth, including nearly 40%

who experienced internalizing disorders ($n = 55$), 27% ($n = 23$) with psychological distress, and

nearly 30% ($n = 39$) involved at some degree with crime or violence. These unmet needs were

coupled with other unmet needs including unhappiness with social life, drug abuse and substance

disorders, self-harm, and issues navigating every-day life activities and finances (p. 605).

In addition, Cappelli et al. (2014) found that youth who cancelled services were significantly more likely to score higher in attributes of antisocial behaviour and anxiety disorders. Those who had transitioned were more likely to have more unmet health needs in relation to psychological distress. Cappelli et al. (2014) highlights some important unmet needs, however, they fail to define what those needs specifically entail, such as what types of crime or violence an individual is experiencing. Although Cappelli et al. (2014) did not address transition as a strain outright, early on they addressed how a significant barrier to successful transition from youth mental health to adult mental health services is the "mismatch between institutional transitions at the systems level to developmental transitions at the individual level" (p. 598) and how this can lead to mental health professionals struggling to provide or find appropriate adult services for youth.

Davis, Banks, Fisher and Grudzinskas (2004) examined the criminal justice histories and clinical records of 131 people ages 8 through 25 receiving public mental health services to identify the proportion of mental health service users with criminal justice histories. They also sought to identify patterns and risk factors for individuals emerging into adulthood involved in the mental health system. The authors found that 64% ($n = 84$) of participants had juvenile or adult court records. Charges included property charges, public nuisance, and numerous other offences. One participant had 195 changes, and was later eliminated from the study on account of being an extreme outlier. Out of the remaining 83 subjects, 67% (43% of all subjects) had been charged with serious person offences— the most common of all charges (23%) — and 67% had been charged with serious property offences, found to be an "adolescent-limited phenomenon" (p. 362). Three offending trajectory groups emerged from the results. Fifty nine

percent were categorized as the trajectory of a low serious person offence, peaking at 18 years old and declining to age 25 (p. 358). Meanwhile, 25% of subjects displayed a rising trajectory pattern of serious person charges at a persistent and intermediate frequency— accounting for 44% of all serious person charges— up until age 18 and then declining slightly through age 25. The smallest trajectory (16%) accounted for 38% of all serious person charges, where charges of individuals rose rapidly to a high rate at 18 years old, slowly decreasing age 23 and then increasing sharply yet again.

They characterize that the current sample's patterns of offending in the high and intermediate groups fit the early onset or life course persistent offending profile (p. 360), and that individuals within these categories represent a significant portion of the population. However, Davis, Banks, Fisher and Grudzinskas (2004) highlight how it is difficult to determine if this rate— 19% of the entire sample, 30% of those with criminal charges— remains higher in the general population or just this sample specifically. They conclude that, while the majority of youth offending declines, upon emerging into adulthood, "violence continues to serve a purpose well after adolescence" (p. 362). The purpose of violence and crime was not clearly identified by the researchers; however, this increase in offending at a time of transition between mental health services indirectly supports the notion that the disconnect between youth and adult mental health services creates a strain on youth, specifically regarding diagnoses and eligibility criteria for continuity of services into adulthood.

Using the Massachusetts Department of Mental Health (DMH) database and Criminal Offender Record Information (CORI) for criminal and juvenile courts, Davis, Banks, Fisher, Gershenson, and Grudzinskas (2007) conducted a longitudinal study of 1,519 adolescent public mental health service users between ages 7 and 24 years who were born between 1976 and 1979.

The study sought to gain insight on the effects of gender and age on the risk of arrest throughout adolescence and young adulthood to inform policy and practice about when to intervene with this adolescent population to minimize offending. The sample was 51% male ($n = 781$) and 49% female ($n = 738$), and 74% white ($n = 1,111$). They found that, of the 1,519 participants, 58% ($n = 870$) had at least one arrest by the age of 25. The arrest rate was 37% higher among males (69%, $n = 533$) than females (46%, $n = 337$). Males were typically younger than females at the age of first arrest, with the peak ages of arrest between 18 and 19 years for males and between 19 and 21 years for females. The authors state that the peak age for justice system involvement (16 to 22 years) aligns with the ages at which youth are transitioning from child to adult based mental health systems and adolescence to adulthood (p. 1458). A limitation of the study was that they were unable to determine which system youth became involved with first, or what pathways were followed between the justice and mental health systems. They conclude that, although it is important to consider gender when addressing justice system involvement, especially among those with mental illness, both genders share risk factors equally as they pertain to potential criminal justice system involvement.

A longitudinal study by Pullman (2010) expanded on the previous study by Davis et al. (2007) to examine the relationship between receiving mental health services during transition to adulthood and the risk of criminal charges. The study found that the risk for being charged with a criminal offence was not affected by whether youth received mental health care out-of-home, in inpatient care facilities, or within the general mental health population. While inpatient hospitalization was significantly related to decreased odds of being charged specifically for drug crimes among females, it increased the likelihood of all charges among males. Pullman (2010) highlights how this study supports previous findings that cross-collaboration is needed between

child and adult services throughout the transition to adulthood, and that "collaboration should not end at adulthood; rather, an increased emphasis needs to be placed upon collaboration through the years of late adolescence and into early adulthood" (Pullman, 2010, p. 490) across systems and services. Overall, Pullman (2010) found that youth using mental health services are at an increasingly high risk for justice system involvement when transitioning to adulthood, specifically for males with compulsory disorders or substance abuse disorders. Pullman (2010) concludes that youth with compulsive disorders and substance use disorders should be given increased attention and care when transitioning into adult care, because "families may need support and preparation appropriate to the potential for later criminal involvement" (p. 490).

Qualitative Results

Paul et al. (2015) conducted a systematic review of 19 studies which drew from service user and staff perspectives and focused on the effectiveness of various models of transitional care between youth and adult mental health services, and the barriers and facilitators of effective transition between these system services. They found there is limited or inadequate research that evaluates the effectiveness of different models of transitional mental health care for youth. Some of the transitional care models identified in the study include: transition programme models, protocol and reciprocal agreement approaches. Paul et al. (2015) identify that there is limited research available on the shared management framework intervention model (p. 449). Though there is a lack of research available regarding the effectiveness of different transitional care models, the findings across the 19 included studies emphasize "significant gaps in the provision of transitional care in the area of mental health (p. 449). Overall, these gaps included reduced transfer rates between youth mental health services and adult mental health services due to gaps in the provision of services for those with emotional/neurotic conditions. Additionally, there is

an overall lack of services that are "acceptable, age-appropriate and responsive" (Paul et al.,

2015, p. 449) for those transitioning between youth and adult mental health services. Paul et al.

(2015) assert that transitional care is not only complex in nature, but "sparse and patchy" (p.

449), with limited if any community-oriented, wrap-around, or holistic approaches to transitional

care.

Paul et al. (2015) argue that there is a lack of prioritization of transition-aged youth, and

much of this stems from the impediments of the segregated and age-differentiated child and adult

mental health systems Many staff highlighted the overall lack of communication and

understanding between youth and adult mental health services and providers. This lack of

communication leads to role confusion with mental health professionals not knowing their own,

and their system's, roles and responsibilities. Moreover, training gaps led to difficulties in

identifying or referring those in need of mental health services. As well, these gaps can lead to

difficulties in appropriately engaging youth in treatment services, especially when the differing

treatment philosophies in youth mental health services do match with a youth's treatment needs,

and are incompatible with the treatment philosophies of adult mental health services.

Munson et al. (2011) explore the experiences of former service users ($n = 60$) aged 18 to 25

who were previously involved with child and adolescent mental health services. Through their

interviews, different service use experiences emerged, including: continuity of services into

adulthood, one or more interruptions in services during the years of transition, and discontinuity

of services altogether (Munson et al., 2011, p. 2263). At the time of the interview, approximately

59% ($n = 35$) of participants were categorized as using services; however, three experiences of

service use emerged upon closer examination; including 15% of which were interrupted

(multiple gaps; $n = 9$), 22% interrupted (one major gap; $n = 13$), and 22% had continuous use (n

= 13). Meanwhile, 42% (*n* = 25) of participants were categorized as service "discontinuers" (p.

2263). Common reasons for discontinuity of services were the lack of financial supports and

insurance to continue with care, discontent with medication side effects, and perceived

ineffectiveness of services or lack of need for services. Munson et al. (2011) identify that many

youth actually reconnected with adult mental health services when in crises, such as: difficulties

in personal relationships, death of a family member, suicidality, homelessness, hospitalization, or

criminal involvement. Important facilitators for youth to reconnect or engage with adult services

included physicians (p. 2263), other professionals such as case workers or independent living

workers, and family (p. 2264).

Mixed Methods Results

Styron et al. (2006) conducted a cross-sectional study with randomly selected youth aged

18 and older (*n* = 60) who participated in Young Adult Services (YAS) offered in Connecticut to

help guide the development of supports and services for young adults with mental health issues

(p. 1089). The average age of participants was 20 years old, with 47 participants being male, and

13 being female. The Young Adult Services (YAS) program was developed out of the growing

need for at-risk youth to continue to receive mental health services upon aging out of child and

adolescent based mental health services. At-risk youth were conceptualized in this study as youth

living with "pervasive developmental disorders" (p. 1089) or who had a "history of psychosexual

behavior problems" (p. 1089). Data collection included face-to-face structured interviews, face-

to-face qualitative interviews with a sub-sample of participants, clinician surveys, and chart

reviews (p. 1091).

Styron et al. (2006) found that the YAS program was generally capable of meeting the

needs of its clients, and longer program tenure was associated with higher quality of life and

greater levels of satisfaction. The most notable finding was the significance of strengths- and

community-focused treatment to outcomes for success (p. 1100). Strengths-focused treatment

prioritized youth's cognitive strengths and assets, whereas community-focused treatment focused

on increasing community supports as a treatment goal. These components were significantly

associated with less loneliness, fewer problems and symptoms, higher functioning and greater

service satisfaction, and community-focused treatment planning was found to contribute to fewer

arrests (p. 1100). Styron et al. (2006) stated how aging out of child and adolescent based services

can create significant issues for youth, particularly those who demonstrate risk-related

behaviours which could endanger themselves or others. Furthermore, Styron et al. (2006) argued

that interest in pursuing treatment services was often outweighed and complicated by their need

for agency and independence as an emerging adult. They address this issue by arguing that

treatment efforts must be "balanced by an equal, if not even more prominent, focus on

addressing the basic needs and concerns these youth encounter in having to establish and

maintain community tenure as adults" (p. 1100). They conclude that other transition-based

programs for young adults would or be most effective if they integrated strengths and

community-based treatment components "as early on and continually as possible" (p. 1100) so

that young adults are adequately supported in the community.

Discussion

In studying the transition of youth with mental illness from youth-to-adult mental health

systems, it is worth noting that this scoping review located no articles that directly studied the

transition process as a strain or risk for criminal justice system involvement. However, most

researchers reached approximations of this study's research question by highlighting and

reinforcing the themes which were previously explored throughout a primary review of literature

in the subject area. Most research focused on the impact of the transition processes and the range

of important, and often detrimental, factors that can either facilitate or inhibit successful

transition, completely disconnect service-users altogether, and subsequently make youth

increasingly vulnerable to justice system involvement. For instance, Cappelli et al. (2014) and

Styron et al. (2006) highlight how aging out of services— and the possible implications of

disconnect with those services and unmet needs upon aging out—can create significant

criminological risks for young adults with mental illness because they may be at risk of

experiencing crime or violence, hurting themselves or others, or being unnecessarily arrested or

charged with a criminal offence due to unmet mental health needs.

    Similarly, Davis et al. (2007) and Pullman (2010) indicate that there is a significant risk of

juvenile and criminal justice involvement for youth throughout the transition to adulthood,

especially for young males. Cappelli et al. (2014) argues that there is "no formal model to

facilitate the transition" (p. 598) in place, which offers an explanation for the overwhelming lack

of services and care, as well as the potential for youth at this age to slip through service cracks

and possibly be taken up into another service environment, such as the justice system. However,

a direct relationship between criminal justice involvement and service deficiencies (e.g., lack of

services) in supporting the transition of youth between age-differentiated mental health systems

was absent from the literature, and should be explored more carefully.

    Davis, Banks, Fisher and Grudzinskas (2004) and Davis et al. (2007) identify patterns of

offending which peak during ages of transition, which suggests that strains experienced during

this time of an individual's life may alter their lifetime trajectory for mental health care and

increase the risk of criminal justice involvement. This is, perhaps, indicative of the indirect

relationship the transition process has with determining, not only the possibility for youth living

with mental illness becoming involved with the justice system, but any marginalized or minority group's potential to become involved in the justice system while trying to navigate society's complex social structures. Styron et al. (2006) found that utilizing a strengths and community oriented approach had lead to greater satisfaction, higher functioning, and fewer problems among youth with mental health issues. Furthermore, Styron et al. (2006) argued that youth in transition between child and adult mental health services would benefit significantly from a strengths and community focused approach treatment plan. Such an approach has the potential for decreasing the likelihood of arrest and other forms of justice system involvement.

One shortcoming of the included studies was the overall variance in language used. Different definitions of transition, and how it was conceptualized, along with the words used to describe this population of youth (e.g., youth, young adults, emerging adults, transition-aged youth, adolescents, juveniles) mostly varied between study locations (e.g., United States, United Kingdom, Canada). These variances indicated the need for a larger umbrella term— or perhaps a more specific term— which could be used to describe this population in an appropriate and consistent way. A second shortcoming of these studies was the variability between transition ages, with each study identifying different but overlapping transition ages, or not identifying or defining the transition age at all. The transition age was conceptualized differently again among different studies geographical setting. The last shortcoming of these studies includes the lack of qualitative research available on this population. From the qualitative research that was available, most "service-users" represented were actually parents of the youth undergoing treatment services and transitioning through mental health services. Youth themselves had little-to-no voice, if any, of the included studies, suggesting that this area of study would largely benefit from an in-depth qualitative study which would draw on transition-aged youth's perspectives

about the transition between a youth and adult mental health system.

Limitations

The limitations of this study are primarily due to not anticipating difficulty during

article relevance screening. Many of the articles did not adequately fit the inclusion criteria and

rarely met all three conditions for inclusion. Most articles either addressed criminal justice

involvement of mental health users as their primary focus, or not at all. Similarly, those that did

not focus at all on criminal justice system involvement focused solely on the transition to

adulthood or the transition through youth-to-adult mental health systems, and often narrowed

their focus to effectiveness of transitional care services or programs. Subsequently, the focus of

"transition" in much of the research was left open for interpretation by the reader or was

discussed through only one particular lens, and not conceptualized as both an administrative and

developmental process which may create strain. Similarly, few of the studies addressed how the

full transition process in-and-of-itself could contribute to justice system involvement. In

retrospect, having only a few of the studies address the transition between mental health systems

and services in both an administrative and development context identifies the dearth of research

on this subject.

It is also important to acknowledge the potential bias inherent to selecting strictly English

publications. By excluding non-English studies with non-Western perspectives, the current

understandings of transition between youth and adult mental health services/systems and

subsequent justice system involvement are replicated and reinforced. It is important to

acknowledge the drawbacks of this design choice, and the implications it has for transition-aged

youth with mental health issues across cultures.

Conclusion

The two perspectives underpinning the conceptualization of transition from a youth mental health system to an adult mental health system in this study were the simultaneous administrative transition between services that occurs at the same time youth are making a developmental transition into adulthood. The selected studies did not serve to answer the research questions specifically, and, as such, this review indicates the need for future and more in-depth research which focuses on the transition process as a strain in-and-of-itself through a lens which utilizes general strain theory. Additionally, future research is needed to examine how the transition between youth and adult mental health systems produces crime and justice system involvement among youth with mental health needs.

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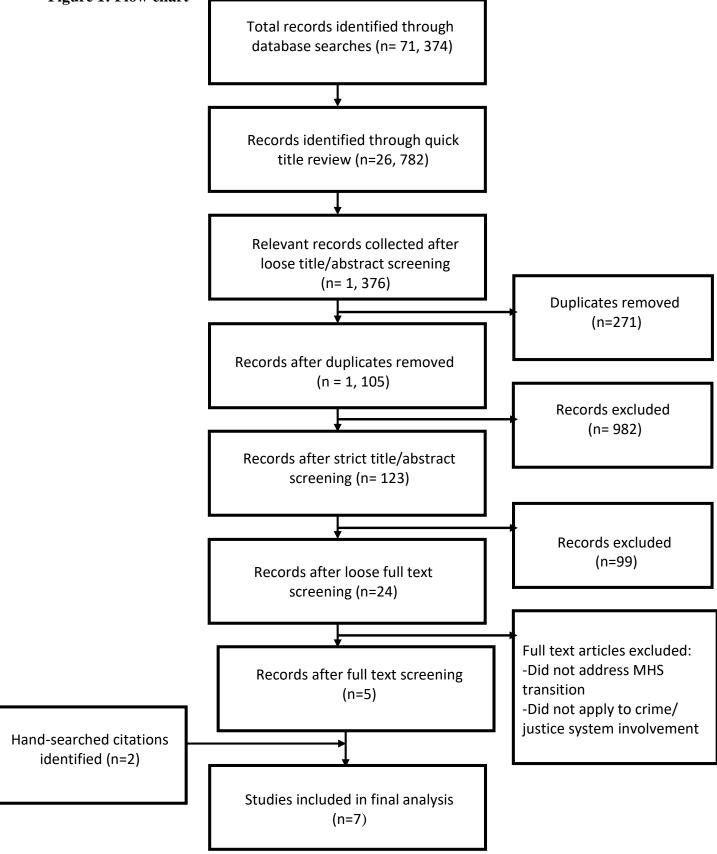
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Figure 1: Flow chart

Table 1: Study Characteristics

STUDY	DEMOGRAPHICS		RESEARCH OBJECTIVE	METHODS	
NAME	COUNTRY	POPULATION		SAMPLE SIZE (n=)	DESIGN
Cappelli et al. (2014)	Canada	Youth mental health services-adult mental health services	To determine whether continuity of care for youth transitioning from CAMHS to AMHS is possible through a shared management model (Youth Transition Project).	215	Quantitative, longitudinal
Davis et al. (2004)	United States of America	Mental health system service users	To examine clusters of criminal justice involvement patterns from ages 8 through 25, from database records in public adolescent mental health services.	131	Quantitative, longitudinal
Davis et al. (2007)	United States of America	Mental health system service users	To explore strategies for prevention of arrest as a major focus of adolescent mental health systems.	1,159	Quantitative, longitudinal,
Munson et al. (2011)	United States of America	Former mental health system users	To explore the mental health service use experiences among former mental health system youth and use of additional public systems of care.	60	Qualitative, in-depth interviews
Paul et al. (2015)	United Kingdom	Youth mental health system-adult mental health system	To review evidence on the effectiveness of different models of CAMHS–AMHS transitional care, including barriers and facilitators and service user and staff perspectives.	19 articles Users (n=191)	Systematic review

Pullman (2010)	United States of America	Mental health system service users	To examine the relationship between receipt of mental health services during the transition to adulthood and criminal charges over the same period of time.		Quantitative, longitudinal
Styron et al. (2006)	United States of America	Mental health system service users	To contribute to a growing literature that can be used to guide the development of specialized services and supports for young adults with psychiatric disabilities.	60	Mixed methods, cross sectional

Table 2: Findings from studies included for full review

STUDY	TRANSITION STRAIN	SUMMARY OF MAIN FINDINGS
Cappelli et al. (2014)	Youth reported more psychological distress and internalizing disorders when involved with the Youth Transition Project. May demonstrate greater need for immediate treatment, such as making frequent or recurring hospital visits.	Characterized successful transition in the Youth Transition Project as those who continued services and completed engagement to adult mental health services. Close to 60% of youth completed the transition and were seen by adult mental health service providers, with close to or just over 20% still on a waitlist for the adult mental health services or discontinuing their mental health services. "The shared management model, through its explicit focus on continuity of care, collaboration, and coordination, has the potential to reduce health care costs and improve patient outcomes" (p. 608).
Davis et al. (2004)	Transition support services scarce in the MH systems. Certain subgroups of offenders raise particular concern for CJ involvement, such as those in early adolescence.	Need for MH and CJ systems to collaborate to prevent and reduce offending during adolescence and the transition to adulthood. "The ages of the peak probability of being charged. 18 through 20 years of ag, coincide with the ages at which systems often identify youth as no longer "children"" (p. 364)
Davis et al. (2007)	There is significant risk of juvenile and criminal justice involvement for youth and males specifically throughout the transition to adulthood.	Arrest onset- 870 (58%) of the 1,519 participants had at least one arrest by age 25, this rate being significantly higher among males than females (69% n=533, 46% n=337) Arrest rate- Higher proportion of males than females (p<.001), with males' arrest rates peaking at age 18. 57% males (n=445) and 36% females (n=269) had first arrest under 18, with many being arrested multiple times (449 males, 58%, and 222 females, 30%) Risk of arrest- Highest risk of arrest was for males aged 14-22 whose previous arrest rates over the last year was around 50%.
Munson et al. (2011)	Many youths overwhelmed with navigating adult mental health services. A lot of effort goes into maintaining a connection with services, and much can go wrong, leading to discontinuity. High levels of mistrust throughout the transition to adult-based services, from day-to-day interactions and service utilization, to broader cultural contexts.	Physicians and parenting programs may prove beneficial to entry points for young adults in need of mental health services. Found significant levels of mistrust among the narratives, as well as the interesting relationship of emotions and service utilization.
Paul et al. (2015)	Transitional care was scarce, and "patchy", not considered a priority within mental health services.	Transitional care was scarce, and "patchy", not considered a priority within mental health services. Policy-practice gap must be addressed to ensure the development of accessible, acceptable, responsive, and age-appropriate provision of service needs.

Pullman (2010)	Youth within the mental health service population at high risk for justice system involvement during the transition to adulthood. Males with SUD and CD are at particular risk throughout the transition to adulthood.	High levels of dual involvement in the mental health and justice systems. Males are at a particular risk of involvement within the justice system if diagnosed with a substance use (SUD) or compulsive disorder (CD). Diagnoses with an SUD or CD was significantly related to increased risk for most charges across gender, and particularly drug-related charges. Out-of-home treatment has no significant risks which would increase the likelihood of justice system involvement.
Styron et al. (2006)	Youth who have undergone a program tailored specifically for their needs, especially in assisting with the transition to more independent living situations. Youth in qualitative interviews identified the transition to and through the YAS program was difficult, particularly in adjusting to living on their own. Dual and competing needs for structure and independence. (p 1099)	The YAS program had considerable success at meeting the needs of youth, including those transitioning to independent living situations. Strengths and community-focused treatment components are of significant importance, significantly correlated with less loneliness, fewer symptoms, fewer reported problems, higher functioning and greater satisfaction with services. Community-focused treatment planning contributed to fewer arrests among this sample of clients.