

Evidence-Based Practice Recommendations for Juvenile Drug Courts

by the National Center for Mental Health and Juvenile
Justice in collaboration with the Louisiana Supreme Court
Drug Court Office

ModelsforChange
Systems Reform in Juvenile Justice

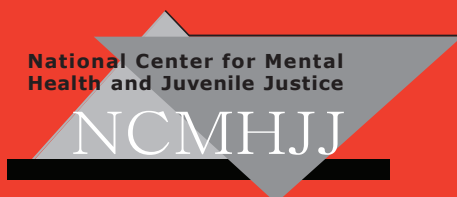
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Models for Change

Models for Change is an effort to create successful and replicable models of juvenile justice reform through targeted investments in key states, with core support from the John D. and Catherine T. MacArthur Foundation. Models for Change seeks to accelerate progress toward a more effective, fair, and developmentally sound juvenile justice system that holds young people accountable for their actions, provides for their rehabilitation, protects them from harm, increases their life chances, and manages the risk they pose to themselves and to the public. The initiative is underway in Illinois, Pennsylvania, Louisiana, and Washington, and through action networks focusing on key issues, in California, Colorado, Connecticut, Florida, Kansas, Maryland, Massachusetts, New Jersey, North Carolina, Ohio, Texas, and Wisconsin.

Evidence-Based Practice Recommendations for Juvenile Drug Courts

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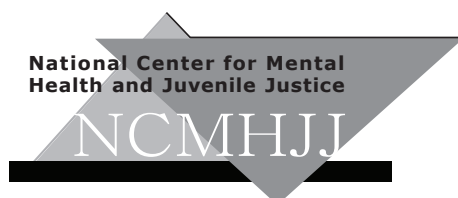
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Executive Summary

Overview of the Louisiana Models for Change Project

The Models for Change Initiative, supported by the John D. and Catherine T. MacArthur Foundation, represents a major effort at improving the nation's juvenile justice systems through targeted investments aimed at key areas in need of reform. The goal of Models for Change is to identify and accelerate promising statewide models for juvenile justice reform. In June 2005, Louisiana was selected as the third state to participate in Models for Change.

Louisiana selected "Evidence-Based Community Services" as one of its three Targeted Areas of Improvement (TAI). This TAI was selected in recognition of this new demand for community-based services as an opportunity to invest in more effective services in the community that reflect the current knowledge about what works for juvenile justice youth, particularly those with mental health problems. The goal of this TAI is to *increase the availability of community services that reflect current knowledge about what works for youths who come in contact with the juvenile justice system.*

The Supreme Court's Juvenile Drug Court Project

Part of the Models for Change effort in Louisiana has involved working with the Louisiana Supreme Court to enhance the state's Juvenile Drug Courts (JDC) by increasing the reliance on scientifically sound screening and assessment instruments and evidence-based or promising practices within the JDCs. Over the past two years, the Supreme Court Drug Court Office (SCDCO) has taken significant steps forward in pursuit of this goal. In particular, the SCDCO has:

- **Completed a survey** of the state's JDCs to identify critical issues related to screening, assessment, treatment, and outcome monitoring.
- **Convened a Juvenile Drug Court Summit** to share the results of the juvenile drug court survey, collect feedback about the survey results and needed directions, and share information about evidence-based practices with the courts.
- **Planned and conducted general and clinical trainings** for the state's juvenile drug courts on scientifically sound screening and assessment instruments and processes, and evidence-based practices (EBPs) and approaches.

In addition, the SCDCO, in conjunction with the National Center for Mental Health and Juvenile Justice, developed this set of **Evidence-Based Practice Recommendations for Juvenile Drug Courts**. These Recommendations are intended to be used as a starting point for juvenile drug courts looking to improve the screening and assessment, treatment, and outcome monitoring aspects of their courts, and to encourage continued movements towards EBPs within the state's juvenile drug courts. Juvenile drug courts are encouraged to use these recommendations to conduct a self-assessment of the assessment, treatment, and outcome monitoring aspects of their court, and to use the results of that assessment as a basis for identifying and implementing strategies to further strengthen their programs.

Overview of the Recommendations

This guide includes a series of recommendations in three areas—screening and assessment (Chapter 2), treatment (Chapter 3), and outcome monitoring (Chapter 4)—that highlight key components of a juvenile drug court that should be in place if the JDC wants to maximize the effectiveness of its programs. These

Recommendations emulate the assessment, treatment and program monitoring characteristics of a “model” juvenile drug court and reflect the goals of the Louisiana Supreme Court Drug Court Office that were developed as part of its Models for Change project.

The Recommendations are organized by Chapter. Within each chapter, an overview of the topical area is provided, followed by a series of recommendations related to that topical area. In order to facilitate self-assessment within the JDCs, and to ensure that this guide also provides guidance to the JDCs seeking to address need areas identified through this self-assessment, a detailed discussion of each recommendation is included, along with examples of strategies and approaches that could be considered. Given the treatment orientation of many of the recommendations, the courts may want to share this guide with their treatment team and consult with them in discussing the recommendations and examples.

A summary of the Recommendations is provided below.

Chapter 2: Screening and Assessment Recommendations

Recommendation #1: All screening and assessment tools used within a juvenile drug court should be standardized, scientifically sound, and appropriate for the population served.

- 1.1. Screening and assessment tools should be standardized.*
- 1.2. Selected tools should be supported by a body of research that demonstrates the reliability and validity of the tool.*
- 1.3. Screening and assessment instruments used within juvenile drug courts should be tested for use with the population served.*

- 1.4. Juvenile drug courts should also take into account other considerations when selecting a screening or assessment instrument.*

Recommendation #2: Clear decision rules and response policies should be in place as a part of any screening protocol.

- 2.1. Decision rule “triggers” should be established based on the guidelines or cut-off rules established by the instrument’s developer.*
- 2.2. Response policies should identify the appropriate response or responses that should be taken based on the results of the screening instrument.*
- 2.3. Staff administering screening instruments should be trained on the decision rules and response policies.*
- 2.4. A partnership with assessment service providers should be in place.*

Recommendation #3: A thorough assessment process should be completed for every youth accepted into the juvenile drug court to validate substance abuse or dependence diagnoses.

- 3.1. The assessment process should provide a full picture of youths’ substance use problems.*
- 3.2. The assessment process should incorporate structured assessment interviews.*
- 3.3. The assessment process should be comprehensive, and assess other domains besides substance use.*

Recommendation #4: Any screening and assessment process within juvenile drug courts should be designed to assess and address the presence of co-occurring mental health disorders.

Recommendation #5: Policies should be in place that clearly establish what information will be shared and how it will be communicated.

Chapter 3: Treatment Recommendations

Recommendation #1: Treatment offered by the juvenile drug court must be comprehensive.

Recommendation #2: Service plans must be well-coordinated and flow smoothly across “levels of care,” treatment providers and social service providers.

2.1. Treatment plans should be coordinated and overseen by a case manager.

2.2. Treatment plans should be coordinated across levels of care.

Recommendation #3: Programs should collaborate in and encourage the adoption of evidence-based practices.

Recommendation #4: Families’ needs must be addressed and they must be fully engaged partners.

4.1. Families and youth must be engaged in treatment.

4.2. Juvenile drug courts should provide support to families and make sure they are fully informed about the juvenile drug court process.

4.3. Services should be provided that address the family needs and issues identified during the assessment process.

Recommendation #5: Integrated treatment should be provided to youth with co-occurring disorders

Chapter 4: Outcome Monitoring Recommendations

Recommendation #1: A sustainable outcome monitoring process should be in place that collects information on key program characteristics and youth outcomes.

Recommendation #2: Information collected through the outcome monitoring process should be stored electronically, so that data analysis and report development can be easily completed.

Recommendation #3: A clear data collection process should be articulated.

Recommendation #4: Data collected as a part of the outcome monitoring process should be reviewed on a regular basis.

Recommendation #5: Information collected should be summarized and disseminated to key stakeholders.

Recommendation #6: Juvenile drug courts should seek out support for conducting a full outcome evaluation.

Chapter 1:

Introduction

Overview

In 2005, Louisiana was selected to participate in the John D. and Catherine T. MacArthur Foundation's Models for Change Initiative. The goal of Models for Change is to create successful and sustainable models of juvenile justice reform that can be replicated across the country by states and local jurisdictions seeking to improve their response to youth who come in contact with the juvenile justice system. Since its selection, Louisiana has joined the three other Models for Change States—Pennsylvania, Illinois, and Washington—in tackling pressing issues facing juvenile justice systems across the country.

Each Models for Change state selects three areas to focus their reform efforts on. One of the three areas selected by Louisiana over the course of several months and with input from stakeholders across the state was "Evidence-Based Community Services." This targeted area was selected in response to the recent shift within Louisiana from a system that has historically relied heavily on residential and institutional placement to one that emphasizes limited use of these placements and maintenance of youth in the community whenever possible. While this is an important shift in policy and practice, there are currently not enough community-based services to respond to the increasing numbers of youth who are now retained at the community level and in need of services. Through Models for Change, Louisiana sought to use this gap as an opportunity to invest in quality, evidence-based practices and interventions to meet this new demand.

The goal of this effort is to increase the availability of community services that reflect current knowledge about what works for youth who come in contact with the juvenile justice system. To accomplish this goal, Louisiana's Models for Change effort is focusing on the following three areas of activity:

1. increasing the use of scientifically-based screening and assessment procedures for youth in contact with the juvenile justice system to identify youth in need of mental health services;
2. expanding the range of services to ensure a complete continuum of care is available for these youth; and
3. developing and expanding evidence-based programs and services to ensure that their needs and the needs of the community are being effectively met.

The Models for Change Juvenile Drug Court Project

In support of these efforts, the Louisiana Supreme Court was awarded a Models for Change grant in January 2007. One of the goals of this grant was to enhance Louisiana's juvenile drug courts by increasing the reliance on scientifically sound screening and assessment instruments and evidence-based or promising practices. Over the past two years, the Supreme Court, in conjunction with several Models for Change partners, has collected information on the current practices of Louisiana's 18 juvenile drug courts, as well as the needs and strengths of the courts, and used this information to:

- Plan and implement a series of trainings on the use of evidence-based practices within the juvenile drug court context;
- Develop a set of recommendations, set out in this guide, for incorporating evidence-based practices into juvenile drug courts; and
- Design a pilot project for implementing the recommendations.

Louisiana’s Juvenile Drug Courts: Overview of the Survey Results

The first step in the Louisiana Juvenile Drug Court Project was to collect information from the state’s 18 juvenile drug courts through a two-step survey process. The purpose of this study was to a) collect some basic information about the structure and functioning of the courts, and b) assess the current state of affairs within Louisiana’s juvenile drug courts in terms of the referral, screening, assessment, and treatment practices. This survey was administered by the National Center for Mental Health and Juvenile Justice, and the Louisiana State University Health Sciences Center in collaboration with the Louisiana Supreme Court Drug Court Office and other Models for Change National Resource Bank Members, as well as the Lead Entity.

It was clear from the survey that Louisiana’s Juvenile Drug Courts and the individuals who are responsible for their implementation are dedicated to doing the very best for the youth they serve. They were enthusiastic about the opportunities presented by the Models for Change project and to further strengthening their programs. The survey respondents were also very helpful in identifying the critical areas of need within the state’s juvenile drug courts. Critical areas of need identified during the survey process included:

- **Family Interventions.** All of the JDCs emphasized the critical role of family support and involvement in a youth’s success in juvenile drug court. Despite this, very few of the courts rely on confirmed research-supported practices in working with families. As a result, the courts reported that a lack of family involvement is a major contributor to a youth’s failure to complete the program and identified improved family interventions as one of the most common program needs.
- **Evidence-Based Practices that Address Substance Use Issues.** It was clear from the survey that the majority of juvenile drug courts are not relying on nationally recognized evidence-based practices to address a youth’s substance use issues (e.g., Motivational Enhancement Therapy). While many of them recognized the importance of using evidence-based approaches, and were working to incorporate elements of those practices in their treatment services, very few of the courts had fully implemented evidence-based practices with fidelity.
- **Screening and Assessment.** The majority of JDCs reported that they are using research-based instruments to identify needs of youth who become involved in their program. However, the survey clearly revealed areas in which this process could be enhanced:
 - » First, not all of the JDCs are using standardized instruments to determine the presence of a substance use diagnosis.
 - » Second, not all of the courts are using research-based instruments to assess all critical issue areas.
 - » Third, research-based instruments were more likely to be used in making treatment and eligibility decisions, but were used much less frequently to monitor progress in juvenile drug court, in discharge from juvenile drug court, or to assess treatment outcomes after discharge.
 - » Fourth, the courts often reported using multiple instruments to measure the same need, which could be creating unnecessary duplication.
- **Mental Health Interventions.** Many of the courts reported a lack of mental health treatment as one

of the biggest issues they face. Youth in the JDCs often have co-occurring mental health needs and the courts report struggling to meet these needs. Furthermore, the availability of evidence-based mental health interventions appeared from the survey to be very limited.

somewhat detailed. Therefore, consideration of these recommendations will require a collaborative effort within the court.

Purpose of this Guide

This guide is intended for the many stakeholders involved with juvenile drug courts in Louisiana that are interested in incorporating evidence-based practices and approaches into their programs. In addition to the Introduction, the guide includes three chapters:

- Chapter 2: Improving Screening and Assessment
- Chapter 3: Treating Youth With Substance Use Disorders in Juvenile Drug Court
- Chapter 4: Measuring Outcomes in Juvenile Drug Court

Each Chapter provides a brief overview of the topic and includes a set of basic recommendations for addressing that topic, as well as practical examples of how the recommendations in each section can be implemented. The guide is written with the understanding that there is significant variation among the juvenile drug courts in Louisiana and that not all recommendations or examples are appropriate in each JDC. However, the guide is intended to provide a starting point for courts looking to improve their programs and some suggestions for how to focus those efforts.

Given the treatment orientation of the recommendations, it is suggested that JDC personnel work with their treatment teams to understand and consider each of the recommendations. While the guide was written with the goal of being appropriate for a wide range of audiences, some of the discussion around specific treatment and assessment recommendations is, by necessity,

Chapter Two:

Improving Screening and Assessment

Why do screening and assessment?

The success of any juvenile drug court relies on identifying and accepting appropriate youth for involvement in the JDC. Therefore, establishing a valid, scientifically sound screening and assessment process for referring youth to the juvenile drug court and determining eligibility and acceptance into the program is integral to the success of the program.

An effective screening and assessment process can be beneficial to a juvenile drug court in many ways. Screening and assessment results can inform the decision about who is eligible to participate, and the types and intensities of services youth should receive once they are accepted. If good quality information can be obtained before a youth is accepted as a JDC participant, or before treatment planning decisions are made, there is a higher likelihood that they will stay until completion and do better in the juvenile drug court program. The use of “objective, evidence-based screening and assessment instruments to inform the decision-making process” is considered a “key ingredient” in realizing successful outcomes (Knight, Flynn, & Simpson, 2008).

Over the past decade, numerous research-based screening and assessment instruments have been developed and are now widely available. Use of these measures represents a significant advancement in the field and allows juvenile drug courts to comprehensively evaluate the complexities and challenges of the population being served.

The Difference between Screening and Assessment

Screening and Assessment are both terms associated with evaluating a youth’s mental health and substance use needs. However, the terms have distinct meanings,

serve different purposes, and require different methods and resources. Screening involves a very brief effort to determine whether a youth shows some indication of having a substance use (or other mental health disorder) and may require a more comprehensive, “individualized examination of the psychosocial needs and problems” as a part of an assessment process (Grisso & Underwood, 2003). Screening efforts are also used in a “triage” capacity to determine whether any urgent need for observation or intervention might be required.

Screening typically involves the administration of a brief, standardized tool to look for indications of a possible substance abuse and/or mental health disorder. Screening measures can be administered by a range of clinical and nonclinical staff who have been appropriately trained in their administration and who understand the policies about who may have access to the information generated and what “next steps” should be undertaken based on the results.

In the context of juvenile drug courts, screening instruments can be used for a variety of purposes, including to:

- Triage youth to a juvenile drug court based on their possible needs, and to facilitate a standardized decision process within referring agencies for making referrals to the juvenile drug court or other referral options;
- Identify youth who *may* have mental health or substance use problems that require additional evaluation or attention by the juvenile drug court;
- Attempt to reduce the risk of self harm by identifying those youth who may pose an immediate risk for self-harm, and to increase the safety of youth and staff;
- Gather data about the service needs of the population of youth served by the JDC, or to meet

licensure or other regulatory obligations, and to avoid legal liability associated with failing to detect risk factors that existed as indicators of self injury; and

- To track the progress of youth in the juvenile drug court and re-evaluate their substance use and mental health symptoms.

Training requirements vary depending on the screening measure used, with more instruction typically required if the screen is an interview measure (where the interviewer is trained to ask specific questions in a prescribed order), as opposed to a “self-report” measure, that the youth completes on their own (either as a “paper and pencil test” or “computer-based test”). What most widely used screening measures *do not* require is that the person administering it be a licensed mental health professional.

In addition to these standardized screening measures, other evaluative methods commonly used in the juvenile drug court context, including biochemical measures that detect the use of substances in different bodily fluids (breath, blood, urine, saliva, hair), may be commonly referred to as screens. Methods of detection evaluate either recent (current) use or use that occurred over an extended time period. Most commonly, youth will be required to undergo drug testing in the form of urinalysis or breathalyzer. Breath tests for alcohol use are very inexpensive and quite accurately measure the person’s blood alcohol content. Urinalysis can detect a range of drugs used as well as the amount of drug (or its metabolite) currently in their system. Urinalysis cannot tell you precisely when the drug was taken and for drugs with “long half-lives” (such as marijuana), use could have occurred weeks to months in the past.

Assessments, on the other hand, are typically performed by trained clinicians and are designed to comprehensively evaluate a youth’s need for treatment

and other supplementary social services. This level of evaluation is typically performed on a subset of youth whose screening results indicate the need for further assessment. Conducting an assessment is a multistep process that usually results in the generation of one or more diagnoses (including both substance use and mental health disorders), if specific criteria are met. In addition, information from a comprehensive assessment will typically be used to 1) initiate specific treatment planning, 2) identify other psychosocial needs, 3) describe the specific strengths of the individual, or 4) evaluate the individual’s motivation for treatment.

Within the context of an assessment process, multiple assessment measures may be administered. The goal in choosing these measures is to determine how much necessary information they add to the process of developing a unique service plan, without being redundant with other measures or sources of information being gathered.

Screening and Assessment Recommendations

Recommendation #1: All screening and assessment tools used within a juvenile drug court should be standardized, scientifically sound, and appropriate for the population served.

1.1. Screening and assessment tools should be standardized.

Screening and assessment tools that are selected and implemented within juvenile drug courts (or within referring agencies for triage purposes) should be standardized. Standardization means that the measure has been developed to be delivered in a specific way every time. The use of standardized screening measures allows for consistent and specific decision rules to be established and for

the collection of consistent outcome measures (and, therefore, the ability to evaluate the program across subpopulations of youth and across time), and ensures that the program is making consistent decisions based on accurate information about the youth served.

1.2. Selected tools should be supported by a body of research that demonstrates the reliability and validity of the tool.

Best practice in the implementation of screening and assessment processes includes using standardized instruments that have also been developed and tested with adolescent populations. It is important to choose measures that have been thoroughly researched so that the user can be certain that it measures the same construct each time (“reliability”) and that the items measure the problems or symptoms that they claim to measure (“validity”).

Reliability and validity can only be determined through scientific studies that compare scores obtained over time and across different persons administering them, and that compare those scores with the results of other research-based instruments. Measures that have been validated have often been administered to thousands of youth.

1.3. Screening and assessment instruments used within juvenile drug courts should be tested for use with the population served.

In selecting tools, juvenile drug courts should consider tools that have been tested with populations that look similar to the youth served in their program. This should include consideration of whether the tool has been tested for use with the juvenile justice population, as well as whether

the tool has been tested with a population that has similar demographic characteristics as the juvenile drug court’s participants. An instrument that has not been tested for the specific population it will be used with may not yield accurate results. For example, an instrument that was not tested for the age range of the target population may not include appropriate content and may not be written at an appropriate reading level for the target population. *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System: A Resource Guide for Practitioners*, written by Dr. Thomas Grisso and Dr. Lee Underwood, provides profiles of more than 50 instruments that include information on whether the instruments have been tested for use with the juvenile justice population and the age range for the instrument. The Guide is available at <http://www.ncjrs.gov/pdffiles1/ojjdp/204956.pdf>.

1.4. Juvenile drug courts should also take into account other considerations when selecting a screening or assessment instrument.

In addition to choosing a valid and reliable measure(s), additional factors should be considered when selecting an instrument. Cost considerations are often among these factors, including the amount and type of training required to be able to use the measure, and the length of time required for administering the instrument. In addition, the JDC should consider requirements about who can administer the instrument and whether staff with those qualifications are available to the juvenile drug court, and information sources required for the instrument (e.g., Does the instrument require information about a youth’s educational record), and whether that information is or could be available (Grisso & Underwood, 2004).

Examples of Screening and Assessment Instruments

Examples of standardized screening instruments commonly used in juvenile justice populations are:

- **GAIN-SS** (GAINS-Short Screener) is a 3–5 minute, 20-question screening measure that can be administered as an interview or through self-report. It quickly and accurately identifies youth who may have one or more substance use disorders. This measure also screens for internalizing and externalizing psychiatric disorders and “crime/violence” problems. Information about this screening tool is available at http://www.chestnut.org/LI/gain/GAIN_SS/.
- **MAYSI-2** (Massachusetts Youth Screening Instrument – Second Version) is a 52 item self-report instrument that is used to identify mental health and substance use problems in youth. The MAYSI-2 takes about 10–15 minutes to complete and measures alcohol and substance use, angry, irritable, and depressed moods, thought disturbance, somatic complaints, suicidal ideation and traumatic experiences. Information about the MAYSI-2 is available from the National Youth Screening and Assistance Project (www.umassmed.edu/nysap).

For juvenile drug courts looking to modify their screening and assessment strategies, reviews of standardized measures are available in the following resources:

- *Progress and Perils in the Juvenile Justice and Mental Health Movement* (Grisso, 2007).
- *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System: A Resource Guide for Practitioners* (Grisso & Underwood, 2004),

available at <http://www.ojjdp.ncjrs.org/publications/pubabstract.asp?pubi=11936>.

- *SAMSHA/CMHS Treatment Improvement Protocol (TIP) 31: Screening and Assessing Adolescents for Substance Use Disorders*, available at <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.54841>.
- National Addiction Technology Transfer Center (www.attcnetwork.org).

Recommendation #2: Clear decision rules and response policies should be in place as a part of any screening protocol.

One of the benefits gained from using standardized instruments is that it allows a juvenile drug court to establish decision rules for how to respond to screening results. These decision rules, in turn, ensure that decisions that are made about referrals, further assessments, and services are made consistently and appropriately within the juvenile drug court. These decision rules also have the added benefit of providing clarity and consistency to any outcome monitoring process that is established.

2.1. Decision rule “triggers” should be established based on the guidelines or cut-off rules established by the instrument’s developer.

Establishing decision rules involves, as a first step, a determination about what scales and scores on those scales will trigger additional response. Guidelines or “cut-off” rules that have been established by the tool’s developer should be consulted in making this determination. For example, the MAYSI-2’s author has identified “caution” and “warning” cutoffs, or thresholds, for each of the MAYSI-2 scales that are based on a youth’s scores on those scales. While a juvenile drug court will clearly need to determine which combinations

of cautions and warnings trigger a response, the scores that actually result in a caution or warning on the MAYSI-2 should not be changed.

2.2. Response policies should identify the appropriate response or responses that should be taken based on the results of the screening instrument.

Written response policies should be identified that indicate the appropriate response or responses based on the results of a youth's screening, and the decision rule "triggers" that have been established by the program. These response policies should provide clear instructions about what further information should be obtained (i.e., what assessments are needed) and what additional action is required. This may include 1) immediately requiring observation, if evidence of suicidality is indicated, 2) recommending more in-depth assessment that can confirm a suspected mental health diagnosis, if the initial findings meet the threshold, or 3) determining that the youth is ineligible to participate based on previously established criteria.

2.3. Staff administering screening instruments should be trained on the decision rules and response policies.

After the screening instrument is administered and the scores obtained, it is essential that the persons collecting the information be aware that it is either their responsibility to act on the information or that they understand how to communicate with the person who will perform this action in a timely fashion.

2.4. A partnership with assessment service providers should be in place.

If the scores and related decision rules on screening measures suggest that the need for further assessment, it is imperative that JDC have an identified set of collaborative partners that can complete these assessments in a timely fashion. To ensure the timeliness of this activity, it is essential to discuss, at this point in the court's decision making process, how much emphasis should be put on cognitive, neuropsychological, personality, and family dynamics, in addition to determining their diagnostic profile and providing relevant information on functioning so it can be determined if they will meet program eligibility. Some elements of a comprehensive assessment that may be important for long range planning may need to be deferred in this initial step of the assessment process.

If a truly collaborative relationship exists between the court and these service providers, it will be essential to have a frank conversation about the "added value" of any measure that is administered. If the emphasis at this stage is to determine diagnostic eligibility, courts should have a clear idea of what standardized measures will be used to determine diagnoses. Structured interview measures are now widely available and exist as the best methods to accurately and comprehensively determine a diagnostic profile.

Recommendation #3: A thorough assessment process should be completed for every youth accepted into the juvenile drug court to validate substance abuse or dependence diagnoses.

3.1. The assessment process should provide a full picture of youths' substance use problems.

Consistent with the above recommendations, standardized research-based instruments should

be used to screen for the presence of a substance abuse or dependence diagnosis, which would then be followed up, if indicated, with a comprehensive assessment. The type and intensity of any service offering can only be accurately assigned if a full picture of the youth's substance use problem is known.

3.2. The assessment process should incorporate structured assessment interviews.

Structured interviews are generally considered to be the “gold standard” for obtaining an accurate diagnostic picture. Multiple tools are available; however, these tools vary on the degree to which they are explicitly linked to diagnostic criteria, and the extent to which they comprehensively assess both mental health and substance use disorders. Selection of a measure typically involves considering the validity and reliability of the instrument, recurring cost of use, time to administer, and training-level requirements. Structured diagnostic interviews available for use in assessment of youth include:

- » Children's Interview for Psychiatric Syndromes (ChiPS; Weller, et al., 2000)
- » Adolescent Diagnostic Interview (www.wpspublish.com)
- » Mini-International Neuropsychiatric Interview (M.I.N.I.-Kid; www.medical-outcomes.com)
- » Diagnostic Interview Schedule for Children-Revised (DISC-R; Shaffer et al., 1993)
- » Global Appraisal of Individual Needs (GAIN; www.chestnut.org/li/gain)

- » A detailed overview of a subset of these measures can be obtained from www.scattc.org.

Recommendation 3.3. The assessment process should be comprehensive and assess other domains besides substance use.

Outcomes in treatment are strongly tied to accurate treatment matching, which cannot be accomplished if the picture that the juvenile drug court has of the youth is incomplete. The implementation of a comprehensive assessment can also facilitate an ongoing monitoring and feedback process within the juvenile drug court. The availability of comprehensive information on the youth served by the program can provide information about what types of services are routinely needed, and help the court determine how best to allocate typically scarce resources appropriately.

As discussed, it is important to think about conducting an assessment as a multistep process that gathers information. But it also can be the youth's first interaction with a treatment system that is attempting to engage them in seeking care. In that context, a comprehensive assessment should:

- Review the findings from any screens that have been conducted. Issues around safety and risk behaviors, current symptom experience, and historical treatment information will provide a valuable basis to start the process.
- Identify collateral sources of information. The youth being evaluated may not be able to give an accurate, longitudinal picture of how they have functioned. A parent or other family member, for example, might be able to offer important information that supplements what the youth can provide, and what kinds of service offerings have been well received in the past, if any.

- Establish a current diagnosis across categories of substance use and other mental health disorders. This may be one of the few opportunities the youth may have to receive a thorough evaluation of their mental health symptoms. Therefore, structured interviewing methods should be utilized to ensure that all important and relevant disorders that are present can be identified and considered in treatment planning.
- Consider disabilities, impairments, and challenges. A likely outcome of the assessment process will be a treatment recommendation. This treatment recommendation should take into account the youth's cognitive capacity, social skills, and level of social support for treatment engagement.
- Evaluate current personal strengths and supports. A comprehensive treatment plan must also assess and identify a youth's strengths and supports. Any effective treatment plan should take into consideration not only a youth's needs and challenges, but also those areas of strength that can be built upon and enhanced during the treatment process.
- Describe the role of the family. As families play a large role in the success of a youth in a juvenile drug court program, an assessment of family strengths, dynamics, and willingness to collaborate in implementing a treatment strategy must be undertaken.
- Identify cultural and linguistic needs. The assessment should address any supports or modifications to service delivery protocols that help the youth respond positively to recommended treatment settings. Any cultural, linguistic, or literacy issues that could be impediments to successful treatment engagement should be articulated and addressed.
- Identifying other "problem domains." Are there medical problems, or legal, social, or housing issues impacting the family that may impact the youth's ability to be successful in their court or treatment involvement?
- Describe current "stage of change." Do they appear to be accepting and open to engaging in treatment? Do they readily acknowledge that problems exist which need to be addressed?
- Offer a treatment plan. For treatment to be successful, the appropriate level of care must be determined, but also the specific interventions that will be required to address the diagnoses that have been identified. Contextual issues (of family support, housing) that may impact treatment should also be described. Having information about a youth's experiences, abilities and challenges—in addition to obtaining an accurate diagnostic picture of them—will help the drug court team build an effective case plan.

Program Example: Cook County Juvenile Court Clinic Model

In the Cook County program, the Clinical Coordination Unit processes all requests for clinical information. Once the family is ordered to undergo a clinical evaluation, the information request is evaluated, documented, and an appointment is arranged. The assessment is completed by a psychiatrist or psychologist and is delivered before the family's next court date. The information contained in the assessment is used by judges, lawyers, and probation officers to make informed decisions about the youth's involvement in the program.

Recommendation #4: Any screening and assessment process within juvenile drug courts should be designed to assess and address the presence of co-occurring mental health disorders

The research literature indicates that many youth referred to juvenile drug court programs will, if evaluated accurately, meet criteria for other mental health disorders, in addition to their substance use disorder diagnosis. While some drug courts across the country have tried to limit participation to those with substance use disorders only, in many cases, depending on when this decision is made (and what type of historical or assessment information is available at the time), this effort results in removing only those youth with the most severe and persistent mental health disorders.

The rationale for this exclusion has been based primarily on more historically “siloes” service models (i.e., programs delivering service to persons with either substance use or other mental health disorders). However, excluding youth with co-occurring disorders has proved largely impractical. The majority of youth in the juvenile justice system—over 60 percent—have both a mental health and substance use diagnosis (Shufelt & Coccozza, 2006). Because rates of co-occurring mental health disorders are so high among youth in the juvenile justice system, excluding all youth with mental health disorders from participation in juvenile drug courts would dramatically reduce the eligible population.

In recent years, substance abuse service providers have come to accept that co-occurring mental health disorders are an “expectation” and not the “exception”—and that positive outcomes *cannot* be achieved unless these disorders are addressed. Throughout the country, communities are becoming more “integrated” in their treatment offerings, with service providers addressing both the youth’s substance use, and other mental health disorders, in the same practice setting.

Given that the range of mental health disorders that can co-occur in youth with substance use disorders is very diverse, and given that those disorders can have an impact on treatment outcomes, comprehensive assessment of mental health disorder diagnoses must be undertaken within juvenile drug courts. If standardized, research-based, structured interview measures are used, both mental health and substance disorder diagnoses will be evaluated.

Recommendation #5: Policies should be in place that clearly establish what information will be shared and how it will be communicated.

Clear rules should be in place regarding information sharing. Policies should be developed to articulate how much information will be shared with whom and for what purpose. Considerations here include the protection of health information and the protection of a youth’s legal rights. The overarching goal is to have clear pathways for communication that protect the youth’s rights but also allow for the communication of necessary information about changes in their symptom or family life experience that may impact their success in the program.

Formalizing these rules into written policies will make it clear to the youth, their family, any legal counsel, service providers, and the court, what boundaries or limitations exist on what can be communicated. These policies should be clearly explained to youth and their families upon entry into the program. Having these established, in writing, will also make it clear to new staff that join the team what the expectations around communication are.

Chapter Three: Treating Youth with Substance Use Disorders in Juvenile Drug Court

Once a youth is accepted into the juvenile drug court and the youth and their family have agreed to the terms of the program, the next critical step is the development of an individualized treatment plan. Their success in the JDC not only relies on their willingness to actively participate in the activities outlined in their case plan, but on the JDC's accurate identification of the treatment components necessary to achieve the desired outcomes. Beyond the identification of these services, the JDC has to ensure that the services are available at times that are convenient, in a location that is readily accessible and, of course, affordable.

The treatment plan necessarily will have to be comprehensive, incorporating not only a focus on how to address the youth's substance abuse problem, but also integrating treatment elements that will address any co-occurring mental health disorders. Additionally, the treatment plan will need to incorporate services that improve functioning and address skill deficits in educational and vocational arenas. Addressing concomitant physical disorders is also increasingly viewed as a necessary component to ensure compliance and commitment to the treatment of their substance abuse and mental health disorders.

An emphasis on family-based interventions has also been recognized as an essential element of treatment plans, as family issues often predict successful outcomes over the long term—beyond the term of the JDC's involvement. Active engagement of the family in understanding the long term nature of the issues identified by the evaluation, and their buy-in to the need for commitment to service involvement, will serve to sustain and build on the gains achieved through their involvement in the juvenile drug court.

Described below are a series of recommended practice guidelines that have emerged from the research literature and clinical "consensus" documents over the past decade. Community-based treatment settings,

in collaboration with juvenile drug court programs throughout the country, have been begun to incorporate these strategies into their quality improvement plans and service offerings.

Treatment Recommendations

Recommendation #1: Treatment offered by the juvenile drug court must be comprehensive.

Providing immediate entry into substance abuse treatment is at the core of the juvenile drug court model (BJA, 2003). An overarching goal of this treatment is to improve the youth's level of functioning so that they may develop the ability to lead crime-free and drug-free lives. Focused, psychosocial interventions, typically cognitive-behavioral in orientation and family based, are considered the "first-line" of treatment for most youth.

However, an effective juvenile drug court treatment plan must also take into account the complex personal, emotional, and family problems with which the youth present. Many have been the victims of physical and sexual trauma, have difficulties in learning and histories of limited academic success, and have symptoms consistent with the presence of multiple mental health disorders. Their family histories may be complicated by intergenerational substance abuse and criminality. They are at risk for the acquisition and transmission of HIV and other sexually transmitted diseases.

Treatment, for these reasons, must be comprehensive in its approach and be supported by other social and educational services (Belenko & Dembo, 2003). Fundamentally, all interventions offered should build on the strengths of the individual and the family and build skills to move them toward better symptom management, and the development of prosocial behaviors.

Recommendation #2: Service plans must be well-coordinated and flow smoothly across “levels of care,” treatment providers and social service providers.

The comprehensive assessment and treatment planning process undertaken by juvenile drug courts often results in a comprehensive and multifaceted treatment plan. As discussed earlier, this plan should be individualized to the specific needs of the youth and their family, and address the complexities of the youth’s needs, and offer a continuum of services that are focused on harm reduction and have the goal of abstinence (BJA, 2003). However, the success of a comprehensive treatment plan can be compromised if the various aspects of that plan are not coordinated and clearly articulated.

2.1. Treatment plans should be coordinated and overseen by a case manager.

Whatever services are recommended by a treatment plan, they should be coordinated by a “case manager.” This individual matches the needs of the youth to available services in their community, taking into consideration program access, costs, and potential for positive outcomes. The case manager should continually evaluate the implementation of the treatment plan during the period of the youth’s involvement in the juvenile drug court.

2.2. Treatment plans should be coordinated across levels of care.

Within the continuum of service delivery, treatment plans may offer different “levels of care.” This means that, depending on the impact of their symptoms on their functioning (academically, emotionally, or socially), different intensities of service may be offered. Commonly, juvenile drug courts engage youth in *Inpatient* or *Outpatient* treatment.

Inpatient services offer 24-hour care in residential settings. Inpatient services may range from very intensive professional coverage, including onsite psychiatry and nursing, to limited-to-no professional supervision onsite at the least intensive end of the service range. Within the inpatient range, service options (defined in BJA, 2003) may be described as

- » Medically monitored intensive inpatient treatment
- » Medically managed intensive inpatient treatment
- » Intensive residential treatment
- » Psychosocial residential care
- » Halfway House
- » Group Home / Therapeutic Foster Home.

Outpatient services are also sometimes called “ambulatory care,” offering no overnight services, and are delivered with varying frequency. They may be offered as the first line of intervention, depending on the person’s symptom severity and what is available in their community, or may be delivered following a residential intervention. Outpatient service types may include

- » Non-intensive outpatient treatment
- » Intensive outpatient treatment
- » Day treatment or partial hospitalization (BJA, 2003).

Psychotherapeutic services are designed to be delivered to either to groups of patients, to individuals in treatment, or sometimes to multiple members of a family. In recent years, greater attention has focused on modes of intervention, with concerns being raised about group sizes,

mixed-gender groups, and a lack of “fidelity” with evidence-based interventions. These issues will be described in more detail below.

Over the course of their involvement in the JDC, the youth and their family may be involved with multiple social and treatment service providers, as well as school staff. It will be essential that the case manager assist the family in scheduling these interactions, and ensuring that necessary information gets to the right person in a timely fashion so that involvement in the JDC processes across these levels of care can flow smoothly. If the youth’s case plan cannot be reviewed because releases were not signed, or evaluation appointments were unavailable, or reports do not get transmitted, the youth will be, at a minimum, unfairly penalized in the process. Case managers must be vigilant for disruptions or delays in service access that may occur due to movements across levels of care that may occur during the term of their involvement in court.

Recommendation #3: Programs should collaborate in and encourage the adoption of evidence-based practices

In recent years, increased attention has been placed on the implementation of “evidence-based” interventions. Though several different approaches for classifying interventions as evidence-based have been developed, they all rely on the premise that, through the application of scientific methods such as randomized clinical trials, an evidence base must demonstrate the effectiveness of the intervention on outcomes (Hoagwood et al.,

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of scientific methods such as randomized clinical trials, an evidence base must demonstrate the effectiveness of the intervention on outcomes (Hoagwood et al., 2001). Across the country, as the concept of delivering “evidence-based” practices (EBPs) has evolved, more states are mandating the use of evidence-based practices in the service settings that they fund.

Efforts at adoption of EBPs have included increased efforts at training providers associated with JDC programs in the implementation of effective practice models. For example, Louisiana recently contracted with David Stewart, Ph.D. to provide clinical training on “Motivational Interviewing,” which is based on the work of Miller and Rollnick (2002). This therapeutic strategy focuses on helping the client address their ambivalence about changing their behavior and works with them to develop an action plan that they feel they can carry out.

Importantly, access to information on Motivational Interviewing, and other evidence-based practice models, has become more widely available. A commonly cited source of this information is the website supported by the Substance Abuse and Mental Health Services Administration of the Federal government—SAMHSA’s National Registry of Evidence-based Programs and Practices (www.nrepp.samhsa.gov). This registry has become an invaluable source of information on programs and practices that are supported by a research base. This searchable database allows the user to specify qualities of the study populations that were used by the developers and the level of scientific evidence that supports its implementation. Currently, (February 2009), the NREPP database lists over 60 treatment programs and strategies that were developed for and validated on adolescent populations (13–17 years of age). The rapid and easy availability of this information has greatly assisted communities in evaluating what program models may fit into or are necessary additions to their treatment continuum.

Additional resources for the best practice models include:

- Blueprints for Violence Prevention (www.colorado.edu/cspv/blueprints). Operated by the Center for the Study and Prevention of Violence, Blueprints for Violence Prevention provides information on Model Programs, which have the highest level of research evidence about their effectiveness, as well as Promising Programs that have undergone some research studies that indicate they may be effective.
- Office of Juvenile Justice and Delinquency Prevention Model Programs Guide (<http://www.dsgonline.com/mpg2.5>). The OJJDP Model Programs Guide offers a database that is searchable by age group, ethnicity, gender, problem area, offender groups, target settings and strategies and program type. The evidence ratings for inclusion in this guide considered the conceptual framework of the program, the evaluation design and its fidelity to the original model, the strength of the empirical evidence showing reduction in risk factors and problem behaviors, and the “enhancement of protective factors.” Descriptions of three juvenile drug court programs are included under the “intermediate sanctions” tab of this site (located in Maine, Delaware, and Orange County).
- The Addiction Technology Transfer Network’s Best Practice Resource Manual (<http://nattc.org/resPubs/bpat/docs/bpatmanual>) is a guide for trainers (with an accompanying PowerPoint presentation) that describes core features of best practices in addiction treatment and provides a handout on a range of website links to acquire “best practice” information.
- SAMHSA’s Treatment Improvement Protocols (TIP), available at <http://csat.samhsa.gov/treatment.aspx>.

Recommendation #4: Families’ needs must be addressed and they must be fully engaged partners.

4.1. Families and youth must be engaged in treatment.

The ultimate success of the treatment “package” that the court offers a youth and their family hinges on the willingness of the youth and their family to participate in the treatment process. Therefore, a significant effort must be made up front to engage youth and their families in care by creating more incentives than disincentives to do so.

Engaging family members as a part of any treatment process is undertaken with the goal of strengthening the family and enhancing their ability to provide structure and guidance to their children. Importantly, families have to “buy-in” to the idea that their child needs to receive ongoing treatment, not only for their substance use disorder, but also for their (likely) co-occurring mental illness. Families will not collaborate with the juvenile drug court team if the burden is too great. If the length of court involvement is too long, appointment times inconvenient, or childcare unavailable, families may elect not to participate. Physical health issues of a youth will take precedence over making substance abuse treatment a priority, and so must be addressed as well. These issues should be recognized and addressed by the treatment team and case manager.

4.2. Juvenile drug courts should provide support to families and make sure they are fully informed about the juvenile drug court process.

Families exert a very important influence on the social, cognitive, and emotional development of their children. Increasingly, treatment programs have focused on the role of family members as being

integral to the youth's success in treatment. Though their child's involvement in juvenile drug court may come during the course of a difficult period in their relationship, family members or identified surrogates will likely be the primary overseers of a youth's involvement in substance abuse treatment. The burden of this role should be acknowledged and supported whenever possible.

To feel respected and engaged in the process, families need to get all of the information that they need to be meaningfully involved in any form of decision-making. Use of professional jargon, or the unavailability of translators, can be alienating to them. Access to staff members during evening hours and having written materials provided to them in advance of any treatment planning sessions will serve to engage them in the treatment process.

Family members or significant adults in a youth's life can serve an integral role in advocating for services, assisting with decision-making, and navigating complicated systems. Across multiple investigations over the past twenty years, a consistent finding has been that larger, or more "dense," social networks, can predict positive outcomes in treatment and in coping with life stresses.

Families are also integral in facilitating re-entry into school, and approaches to improve re-entry prospects have included hiring experienced family members to build relationships with new families coming into the system to put them at ease and build their trust. Persons in this role have the benefit of their experience and can help family members build a bridge to community-based services and school-based assistance.

4.3. Services should be provided that address the family needs and issues identified during the assessment process.

For many families, addressing substance use disorders may be a multi-generational conversation. Many interventions over the past decade have been developed to focus on the disruptions in familial relationships and the presence of pathological patterns of interaction. Familial interventions typically 1) emphasize that parental drug use affects the bond with the child, 2) discuss how parental role modeling influences the child's behavior, and 3) work on building more adaptive coping skills in both the child and parent.

Specific evidence-based interventions that address familial issues, some of which are currently being employed in some of Louisiana's JDCs, include:

- » **Multisystemic Therapy (MST):** Focuses on building independent skills in populations of youth who have behavior problems and engaging their families in an effort to cope with issues in peer, school and neighborhood environments. MST was designed to be delivered on an outpatient basis over a fairly short duration (less than four months) but with significant intensity (sometimes involving daily treatment contacts). This intervention combines elements of cognitive, behavioral, and functional family therapy.
- » **Brief Strategic Family Therapy (BSFT):** Focuses on improving issues in familial relationships that are seen as directly related to the youth's behavioral problems. The interventions are individualized and highly problem focused. Therapists work to restructure the interactions between family members. The intervention is brief, problem-focused and is delivered on an outpatient basis.

- » **Functional Family Therapy (FFT):** Focuses on engaging the family in pursuing behavioral changes including parenting strategies, increasing communication and reducing conflict, and being able to apply these skills outside of the family environment. It is also delivered in a short-term, outpatient basis.
- » **Family Behavior Therapy (FBT):** Uses behavioral contracting procedures to establish an environment that facilitates reinforcement for performance of behaviors that are associated with abstinence from drugs, skill-based interventions that focus on reducing time spent with individuals and situations that involve drug use and other problem behaviors, and decreasing drug use urges and impulsive behavioral problems. Delivered on an outpatient basis, typically in 15 sessions over a six month period.

Descriptions of the research base for these interventions can be found on the evidence-based practice websites described above.

Recommendation #5: Integrated treatment should be provided to youth with co-occurring disorders

Integrated services for co-occurring disorders are just being developed in most community and justice-based settings despite the increasing clinical awareness and epidemiological data over the past 15 years demonstrating high rates of the co-occurrence of mental health and substance use disorders in adolescent populations. Findings from the research literature also strongly indicate that if co-occurring mental health disorders are not addressed, sustained abstinence from substance use is not likely to be achieved. For example, Tomlinson, Brown, & Abrantes (2004) found that 87 percent of youth in the “co-occurring disorders” group

returned to substance use within the first six months, as compared to 74 percent of the “substance use disorder only” group. Additionally, the presence of significant symptoms of Posttraumatic Stress Disorder in youth with co-occurring substance use disorders is common in juvenile populations.

Offering “integrated” care or services for adolescents with “co-occurring disorders” has become the new “buzzword”—many service settings say that they offer it, but what is delivered can vary widely, even within a given agency. Some providers consider “integrated” treatment to consist of collaboration between mental health and substance abuse service providers while others interpret it to mean the application of more comprehensive models of care, incorporating models of evidence-based practice, such as Multisystemic Therapy, as described above. The latter interpretation of comprehensive care, delivered by a multidisciplinary treatment team, and incorporating evidence-based practices, is more consistent with an “integrated” care model supported by experts in the field.

Multisystemic Therapy (MST) and Family Behavior Therapy (FBT) have demonstrated positive outcomes in populations with co-occurring disorders. Additional programs and practice strategies focused on addressing co-occurring disorders in adolescents include

- **Trauma Focused Cognitive Behavioral Therapy:** Determined to be a “well established” treatment (Silverman et al., 2008), this intervention is delivered to youth in an individual, outpatient format, and provides training in cognitive and behavioral procedures. It also utilizes exposure tasks using narratives, drawings and imaginal methods.
- **Motivational Enhancement Treatment (MET/CBT5):** This five-session intervention was developed as a part of the Cannabis Youth Treatment Study and involves the administration

of two individual sessions of MET and three group sessions of CBT (cognitive behavioral therapy). The motivational component focuses on moving the adolescent through the stages of change (to increase treatment readiness and receptiveness) and then follows with the cognitive component, which teaches and rehearses coping skills to use in high risk substance use situations (Diamond et al., 2002).

- **Continuous, Comprehensive, Integrated System of Care Model (CCISC, Minkoff, 1997):** Developed as a conceptual model and offering a set of practice guidelines, the CCISC model offers specific criteria that are consistent with offering “dual diagnosis capable” treatment. Among the “best practice” strategies are:
 - » Integrating clinical records for both mental health and substance abuse treatment interventions;
 - » Creating multidisciplinary treatment teams that include mental health and substance abuse treatment professionals; and

- » Delivering evidence-based interventions that explicitly address the relationship between mental health and substance use disorders.

Additional models of care for adolescents with co-occurring disorders can be found in (arjournals.annualreviews.org and through a search of the ATTC website at <http://www.attcnetwork.org/index.asp>).

Program Example: Integrated Co-Occurring Treatment Program, Akron, Ohio

Youth in this program are evaluated and must meet criteria for both a substance use disorder and another mental health diagnosis (either mood, anxiety, or psychotic disorders). The ICT program is based on System of Care principles and employs an intensive home-based model of service. Assessment and interventions are delivered at home, school, and in the community. Individual therapy focuses on skill development and risk reduction; family therapy interventions focus on building parenting skills and rebuilding relationships.

Chapter Four:

Measuring Outcomes in Juvenile Drug Court

An outcome monitoring process is an integral element in the continued success of any juvenile drug court program. If designed well, the data generated from these efforts can provide ongoing validation regarding the successes, challenges, and impact of these courts. Monitoring systems should be conceptualized as tools that can provide important feedback throughout the term of the court's operation. Outcome *monitoring* is distinct from outcome *evaluation*. Outcome evaluations are developed with a short-term perspective, serving an evaluation purpose during a circumscribed term of a grant-funded effort. In contrast, outcome monitoring involves the routine and ongoing collection of data to monitor compliance with the program design, provide feedback to the program and areas that could be strengthened, and to collect information on who is being served, what they are being given, how it is being delivered, and the impact it is having on youth and their families.

Outcome monitoring systems are developed from the decisions that have been made about the court's design. Typically, an outcome monitoring system measures characteristics of the target population, length of contact, the utilization of services and resources, and juvenile justice status. A well designed system should be able to answer questions about who is being served by the court's efforts, and should be able to clearly and comprehensively articulate what was delivered. The fundamental questions addressed through outcome monitoring are:

- Is the program being implemented as it was designed (screening dates, court dates, timely development of case plan, documentation of services delivered, etc.)?
 - Is the program serving the population that it was targeted for (age, gender, diagnosis, juvenile justice history, etc.)?
 - Are there characteristics or differences among participants or services that determine which youth are successful and which youth have difficulty in achieving the program's intended outcomes?
- The findings from any outcome monitoring should be reviewed on a regular basis—more frequently in early years, perhaps less frequently later on—so that managers can make adjustments in the type and breadth of services being offered or expand or contract the allowed characteristics of the target population so that enrollment numbers can be met. Data from outcome monitoring can be used to identify gaps in service access and availability (for example, if times from case plan adoption to service delivery initiation increase) and can provide feedback to the court team about this and other “variables” that are likely to impact the court's effectiveness and that are outside of the individual participant's ability to influence.
- To be efficient in designing this “feedback” loop, court programs may need to conduct two forms of monitoring. “*Process*” monitoring strategies look at the day-to-day operation and implementation of the court program to determine its “fidelity,” or consistency, with what was designed. In the early operation of the court—but also in an ongoing way—the team should be able to assess and discuss:
- Is the juvenile drug court team adequately staffed and have decision-making strategies been outlined so that the target population is being referred and evaluated in a timely fashion?
 - Are referral and communication mechanisms in place so that the youth has expedited access to community-based care?
 - Are the arrays of community-based services offered to participating youth adequately comprehensive, or do more service offerings need

to be identified, so that the complex needs of the youth and their family can be addressed?

- Are the services identified being delivered so that the intended outcomes can be achieved?

In ongoing *outcome monitoring*, the focus will be on measuring what is being delivered and to whom, so that impacts can be assessed. Below is a discussion of recommendations and strategies to achieve these goals.

Outcome Monitoring Recommendations

Recommendation #1: A sustainable outcome monitoring process should be in place that collects information on key program characteristics and youth outcomes.

Successful implementation of an outcome monitoring strategy requires that it be a seamless part of the design of the juvenile drug court. The processes for collecting the data have to be well organized and collected by the members of the team who will have ongoing responsibility for its implementation. Data elements to be collected have to be easily accessible and the effort of gathering this information has to become part of the routine work of those involved in the program.

Measurement of client characteristics and impacts should occur on an ongoing basis. Core elements of this data collection will include measurement of:

- Characteristics of clients referred and accepted into the program;
- Service referral and delivery information, and
- Elements capturing progress and success in the program.

Client characteristics will likely include basic demographic information (age, gender, educational level attained), juvenile justice parameters (eligible charge,

offense category, prior adjudications), prior mental health and substance abuse treatment involvement, scores on screening measures, current diagnoses, educational / vocational information, and reasons for rejection, if deemed ineligible.

Service data, while in the court program, should include descriptions of the types of services they were referred to, the admission date(s), the number of sessions or treatment “units” attended, and findings from drug tests.

Progress or status variables may include program phases achieved, sanctions or incentives delivered, in-program/post-program arrest data, sentence types and lengths, and educational / vocational benchmarks achieved.

Appendix I offers a list of possible variables that a JDC may want to consider in designing an outcome monitoring process.

Recommendation #2: Information collected through the outcome monitoring process should be stored electronically, so that data analysis and report development can be easily completed.

Data collected during the ongoing operation of the court should be centrally held in an electronic data base in a format that can be easily accessed and reviewed by program managers. If the data entry is cumbersome, or the running of basic program statistics is considered too complicated, program information will not be made available to the entire team in a timely fashion and the system will be under utilized.

Many of the data elements that the court program will want to evaluate may not exist in any current database or electronic form. While it is appealing to think that there will be cost and time efficiency in gathering the majority of needed data from existing databases, this can be a complicated and time consuming task which may rely on the generosity of others to extract and communicate. The reliance on a wider web of persons

not directly involved in the court to be invested in extracting and providing data, in all likelihood, will bog down the court's monitoring process and will not allow for the "course corrections" that are highly desirable. Decisions will have to be made, however, as to who will have access to differing types of data, what laws and regulations will allow with regard to the release of a participant's personal and treatment information, and what kinds of safeguards (assent and consent forms, data confidentiality protections) will have to be put in place.

Ideally, data on client characteristics, "time to" services, and types of services delivered would be reviewed multiple times each year, so that course corrections can be made if the target population is not being served, or services are not being delivered as planned. If the court intended to accept males to females on a 2:1 ratio, for example, but finds that in the last 90 days only females were accepted, this would be important information for the team to address before an entire year's operation goes by. Similarly, if the services identified have long delays to admission, expectations about client compliance will have to be modified and alternative points of intervention identified. This "real time" monitoring will keep the program on track and help it to achieve the outcomes desired.

Recommendation #3: A clear data collection process should be articulated.

As described above, many decisions will have to be made about what data to collect, how it will be collected and entered, and when reports will be produced and discussed. This process should be fully defined and, ideally, in place prior to the initiation of the program. In an initial phase of program development, the gathering of "baseline" data can provide information about populations that are in critical need of service. As a part of the ongoing monitoring, it must be clear 1) who will collect the client, service, and justice data elements;

2) who will enter this information into the program's database; 3) how the data will be checked for accuracy; 4) who will oversee the timeliness of data collection, and 5) how, when, and by whom, reports will be generated, disseminated, and discussed.

The "Who," "How," and "When" of Data Collection. Although many of the systems involved in any JDC process have their own data systems and routinely collect data, it is unlikely that all variables of interest will be able to be drawn from any partner's existing system. Programs inevitably must address the specifics of who will collect important data elements, when those elements will be collected, how they will get entered into the database, and who will monitor and oversee this activity.

If the team agrees that a more comprehensive research-oriented evaluation is desired, as described in Recommendation #4 below, then additional staffing resources may have to be identified to analyze and interpret the data and write up and disseminate the results. A comprehensive program evaluation is a significant undertaking, however, and often requires additional funding to be accomplished.

Recommendation #4: Data collected as a part of the outcome monitoring process should be reviewed on a regular basis.

Over the course of the drug court program's development, information needs may change and data fields may be modified. If the data is reviewed regularly, it may become clear that there are fields that are routinely not completed and this should be addressed. Is this information that is not routinely available or difficult to obtain? It also may become apparent that there are multiple fields that are not being collected, which perhaps were not deemed to be relevant when the data design was created. This should also be addressed as the experience of the court evolves.

Recommendation #5: Information collected should be summarized and disseminated to key stakeholders

Information from the data collection process, as well as anecdotal experiences, should be summarized and disseminated to key staff, stakeholders and program partners on a regular basis. The information obtained from the data collection process serves an important feedback function to the partners actively involved in the JDC process. Both group-level and individual-level reports may be desirable. For example

- Group level data may describe how many youth are being served, where and what types of services are being delivered, and the numbers of sanctions or incentives that have been provided.
- At the individual level, teams may want to know the types and amounts of service units received, whether intensity of service changed during a given period, and whether any juvenile justices violations or contacts occurred.

Particularly with individual level reporting, however, privacy and legal protections must be upheld and taken into consideration when deciding who has access to the information and how it is reported. Any reports that are produced and disseminated should not include identifying information and should be reported in the aggregate only. Aggregate information can also be summarized to provide information to community stakeholders and build support within the community for the work of the juvenile drug court. This “good will” for the work of the court can build momentum for future court-community partnerships.

Recommendation #6: Juvenile drug courts should seek out support for conducting a full outcome evaluation.

While an outcome monitoring process can provide juvenile drug courts with important information about how their program is functioning and help them make adjustments to the program in real time, it does not provide a rigorous evaluation of the effectiveness of their program. Therefore, juvenile drug courts should be open to, and seek out, opportunities to conduct a more rigorous evaluation of their juvenile drug court. The results of such an evaluation can help the court make decisions about how their program is affecting youth and whether program modifications are needed to increase its effectiveness. In thinking about and designing such an evaluation, the following should be kept in mind:

- Data collection follow-up points need to be adequate to make statements about the long term influences of the program’s impact. Little political support will be gained by measuring rearrest rates during the period of contact with the individual under review, but significant capital can be gained by demonstrating that in the two-year period, for example, after the end of the court’s active observation of the youth, rearrest rates are significantly reduced compared to a matched comparison group. Many evaluations are criticized on their “too short” follow-up times and the fact that this limits their ability to make statements about the longer term effects.
- To be able to make important statements about the program’s effectiveness, an adequately matched comparison group must be identified and followed. Though this would appear to double the workload associated with data collection, it moves the data interpretation away from conjecture about impacts and into the realm of scientific integrity.

- Data should be collected on the multiple influences on juvenile drug court outcomes, including continued drug use, health complications, educational / vocational skills and abilities, failure to actively participate in planned activities, and a “mismatch” between recommended service offerings and the youth’s actual (perhaps unmet) service needs. In measuring longer term impacts, achievements in the domains of educational and vocational success, in addition to the measurement of recidivism rates, will be compelling information to have to build further support for the program.
- Cost-related analyses such as “cost-effectiveness” studies, “cost-benefit” analyses, and “cost-offsets” provide useful information about a program’s “effectiveness.” Though these can be more complicated data collection strategies to design, conducting these types of analyses and demonstrating benefits are often the most compelling data elements to legislators and others.

the target group and any comparison population, and the number and types of reports that must be generated.

If an outcome evaluation is performed, hiring an outside evaluator to plan, implement, and analyze the data will likely bring needed skills and objectivity to the data collection process. This evaluator ideally should have prior experience with working on data generated by the JDC target population. They may have expertise in the domains being measured, recommendations on tools to be utilized, and important methodological suggestions that will improve the value of the data collection effort. Costs are obviously associated with this type of consultative activity, but there will likely be significant value added and increased efficiency in the generation of important outcome information. Evaluation costs will vary depending on the size of the population targeted for data collection, any baseline information collected on

Conclusion

The recommendations included in this Guide are intended to provide juvenile drug courts in Louisiana with guidance about how to strengthen their programs and incorporate scientifically sound effective interventions and services. Programs that screen and assess youth using scientifically sound measures and processes, and that use the results of those measures to refer youth to appropriate, evidence-based treatments and services, will yield better outcomes for the youth and families that they serve, and help to move Louisiana towards a model for developing and expanding evidence-based practices.

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Appendix I: Suggested Data Elements

Demographic or Client Characteristics:

- Type of Court Program
- Referral Source
- Race/Ethnicity
- Gender
- Marital Status
- Eligible Charge
- Docket Number
- Offense Category
- Prior Adjudications
- Prior Substance Abuse History
 - » Age of first drug use
 - » Prior Treatment
- Drug(s) of Choice
- Method of Drug Administration
- Coded Mental Health Diagnoses
- ASAM Placement Criteria
- Recommended Treatment Alternatives
- Current Medications
- Other Mental Health Treatment History
- Highest Level of Educational Attainment
- Employment History
- Number of previous addresses
- Acceptance or Rejection in Drug Court Program

Case Management Variables:

- Arrest Date
- Drug Court Entry Date
- Sentencing Date
- Sentencing Guidelines
- Drug Test Frequency
- Drug Test Results
- Days in Current Program Phase
- Sanction Date(s)
- Sanction Type
- Incentive Type
- Treatment Provider(s)
- Treatment Admit Date
- Types of Treatment Modalities
- Length of Service in each modality
- Intensity / Frequency of Service
- Number of Sessions / Treatment Units attended
- Program Discharge Dates and Reasons
- Disposition at Discharge from Drug Court Program
- Supervision Status at Discharge
- Educational Status at Discharge
- Employment at Discharge
- In-program and Post-program arrest data
- Dates of new offenses
- Categories of new offenses
- Conviction dates
- Sentence Types
- Length of Length of Sentence
- Days in Jail during Drug Court Program Contact
- Days in Jail following Discharge from Drug Court Program
- Sobriety status following Program Discharge
- Current Employment—Post Discharge

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