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Final Report
Outcome and Process Evaluation of Juvenile Drug Courts

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Outcome and Process Evaluation of Juvenile Drug Courts

Executive Summary

On July 1, 2007, the University of Cincinnati, Center for Criminal Justice Research (CCJR), was awarded a grant from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The grant was awarded to fund a research study entitled "Outcome and Process Evaluation of Juvenile Drug Courts." The project was funded for four years, with funding set to expire on June 30, 2011. CCJR was granted a no-cost extension to facilitate a longer follow-up period. This extension was granted for 18 months, with the project expiring December 31, 2012.

This study adds to the existing juvenile drug court literature by providing a national multi-site outcome and process evaluation of nine juvenile drug courts from across the U.S. This study assesses the relative effect of each court, as well as their combined effectiveness in reaching the overall goal of reducing recidivism and improving youths' social functioning. It also identifies, where possible, the characteristics of youth and programs associated with successful outcomes.

The goals of this research are consistent with those stated in the OJJDP-approved grant proposal. There were six original goals. One additional goal was added at the request of OJJDP. The goals of this research are:

1) To determine if there is a reduction in recidivism and substance abuse associated with participation in a juvenile drug court program, relative to comparison groups.

2) To determine if there are increases in social functioning related to participating in juvenile drug court programs relative to comparison groups.

3) To identify the characteristics of successful juvenile drug court participants.

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4) To determine if juvenile drug courts are operating in a manner consistent with evidence-based approaches.

5) To identify the programmatic characteristics of effective juvenile drug courts.

6) To provide policymakers with information about the effectiveness of juvenile drug courts.

7) To determine if the 16 strategies for juvenile drug courts recommended by the National Drug Court Institute (NDCI) are effective practices (Bureau of Justice Assistance, 2003).

The nine juvenile drug courts participating in this research study are located in: Ada County, Idaho; Clackamas County, Oregon; Jefferson County, Ohio; Lane County, Oregon; Lucas County, Ohio; Medina County, Ohio; Rhode Island (the state); San Diego County, California; and Santa Clara County, California. As discussed above, the study included both process and outcome evaluation components. The process evaluation component was completed by researchers at CCJR. All nine juvenile drug court programs were assessed using the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC), a tool that CCJR developed for assessing drug court programs. The tool is used to measure how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. The CPC-DC consists of two components: one tool for the formal drug court and one tool for the major referral agencies involved in providing treatment and services to drug court participants.

Each of these tools is divided into two basic areas: capacity and content. The capacity area is designed to measure whether the drug court and its referral agencies have the capability to deliver evidence-based interventions and services for juvenile offenders. The content area focuses on the extent to which the drug court and its referral agencies meet the principles of risk, need, responsivity, and treatment. The Drug Court (CPC-DC) tool includes 41 indicators worth 43 total points. The Referral Agency (CPC-DC: RA) tool has 49 indicators worth a total of 51 points. Each area and all domains are scored and rated as either "highly effective" (65% to

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100%); "effective" (55% to 64%); "needs improvement" (46% to 54%); or "ineffective" (less than 45%). The scores in all domains are totaled, and the same scale is used for the overall assessment score. It should be noted that not all of the domains are given equal weight, and some items may be considered "not applicable," in which case they are not included in the scoring.

All nine sites were visited during the summer and fall of 2009. Data were collected through structured interviews with selected program staff, program participants, and parents, as well as through observation of groups, services, and a drug court staffing session. Other sources of information included policy and procedure manuals; schedules; treatment materials and manuals; curricula; a sample of case files; and other selected program materials. Once the information was gathered and reviewed, each drug court and referral agency was scored. A report for each drug court was generated which highlighted the strengths, areas that need improvement, and recommendations for both the drug court and each of its referral agencies.

To complete the outcome portion of the study, a quasi-experimental design was utilized as random assignment was not feasible at any of the sites. In all but one site, Comparison groups were developed from youth who were placed on probation. At the remaining site, youth participating in a diversion Drug Court track were matched with non-drug court diversion youth. For simplicity, Comparison youth are referred to as youth on “probation." In all sites, youth were matched on risk, race, gender, and identification of alcohol/drug abuse or dependence.

Data collected as part of the study were easily found through case reviews. In general, the information requested included offender demographics, current court case, prior criminal history, drug tests, treatment referrals, incentives, and sanctions. In addition, motivation surveys, satisfaction surveys, and follow-up surveys were given to both youth in drug court and youth on

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probation. Motivation surveys were distributed at the time of consent and at six months; satisfaction surveys were distributed at three months and at termination. Both the motivation and satisfaction surveys were distributed on-site by either drug court staff, probation staff, or staff hired by CCJR. Follow-up surveys were distributed by CCJR to all youth at six-, 12- and 18-months post-termination from drug court or probation/diversion. Lastly, official recidivism data was collected in the summer of 2012. This data includes level and type of new referrals/arrests, level and type of new adjudications, and the type of sanction at the time of adjudication/conviction.

A summary of process evaluation findings include:

- Two of the nine drug courts scored "effective," four scored "needs improvement," and three scored "ineffective" on the CPC-DC. None of the courts scored in the "highly effective" category.
- Thirty-five referral agencies were assessed across the nine sites. Four scored "highly effective," six scored "effective," 12 scored "needs improvement," and 13 scored "ineffective" on the CPC-DC: RA.

A summary of baseline characteristics and intermediate outcomes for the full sample include:

- Across all of the sites, the Drug Court and Comparison groups were quite similar on the four matching characteristics (N=686 in each group). However, two significant differences were noted. Drug Court youth were lower risk to recidivate than the Comparison youth. Specifically, youth in the Drug Court (DC) group were more likely to be low risk than those in the Comparison (C) group (DC=17.4%, C=6.2%). Additionally, youth in the Drug Court group evidenced higher frequency of alcohol and drug use. For instance, youth in Drug Court were more likely to use drugs on a daily basis than the

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Comparison youth (DC=31.7%, C=24.3%).

- There were significant differences between the Drug Court and Comparison groups on several other key baseline variables.
    - Drug Court youth were younger and were more likely to have drug and alcohol offenses as the current offense. Drug Court youth also had higher rates of previous drug charges, more out-of-school suspensions, greater truancy records, and higher past reports of drug and alcohol treatment and mental health treatment.
    - Comparison youth were more likely to have personal offense charges and felony level charges as the current offense. In addition, a higher percentage of Comparison youth identified marijuana as their drug of choice. Comparison youth also were more likely to evidence gang involvement.
- Not unexpectedly, youth in the Drug Court group differed significantly on some intermediary variables related to court processing and supervision. For example, youth in the Drug Court group had a higher frequency of case hearings, status reviews, treatment referrals, drug tests, incentives, and sanctions than youth on probation.
- Youth in the Drug Court group had significantly greater motivation levels than youth in the Comparison group.
- Fewer youth in the Drug Court group completed successfully (60.4% graduated from drug court) than youth in the Comparison group (63.0% successfully completed probation). This was a statistically significant difference.
- Time at risk for a new offense was defined in two ways. First, time at risk was calculated from the date that each youth was enrolled into the study to determine time to failure while under supervision. Second, time at risk was calculated from the date that each

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youth was terminated from drug court or probation to determine time to failure after completion of formal supervision. Youth in the drug court had longer times at risk based on both calculations. Since these differences were statistically significant for the sample overall (and in several sites), the period during which a youth could have had a new referral/arrest or adjudication/conviction was controlled for in multivariate analysis.

A summary of baseline characteristics and intermediate outcomes by sites include:

- Sites varied in the number of youth enrolled in the study. This ranged from a low of 72 in Clackamas County to a high of 296 in San Diego County.
- Overall, the matching on key variables within sites was good. Six of the nine drug courts had no significant differences between the groups on the other key baseline variables. One site differed significantly on one matching variable (Clackamas County differed on drug use frequency), and two sites differed significantly on two matching variables (Rhode Island and Santa Clara County both differed on alcohol use frequency and drug use frequency). At these sites, the Drug Court youth had higher rates of substance use/abuse.
- The nine sites had more variation on other key baseline variables (see the full report for a description of these other variables). Out of 17 variables (e.g., age, offense level and type, prior adjudications, gang involvement, truancy), the number of significant differences within sites ranged from one to 11. The largest differences were found in Rhode Island (11 differences) and Santa Clara County (11 differences).

A summary of major outcomes include:

- Given the differences in baseline factors described above, multivariate models were utilized to assess the effects of drug court on recidivism. Controls included months at

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risk of a new offense (calculated two ways as described above), youth age, youth gender, youth race (coded as white/nonwhite), and risk level (coded as low, moderate, high).

- The results for official recidivism—(a) while the youth was still in Drug Court or on standard probation, (b) after termination, and (c) both—suggest that Drug Court youth had worse outcomes than those in the Comparison group. These findings illustrate that drug courts did not meet their intended objectives and, instead, actually had increased risk of new referral and adjudication for its participants.
- The finding that youth who participate in drug court have worse outcomes than youth on probation hold up across numerous analyses including risk level, time at risk, race, gender, substance of choice, frequency of substance use, previous drug and alcohol treatment, parental substance use, and mental health problems.
- There was significant variation in treatment outcomes by site, with only two drug courts showing a positive effect on recidivism in initial multivariate models.
- Self-report follow-up data from both groups indicate a high rate of substance use post-program (drug court or probation) completion. The associated Odds Ratio value suggest that those youth in the Drug Court group had significantly lower odds of substance use at follow up relative to those in the Comparison group. For alcohol use, the Drug Court group had lower prevalence of use (78%) relative to the Comparison group (86%). The Drug Court group (63%) had a significantly lower prevalence on the self-report drug use measure compared to the Comparison group (83%).
- Youth who were successfully terminated from either Drug Court or probation had significantly lower odds of a later referral and/or adjudication than those who did not successfully complete those processes.

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- The courts in this study are not adhering to many of the recommended 16 strategies from NDCI. Since only two of the nine drug courts were effective in reducing recidivism, this may be a result of their lack of adherence to these strategies.
- Differences in effectiveness across the nine sites did not correlate with site CPC-DC and CPC-DC: RA scores.

A summary of goal findings include:

- *Goal 1:* Drug Court youth recidivated at significantly higher rates than the Comparison group in the full sample analysis. Formal modeling results, which included several important control variables (e.g., risk level, age, gender, time at risk for a new offense), confirmed these findings and show that when the two sites with the highest failure rates are removed, results still favor the comparison group (although the results were not statistically significant). When these analyses are broken down by site, outcomes continued to favor Comparison youth. Two of the sites, Jefferson and Lane, evidence lower rates of post-program referrals and post-program adjudications for Drug Court youth, however. Results from the self-report survey indicate that alcohol and drug use was highly prevalent for youth in both the Drug Court and Comparison groups during the follow-up time period. Youth in Drug Court had lower rates of reported alcohol use (nonsignificant) and lower rates of reported drug use (significant) when compared to youth in the Comparison Group, however.
- *Goal 2:* Self-report data limitations hindered a full exploration of this goal. Although the differences were not statistically significant, Drug Court youths reported lower rates of engaging in criminal behavior, higher rates of employment, and lower rates of running away from home.

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- *Goal 3:* There was little evidence that Drug Court youth outcomes varied by risk levels. Race and gender were both determining factors in post-program referrals and adjudications. Nonwhite youth were significantly more likely to have post-program referrals and adjudications, although the assessment of a race-treatment interaction effect was not statistically significant. Similarly, while the gender interaction was nonsignificant, female drug court participants evidenced a greater prevalence of post-program referrals and adjudications than female comparison youth and the relative gaps appear to be wider for females than males. Analyses suggest that older youth tended to have worse outcomes than younger ones. Youth with alcohol as the drug of choice had higher rates of new referrals and adjudications than youth who used marijuana or other substances. Similarly, those who had previous drug or alcohol treatment appeared to be more likely to recidivate.
- *Goal 4:* The CPC-DC and CPC-DC: RA results indicate that the majority of the drug courts assessed for this project were not in a good position to deliver effective services. Most of the courts *and* treatment agencies were not adhering to risk, need, and responsivity principles in a way that is consistent with evidence-based practice. The treatment approaches used by the agencies providing services to Drug Court youth were predominantly talk therapy and education based. These two approaches have been proven ineffective in changing offender behavior. The body of research on juvenile offender rehabilitation overwhelmingly supports cognitive-behavioral treatment approaches for offenders (see Lipsey, 2009 for a review).
- *Goal 5:* Only two of the drug courts evidenced better outcomes for youth compared to youth on probation: Jefferson and Lane. Both of these courts were developed in

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adherence to core drug court practices (e.g., having a program coordinator and providing sufficient case management/supervision) and were sufficiently funded. Both courts offered an adequate length of treatment and had set completion criteria which ensured that youth progressed through the courts accordingly. The Lane drug court also provided exceptional treatment services to youth, with the average category of the CPC-DC: RA categorized as "highly effective." This suggests that, while the structure of the drug court and its processes matter considerably, the referral agencies with whom drug courts contract for services are important in affecting individual youth outcomes, as well.

- *Goal 6:* These findings are consistent with past research (e.g., Belenko, 1998; Blenko, 2001; Hartmann and Rhineberger, 2003; Mitchell et al., 2012; Wright and Clymer, 2001), generally suggesting that policymakers, practitioners, and researchers need to seriously consider the question of whether drug court programs should be used with juveniles—at least as presently constituted. The intensity and inherent structure of drug courts may be resulting in the poor outcomes identified in this study. Youth in Drug Court had considerably more status reviews, case hearings, and drug tests than youth on probation. As such, they had much more opportunity to fail. The Drug Court group had greater prevalence of technical violations related to substance use, treatment noncompliance, and school-related problems, as well. That group also had a far greater volume of these violations. One result of the current study is that Drug Court youths who used substances other than alcohol and marijuana tended to show better outcomes, but the majority of youth included in the study use only alcohol and marijuana. This presents a question with respect to whether youth who only use alcohol or marijuana should be placed in intensive services modeled after treatment regimens given to criminal addicts in the adult

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system. These results may be related to the nature of substance abuse in general. Adult offenders are much more entrenched in their use (i.e., longer duration of use, more variation in the substances used). As such, these results may diverge from those found in adult drug courts, because adults are often further along in their substance abuse and have likely received more negative consequences for their substance use and associated criminal behavior.

- *Goal 7:* Overall, the courts in this study were not adhering to many of the NDCI recommended strategies. Therefore, the lack of success found in this study may be partly a result of the drug courts' lack of adherence to the NDCI strategies.

Conclusion

This study provides valuable insight regarding juvenile drug court practices and performance with respect to individual youth outcomes. On the whole, the key study findings raise important questions about the effectiveness of drug court for juveniles. Given the findings of the outcome analysis and results from the CPC-DC assessment of the courts involved in the current study, it is clear that there is a need for further discussion around the underlying theory and actual practice of juvenile drug courts in terms of potential effectiveness with the target population.

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Section 1: Research Problem and Study Overview

Past research on juvenile drug courts indicates contradictory evidence as to their effectiveness. Some juvenile drug courts have shown reductions in recidivism, while others have not. This study attempts to add to this discussion of effectiveness and to take the discussion one step further by asking what makes drug courts effective or ineffective. This issue has typically been referred to in the research as the "black box" (Goldkamp, 2000; Harrell, Cavanaugh, & Roman, 2000; Peters & Murrin, 2000). In order to help answer this question, the Office of Juvenile Justice and Delinquency Prevention awarded funding to the Center for Criminal Justice Research at the University of Cincinnati (CCJR) for a study entitled *Outcome and Process Evaluation of Juvenile Drug Courts*. The purpose of this project is two-fold: (1) to add to the literature concerning juvenile drug court effectiveness; and (2) to examine the elements of successful and unsuccessful courts.

The outcome evaluation component of this study compares results for drug court participants to a comparison group of youth on traditional probation. Drug Court and Comparison youth were matched on four variables to ensure similarity in the groups. Outcome variables include recidivism data as well as self-report data that explores social functioning variables. The process component of this study included site visits to each court using a standardized process to measure how diligently the court and its referral agencies were adhering to effective practices at the time of data collection. Information from the process and outcome study components will attempt to identify which juvenile drug court processes result in positive outcomes for participants. As such, this study provides some insight into the "black box" of juvenile drug court.

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Nine juvenile drug courts from across the United States participated in the study. One drug court is located in Rhode Island, three drug courts are in Ohio, one drug court is in Idaho, two are in Oregon, and two are in California. The courts serve areas that vary in size: three of the courts are in large localities ranging in size from one to three million persons; four of the courts are located in counties with 350,000 to 475,000 persons; one court is located in a county with approximately 175,000 residents; and the last court is in a small county with a population of approximately 70,000. These courts represent urban, suburban, and rural areas and one small state. Two of the drug courts serve approximately 60 youth per year; another two serve roughly 50 juveniles; two serve between 30 and 50 youth per year, and the remaining three courts serve fewer than 30 youth per year. The stage in the judicial process at which juvenile offenders are brought into these courts also varies across sites. For example, three of the courts use a pre-dispositional model while the other six courts are either post-dispositional courts or follow a mixed model.

Table 1. Drug Court Characteristics by Site

Site	Number of Youth Served Per Year	Pre- or Post-Adjudication	Internal or External Treatment	Number of Treatment Programs
Ada	<30	pre-adjudication	internal	1
Clackamas	<30	post-adjudication	both	3
Jefferson	30-50	both	external	4
Lane	<30	pre-adjudication	external	5
Lucas	30-50	both	both	2
Medina	30-50	both	external	3
Rhode Island	60	both	external	9
San Diego	60	post-adjudication	external	6
Santa Clara	50	post-adjudication	external	4

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Section 2: Background and Literature Review

Juvenile drug court beginnings and procedures

During the 1980s and 1990s, a substantial increase of cases involving substance abusers to juvenile court dockets and a growing belief that the traditional juvenile court setting was insufficient to address the complex needs of these offenders led to the development and proliferation of the juvenile drug court model (Bureau of Justice Assistance, 2003; Johnston, O'Malley, Bachman, & Schulenberg, 2007; National Council of Juvenile and Family Court Judges, 2003). In 1995, the first juvenile drug courts were implemented (Sloan & Smykla, 2003). As evidence accumulated for the effectiveness of adult drug courts, the juvenile justice system enthusiastically embraced juvenile drug courts as a logical solution to the challenges posed by the criminally-involved juvenile substance abuser (Shaffer, 2006).

Juvenile drug courts have been found to operate with considerable variability in terms of their goals, target population, treatment activities, and level of collaboration with outside agencies (Hiller et al., 2010; Sloan & Smykla, 2003). Despite this variation, juvenile drug courts generally strive to provide effective substance abuse treatment and foster long-term behavioral improvements through frequent status hearings and an integrated team approach incorporating a designated judge, social service providers, treatment agencies, schools, and law enforcement officials, among others (BJA, 2003). Furthermore, Sloan and Smykla (2003) observed in their survey of 30 courts that most juvenile drug courts adhere to a four phase approach, with court participants "stepping down" to less-rigorous phases by meeting particular goals.

Juvenile drug courts share many commonalities with the traditional adult drug court model, including frequent review hearings and drug testing; mandatory substance abuse treatment; and an escalating continuum of rewards for positive behavior and sanctions for court

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infractions (Marlowe, 2011). Soon after the first juvenile drug courts were implemented, however, it became evident that drug-using adolescents present issues that are distinct from those faced by adult drug users (Cooper, 2002; Roberts, Brophy, & Cooper, 1997). For example, because adolescent substance abusers are still developing cognitively, socially, and emotionally, juvenile drug courts must consider the influence families, peers, and schools have in helping or hindering these processes (BJA, 2003). Thus, the juvenile drug court also tends to integrate its services to those institutions and individuals to whom adolescents are dependent. Relatedly, juvenile drug courts must consider that adolescents often engage in risky substance abusing behavior for reasons distinct from those factors influencing adult offenders and such considerations are important for juvenile drug treatment interventions (Belenko & Dembo, 2003; Sloan & Smykla, 2003). For example, juveniles may often be strongly influenced by delinquent peers who tend to facilitate and reinforce substance use and delinquency (Warr, 2002). Furthermore, research has suggested that many adolescent offenders are not as motivated or willing as adults to engage in substance abuse treatments (Cooper, 2001). Additionally, adults and juveniles may differ in their prior experience with substance abuse treatment and in their drug of choice.

Juvenile drug court prevalence and effectiveness

In recent years, the implementation of juvenile drug courts has rapidly increased. As of September 2003, there were over 286 juvenile drug courts in operation and another 110 in the planning stages (OJP Drug Court Clearinghouse, 2003). As of early 2012, juvenile drug courts are found or being planned for in 47 states and numerous U.S. territories, and the total number of operating courts increased to 439 (BJA Drug Court Technical Assistance Project, 2012).

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Juvenile drug courts have continued to flourish despite a lack of sound evaluations of their processes and outcomes (Hiller et al., 2010). While adult drug courts have been referred to as the most frequently evaluated of all drug-abusing offender interventions, there have been noticeably fewer juvenile drug court evaluations (Marlowe, 2004). Furthermore, multiple meta-analyses have shown that adult drug courts reduce recidivism over traditional adjudication; there is no such consensus for juvenile drug courts. The literature that does exist on juvenile drug courts is decidedly mixed, and only recently have researchers begun to cease simply asking if the courts work, and instead investigate why some programs and participants succeed while others do not.

One study that points to the ineffectiveness of juvenile drug courts is Wright and Clymer's (2001) comparison of a juvenile drug court to a graduated sanctions program. No significant differences were found between the two groups in rearrest at six-, 12-, and 18- month intervals. However, it is possible that the null findings are a result of the comparison group receiving some services beyond what would be considered treatment as usual. Similarly, Hartmann and Rhineberger (2003) failed to find a treatment effect for the Kalamazoo County Juvenile Drug Court. Members of the comparison group were less likely to be rearrested than drug court participants.

Comparisons between juvenile drug court participants and standard probationers have been more encouraging. Latessa, Shaffer, and Lowenkamp (2002) examined drug court effectiveness for juveniles in the state of Ohio using a comparison group of juveniles who had been referred to drug courts but did not participate. They found that, after controlling for differences between the treatment and comparison groups, the probability of rearrest for those in the juvenile drug court group was 16 percent less than those in the comparison group. Similar

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conclusions were found by Thompson (2002). In his evaluation of two juvenile drug courts in North Dakota, Thompson compared drug court participants to standard probationers and a historical sample of youth. Again, a sizable difference was found in rearrest rates between drug court participants and the comparison group members. Finally, Rodriguez and Webb (2004) found that drug court participants were significantly less likely to commit a delinquent act than juvenile probationers using a follow-up period of three years.

Meta-analyses of drug courts have consistently found that juvenile drug courts are not as effective as their adult counterparts. For example, Shaffer (2006) found that while adult drug courts reduced recidivism on average by 10 percent, juvenile drug courts produced only a 5 percent average reduction in recidivism. Additionally, Wilson, Mitchell, and MacKenzie's (2006) meta-analysis indicated no better outcomes for juvenile drug court participants over typical probationers. In a recent meta-analysis, Mitchell, Wilson, Eggers, and MacKenzie (2012) found juvenile drug courts reduce recidivism less than adult drug courts and DWI drug courts. In fact, juvenile drug courts were found to have a 40% smaller average effect on recidivism than the other two types of drug courts examined. Furthermore, only the studies of low methodological quality included in the analysis indicated that juvenile drug courts significantly reduce recidivism.

The literature reviewed above calls into question the quality of juvenile drug court studies. For instance, Belenko (1998, 2001) found that the majority of studies failed to include adequate comparison groups. Additionally, many studies have failed to include individuals who were unsuccessfully terminated in their analyses, while others have failed to monitor program participants following program completion. Finally, drug court evaluations have not adequately

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examined the degree to which programs adhere to evidence-based practices and empirically derived principles of effective intervention (Gendreau, 1996).

Investigation of effective characteristics

In light of the inconsistent findings, researchers have begun to investigate the characteristics that distinguish drug court participants who have successful outcomes from those participants who do not. For example, Lowenkamp, Holsinger and Latessa's (2005) meta-analysis found the drug court model to be most effective for younger offenders who had the highest risk of recidivism. Additionally, a meta-analysis of 41 juvenile drug treatment courts found several key risk factors to be significantly associated with graduation or premature termination from courts (Stein, Deberard, & Homan, 2012). Specifically, Stein and colleagues found that participants with fewer drug, emotional, and behavioral problems prior to entering the court were more likely to successfully complete the court program.

Relatedly, researchers have begun to tentatively identify the characteristics of juvenile drug court programs that are essential in producing positive effects. In a randomized trial, Henggeler, McCart, Cunnigham, and Chapman (2012) found that drug courts in which therapists were trained to deliver evidence-based substance abuse treatment in combination with family engagement strategies had significantly greater reductions in both substance abuse and recidivism for participants than treatment-as-usual drug courts. This study highlights the importance of both family involvement and evidence-based interventions for juvenile drug court success, findings that have been echoed in a number of other drug court reviews (see Belenko & Logan, 2003; Halliday-Boykins, et al., 2010; Henggeler, 2007).

Mixed results coupled with methodological limitations have limited our ability to draw definitive conclusions regarding the effectiveness of juvenile drug courts. In addition, even in

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evaluations that have shown positive effects, researchers have only just begun to explain the reasons for success (Shaffer, 2011). Developing a better understanding of the elements of successful juvenile drug courts will produce information that can serve as a blueprint for developing new programs and increasing the quality of existing programs. Furthermore, with more insight into the mechanisms of a successful drug court, funding decisions will be better informed, and ultimately, juvenile drug courts will be better able to reduce recidivism and improve the lives of the youth and families they serve.

To that end, this study asks the next questions in this line of research. First: *What is the effect of drug court when accounting for some of the limitations of previous research (e.g., inadequate comparison groups, exclusion of unsuccessful participants)?* Second, this study asks: *What distinguishes a "successful" from an "unsuccessful" juvenile drug court program?* Answering this question has the potential to inform future development and improvement of drug courts themselves, as well as other "specialty court" movements (mental health, reentry, domestic violence and the like). The present study seeks to uncover the mechanisms of a successful juvenile drug court program, thus closing an important hole in our knowledge of this intervention.

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Section 3: Research Questions and Objectives

As discussed above, this study was designed to evaluate both the processes and outcomes for a diverse sample of juvenile drug courts in several states and regions across the U.S. The specific goals of this research were:

1) To determine if there is a reduction in recidivism and substance abuse associated with participation in a juvenile drug court program, as compared to comparison groups.

2) To determine if there are increases in social functioning related to participating in juvenile drug court programs when compared to comparison groups.

3) To identify the characteristics of successful juvenile drug court participants.

4) To determine whether juvenile drug courts are operating in a manner consistent with an evidence-based approach.

5) To identify the programmatic characteristics of effective juvenile drug courts.

6) To provide policymakers with information about the effectiveness of juvenile drug courts.

In addition to these goals, OJJDP asked CCJR to determine if the 16 strategies for Juvenile Drug Courts recommended by the National Drug Court Institute (NDCI) are effective practices (Bureau of Justice Assistance, 2003). The 16 key strategies recommended by the NDCI are listed below. It is important to note that this goal was added after the study began, and as a result, the research team was not able to collect data on all of these strategies. More information about this goal is presented starting on page 118.

- Strategy 1: Collaborative Planning
- Strategy 2: Teamwork
- Strategy 3: Clearly Defined Target Population and Eligibility Criteria
- Strategy 4: Judicial Involvement and Supervision
- Strategy 5: Monitoring and Evaluation
- Strategy 6: Community Partnerships
- Strategy 7: Comprehensive Treatment Planning
- Strategy 8: Developmentally Appropriate Services
- Strategy 9: Gender-Appropriate Services
- Strategy 10: Cultural Competence

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- Strategy 11: Focus on Strengths
- Strategy 12: Family Engagement
- Strategy 13: Educational Linkages
- Strategy 14: Drug Testing
- Strategy 15: Goal-Oriented Incentives and Sanctions
- Strategy 16: Confidentiality

Data and Methods

In order to identify possible study sites, CCJR obtained from OJJDP a roster of juvenile drug courts that were funded by the OJJDP Juvenile Drug Court Planning Initiative during fiscal years 2003, 2004, and 2005. All of these courts were sent a letter requesting their participation in the study. Since very few courts directly responded to the mailing, CCJR contacted courts from the same list by phone. Initially, 10 courts agreed to participate, however, one site was dropped from the study in January 2010 because only six cases were enrolled in the Drug Court group and zero cases were enrolled in the Comparison group. As a result, nine courts comprised the final sample included in this report. The nine juvenile drug courts that participated in the study are: Ada County, Idaho; Clackamas County, Oregon; Jefferson County, Ohio; Lane County, Oregon; Lucas County, Ohio; Medina County, Ohio; Rhode Island (the State); San Diego County, California; and Santa Clara County, California.

As discussed above, the study included both process and outcome evaluation components. To complete the outcome portion of the study, a quasi-experimental design was chosen, given that random assignment of participants to drug court was not feasible at the sites. In all sites except Rhode Island, Comparison groups were developed from youth that were placed on probation. A portion of Rhode Island's drug court is a diversionary drug court program and a comparison group was obtained from youth in a non-drug court diversionary program (N=26). For simplicity, all youth in the Comparison group are referred to as youth on "probation." Each

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site was asked to match Drug Court youth enrolled in the study with Comparison youth on risk[1] level, race, gender, and an identification of an alcohol/drug abuse or dependence. When appropriate matches could not be obtained, sites were instructed to prioritize matching on risk level, followed by gender, and to be more flexible concerning race. As such, youth were not always matched on all four variables. All youth should evidence alcohol/drug issues, either by nature of being in the drug court, or through proof from the file review at each site (for the Comparison group).

It is important to highlight that several sites had considerable trouble enrolling comparison youth into the study. This happened for several reasons. First, the drug court personnel and CCJR-hired data collectors had little contact with the probation departments. This was especially an issue in the larger counties. As such, drug court staff and on-site data collectors were not in a position to easily contact youth on probation. Additionally, Comparison youth were approached by a stranger to participate in a study and were offered no incentives until the end of the study (for the completion of the follow-up surveys). Towards the end of the enrollment period, six of nine sites did not have an equal distribution of youth in their Drug Court and Comparison groups. As such, some of the youth in the Comparison group were enrolled in the study via a blanket consent process. This process allowed for each Drug Court case to receive a matched comparison youth, however, the blanket consent process negatively affected some aspects of data collection. For example, youth enrolled through the blanket consent could not participate in the motivation surveys, satisfaction surveys, or the follow-up surveys. This partially explains the high percentage of missing data from these data sources. See pages 34 and 98 for additional information concerning missing data.

[1] Risk was determined by various risk assessment instruments at all sites except Rhode Island.

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Despite these problems, while there was some variation across the matching variables and sites, this process generally produced groups of Drug Court and Probation-Only youth who were comparable at baseline on the key factors mentioned above. This is investigated further in the results section (beginning on p. 39) and controls were added in multivariate analysis to account for as much of the remaining imbalance as possible.

The outcome evaluation and individual level data were either collected by on-site data collectors or by CCJR researchers. All data collection staff was trained as to their responsibilities on the project and on ethical research practices. CCJR staff members completed all of the data collection at the three Ohio sites and assisted some other sites in completing data collection. CCJR developed all of the data collection forms and created an Access database so that sites entered their own data; however, some sites elected to send their data to CCJR for data entry. Table 2 explains how data was collected at each site.

Table 2. Data Collection Methods by Site

Site	Blanket Consent	Data Collectors	CCJR Assist w/ Data Collection	Data Entry
Ada	Yes	On-site	No	On-site
Clackamas	Yes	On-site	No	On-site
Jefferson	No	CCJR	Yes	CCJR
Lane	Yes	On-site	No	CCJR
Lucas	No	CCJR	Yes	CCJR
Medina	Yes	CCJR	Yes	CCJR
Rhode Island	Yes	On-site	Yes	CCJR
San Diego	No	On-site	No	On-site
Santa Clara	Yes	On-Site	Yes	CCJR

The data elements collected as part of the study were intended to have been easily found through case reviews. The forms are located in Appendix A. As noted in the results section, some variables had significant amounts of missing information. In most instances, this was because the drug court collected more detailed data on youth than did traditional probation. In general, the information requested included offender demographics, current court case, prior

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criminal history, drug tests, treatment, incentives, and sanctions. In addition, motivation surveys and satisfaction surveys were given to both groups of youth. Motivation surveys were distributed at time of consent and then again at six months into either drug court or probation. Satisfaction surveys were distributed to measure the level of satisfaction for youth in drug court versus youth on probation. These were distributed at 90 days post-enrollment and at the termination of their sentences. The satisfaction survey measured participants' attitudes about the judge, treatment staff (if applicable), their supervising officer, and their overall experience with the drug court/probation. Additionally, follow-up surveys were distributed by CCJR to all youth at six-, 12- and 18-months post-termination from drug court or probation. The follow-up surveys contained various questions about home, work, and school. All of the forms are available in the appendices. Given the issues with comparison group enrollment, the motivation, satisfaction, and follow-up survey were affected by missing data.

Outcome Evaluation Measures

Several data collection forms were used at various points throughout the study. Background data on the participants, such as demographic and individual case history data, were collected via an Intake form, and information on the legal processing of the instant offense was captured on a Process form. A number of additional forms were used to collect programming data. Treatment referrals were documented on a Treatment form; drug testing information was collected on a Drug Testing form; court violations and their accompanying sanctions were collected on the Violations form; rewards for compliance/achievements were collected on the Incentives form; and various measures of how well the youth did on probation were collected on the Closure form. All of these forms can be found, in their entirety, in Appendix A. Additional background data consisted of a motivational survey. At initial consent into the study and again

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at 180 days, each youth was asked to complete the Treatment Motivation Scales, adapted from the Client Evaluation of Self and Treatment at Intake (CEST-Intake) created by Texas Christian University (TCU). The exact CEST-Intake that was given to participants can be found in Appendix B. As additional programming data, youths' satisfaction with their drug court or probation experience was measured at 90 days and again at termination using a survey created by CCJR. These surveys can be found in Appendix C. Recidivism information was collected in two ways. The primary outcome measures came from official referral/arrest and adjudication/conviction data that was provided by the sites. As a secondary outcome measure, a self-report follow-up survey created by CCJR was mailed to participants at six-, 12-, and 18-months following termination from the drug court or probation. The entire self-report follow-up surveys can be found in Appendix D.

In addition to identifying information,[2] a variety of demographic information was collected via the Standardized Intake form. Additionally, a number of items on the Intake form concerned the current/instant offense. Data collectors were also asked to indicate whether the youth received any special conditions/sanctions. The Intake form was also used to collect historical information about the participant, including criminal history, drug use history, family history and behavioral history. Additional information was collected regarding antisocial indicators, including whether there was evidence that the youth was a member of a gang and whether the youth had a history of running away from home, out-of-school suspensions, and/or truancy. The Intake form also included a number of measures of drug use history. Family, behavioral and mental health history information was also collected. A number of data collection items on the Intake form focused on assessments and recommendations the youth received at

[2] Identifying information was not collected for those youth enrolled using the blanket consent authorized by their respective court.

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intake (e.g., level of care required, treatment programs the youth should be referred to). These measures included whether the youth received a drug assessment, risk assessment, or need assessment at intake, and their respective scores or recommendations. Finally, on the Intake form, data collectors were asked to make a general estimation of the youth's primary problem areas based on information contained in the youth's file.

On-going programming information was collected via the Treatment, Drug Testing, Violations, and Incentives forms. For each treatment referral the youth received, the Treatment form was used to collect the start date of the treatment, the name of the treatment provider, the treatment setting, whether the participant successfully completed the treatment, the end date of treatment, and the type of treatment (such as drug education, alcoholics/narcotics anonymous, cognitive-behavioral treatment, etc.). If the treatment was not completed, data collectors were asked to indicate a reason for non-completion. Information was also collected on drug tests via the Drug Testing form. Using this form, data collectors documented the date that the drug test was administered, the result of the drug test, and the type of test used. If the youth tested positive, data collectors were asked to indicate the positive substance. Finally, the Violations form was used to collect information on sanctions that were incurred during the course of the study. Measures on this form included date and type of violation. Data collectors were asked to indicate any and all sanctions for each violation recorded. Information on rewards for compliance was collected via the Incentives form. Measures included date the incentive was given, the specific incentive given, and the justification for giving an incentive.

The Closure form was used to collect information on how well the youth did in drug court or on probation. Data were collected on whether the youth was referred to, still active in, or completed certain treatment services. Additionally, information was gathered on compliance

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with court processes, including paying of fees, attendance of court hearing, etc. The Closure form also included measures of school performance and any new referrals the youth had while under supervision. In addition, information was collected on the number of days the youth spent in a confined facility while under supervision. Finally, information on the termination status of the youth was collected via the Closure form, including whether the youth successfully completed all requirements and whether the youth was under court supervision after termination from drug court. If the youth was still under court supervision following their termination from drug court, data collectors were asked to indicate the type of supervision.

As stated, CCJR modified the CEST for use in the study. This modified version consisted of only items related to treatment motivation and was used to assess the motivation of youth in this study at intake and again at 180-days. The surveys were comprised of 29 statements, each followed by a five-point Likert-type scale ranging from "strongly disagree" (1) to "strongly agree" (5). The instrument groups statements into four scales: Problem Recognition (PR), Desire for Help (DH), Treatment Readiness (TR), and External Pressures (EP). A full list of the statements in each category can be found in Appendix B. Scores for each section were computed by adding the values from the Likert-type scales, with higher scores indicating higher motivation for treatment. An additional survey was created by CCJR to assess each youth's satisfaction with their drug court or probation experience. This survey was administered to each youth at 90-days and at their termination. The full surveys can be found in Appendix C.

The motivation and satisfaction surveys are plagued by missing data. Results below include only the motivation survey; the results from the satisfaction survey have been omitted. The researchers felt that of the two surveys, data related to motivation may play a larger role in

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the outcome process. And therefore we reported these findings, even though the number of surveys completed is quite small.

Outcome data were collected in two ways: official and self-report. The primary outcome measures came from official referral/arrest and adjudication/conviction data provided by the sites. These data were requested from each site beginning six months after the last youth was enrolled into the study. Despite this wait time, some of the youth were still under supervision at the time recidivism data were collected. For purposes of data collection, these youth were artificially terminated based on the date their Closure form was completed. This date varied for each site. The following data were collected for up to ten new referrals: date of arrest/referral, most serious level of offense at time of arrest/referral (felony, misdemeanor, or delinquency/status), most serious charge (property, personal, etc.), whether the charge involved alcohol or drugs, disposition status, disposition date, level of offense at disposition (felony, misdemeanor, or delinquency/status), most serious sanction received (diversion, fines/fees/community service, added time on current sentence, community supervision, residential treatment, incarceration, drug court, or other), and specification of "other" sanction (if applicable).

As a secondary outcome measure, a self-report follow-up survey created by CCJR was mailed to participants via the United States Postal Service (USPS) to the address on file from our initial data collection at six-, 12-, and 18-months following termination from the drug court or probation. During the course of data collection, CCJR needed to alter several of the questions. This resulted in the six-month follow-up survey being slightly different than the 12- and 18-month follow-up surveys. Both complete surveys can be found in Appendix D. For each self-

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report follow-up survey that a youth completed and returned, he/she received a $10 gift card to Subway, Pizza Hut or McDonald's.

There are significant limitations to the use of this self-report data. Despite providing incentives for the completion of the surveys, sending multiple surveys, and multiple phone calls to each youth, the response rates were extremely low. In fact, only 21% of eligible youth returned any of the three follow-up surveys (196 youth were enrolled via blanket consent and could not be contacted for the follow-up survey). The response rate for the six-month follow-up survey was 10.9%, the 12-month was 13.0%, and the 18-month was 12.7%. This low response rate significantly impacts our ability to speak to some of the goals of this project. In particular, our ability to thoroughly test and discuss Goals 1 and 2 in relation to the self-report data are limited due to the lack of survey response.

Process Evaluation Measures

The process evaluation component was completed by researchers at CCJR. All nine juvenile drug court programs were assessed using the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC), a tool that CCJR developed for assessing drug court programs.[3] It is used to ascertain how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. Several recent studies conducted by CCJR on both adult and juvenile programs were used to develop the indicators on the CPC-DC.[4] These studies found strong correlations with outcome between both domain areas and individual items

[3] The CPC-DC is derived from the Evidence-Based Correctional Program Checklist (CPC) which is modeled after the Correctional Program Assessment Inventory developed by Gendreau and Andrews. However, only those indicators that were found to be positively correlated with outcome were retained on the CPC. In addition, the CPC includes a number of items not contained in the CPAI.

[4] The CPC-DC has not yet been independently validated. The CPC-DC was constructed based on previous studies of both adult and juvenile drug courts. CCJR had not used the CPC-DC prior to this study. As such, the CPC-DC has not been validated on either adult or juvenile drug courts. This study will allow for some examination of whether this instrument predicts effectiveness for juvenile drug courts.

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(Holsinger, 1999; Lowenkamp, 2004; Lowenkamp & Latessa, 2003; Lowenkamp & Latessa, 2005a; Lowenkamp & Latessa, 2005b; Shaffer, 2006).

The CPC-DC consists of two tools: one for the formal drug court and one for the major referral agencies involved in providing treatment and services to drug court clients. Each of these tools is divided into two basic areas: content and capacity. The capacity area is designed to measure whether the drug court and its referral agencies have the capability to deliver evidence-based interventions and services to offenders. There are two domains in the capacity area: (1) Development, Coordination, Staff and Support, and (2) Quality Assurance. The content area focuses on the substantive aspect of the drug court and its referral agencies, and also includes two areas: (1) Assessment Practices, and (2) Treatment. The content area focuses on the extent to which the drug court and its referral agencies meet the principles of risk, need, responsivity, and treatment.

The Drug Court tool includes 41 indicators, worth 43 total points. The Referral Agency tool (CPC-DC: RA) has 49 indicators worth a total of 51 points. Each area and all domains are scored and rated as "highly effective" (65% to 100%); "effective" (55% to 64%); "needs improvement" (46% to 54%); or "ineffective" (less than 45%). The scores in all domains are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the domains are given equal weight, and some items may be considered "not applicable," in which case they are not included in the scoring.

For this study, CCJR researchers spent between three and five days on-site at each drug court. All of the site visits occurred between June 2009 and October 2009. Data were collected through structured interviews with selected program staff and program participants, as well as through observation of groups, service delivery, and a drug court staffing session. In some

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instances, surveys were used to gather additional information about the key items on the CPC-DC. Other sources of information included policy and procedure manuals, schedules, treatment materials, manuals, curricula, a sample of case files, and other selected program materials. Once the information was gathered and reviewed at each site, the program was scored. A report was generated that highlighted the strengths, areas that needed improvement, and recommendations for each of the items on the tools for both the drug court and each of its referral agencies.

There are several advantages to the CPC-DC. First, it allows researchers to get inside the "black box" of a drug court and its referral agencies. This knowledge extends beyond descriptive indicators, and assists researchers with measuring the degree to which the programs are meeting evidence-based standards. Second, the CPC-DC enables researchers to "quantify" the quality of a program through a scoring process. This allows comparisons across programs, as well as benchmarking. Third, the entire process can be completed relatively quickly. Usually, necessary information can be obtained in two days and the final report written within a few weeks. Finally, the CPC-DC is designed to improve program effectiveness and the integrity of treatment.

In October 2011, each court was provided the results of their CPC-DC, in advance of the final annual advisory board meeting. The advisory board meeting was held annually throughout the project with representatives from each site. Each court and referral agency was given until mid-January 2012 to respond to the CPC-DC report. CCJR then responded to each court and agency and issued final reports to the sites. These are included in Appendix E.

Analytic Plan

The main study objectives were examined using a variety of descriptive and inferential analyses. These procedures included group mean comparisons (t tests) and Chi-square tests for

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the initial comparative analysis and multivariate logistic regression modeling to answer key questions related to drug court outcomes. Descriptive analyses were undertaken to offer some context regarding the types of youth who were involved in the study across the nine sites. This also presented an opportunity to examine balance across the Drug Court and Comparison groups and provides a sense of the similarities and differences across sites. From there, the main results are presented for the sample as a whole and by individual sites. In all cases, the results include controls for key rival variables that (a) have some theoretical or substantive relevance in terms of their impact on recidivism or other outcomes (e.g., standardized baseline risk scores) or (b) were identified as possible between-group differences in preliminary analysis (e.g., time at risk for a new offense).

In addition to the use of multivariate models for the analysis of key outcomes, a host of subgroup analyses and sensitivity checks were undertaken to further unpack the main study findings. This included analysis by risk level, race, gender, and age as well as an examination of the degree to which the observed effects varied by site. In particular, hierarchical logistic regression models allowed for some formal examination of the degree to which there were site-level differences in drug court outcomes and treatment effects (see Snijders & Bosker, 1999). In general, all of the main study results were examined using multiple measures, appropriate controls, and accommodations for possible heterogeneity in effects.

The process evaluation for this study was intended to provide information on programming characteristics of the juvenile drug court programs and assess their fidelity to common elements of best practices in drug court and programming for youthful offenders. These data were primarily analyzed qualitatively and descriptively by drawing out key themes related to benchmark items in the CPC-DC, but some attempt was also made to attach quantifiable

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indicators for process to each site. These measures were then integrated into the quantitative analysis where possible.

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Section 4: Results

Sample Description and Treatment Group Comparison

Table 3 presents the main descriptive analyses stratified by Drug Court and Comparison groups. We also use t or Chi-Square tests to evaluate whether there are significant between group differences and offer some sense of the data coverage around specific items in the final column of the table. Looking at the four matching variables for all cases, there were two significant differences across the Drug Court (**DC**; n=686) and Comparison (**C**; n=686) groups: risk level and frequency of substance use. Overall, the majority of youth fell in the moderate or high risk categories. Relatively more youth in the Drug Court group, however, were classified as low risk (DC=17.4%, C=6.2%).[5] The groups did not differ significantly in the proportion of male and female offenders or in race. Both groups were roughly 75% male, 25% female. The majority of youth in both groups were white, followed by a fair portion of Hispanic youth. In examining the use of alcohol and drugs, Drug Court youth used both alcohol and drugs on a more regular basis than Comparison youth. For example, youth in Drug Court used drugs daily in 31.7% of cases while youth in the Comparison group had daily drug use in 24.3% of the cases. In general, the drug use frequency was far higher than alcohol use for both sets of youth.

As shown in the second section of the table (Other Baseline Variables), marijuana was the overwhelming drug of choice for both the Treatment (71.1%) and Comparison (75.2%) groups. However, this variable evidenced statistically significant differences in that youth in Drug Court have higher percentages of preferring alcohol and other drugs than Comparison youth. The age of first use for alcohol (DC=13.4, C=13.5) and drugs (DC=13.5, C=13.5) are

[5] Outcome analysis includes controls for risk level. It should be taken into consideration, however, that the baseline difference noted here in terms of level of risk might be expected to bias results in favor of greater likelihood of recidivism for the Comparison group.

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comparable for both groups and indicate that these youth generally started using substances early in adolescence. Youth in the Drug Court group also differed significantly concerning previous alcohol and drug treatment and previous mental health treatment. Specifically, 23.5% of Drug Court youth were reported to have received previous drug and alcohol treatment while only 17.3% of Comparison youth had received such treatment. For mental health treatment, 37.6% of Drug Court youth had received past treatment while only 28.7% of Comparison youth had received past mental health treatment.

Looking at other baseline variables, the average age for these youth was not significantly different across groups (DC=16.1, C=16.2). The vast majority of cases in both groups were referred for misdemeanor or felony offenses as opposed to status offenses. However, significantly more Drug Court youth were referred for status offenses (DC=17.9%, C=11.7%) while significantly more Comparison youth were referred for felony offenses (DC=29.7%, C=32.7%). The primary offense type was also considerably different between the groups. Youth in Drug Court were more likely referred for drug and alcohol offenses (DC=42.9%, C=31.2%), while youth in the Comparison group were more likely referred for personal offenses (DC=8.4%, C=21.7%). Property and other offenses (e.g., public order, runaway, beyond control, truancy, etc.), were fairly prevalent in both of these groups as well. Although nonsignificant, Comparison youth had a greater likelihood of prior adjudications (DC= 50.8%, C=53.4%). However, Drug Court youth had a greater likelihood of prior drug charges (35.4% vs. 23.6%) than comparison youth. This difference was statistically significant. The Comparison group had a significantly greater prevalence of gang involvement (DC=12.7%, C=17.2%). However, Drug Court youth had significantly more instances of out-of-school suspensions, and truancy. Significant

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differences between the groups were not identified for running away, family disruption, or school disruption.

The last panel of Table 3 (see p. 43) shows measures for several key court process and motivation variables. Not surprisingly, there were significant differences in the mean number of case hearings (DC=15.3, C=5.1) and status reviews (DC=8.1, C=1.2) for the two groups. Their respective standard deviation values (shown in parentheses in the table) suggest that there was a considerable amount of variation across cases for both groups. There were also significant differences in the number of treatment referrals, drug tests, incentives, and sanctions, with greater mean values for the Drug Court group in each instance. The baseline motivation survey also evidenced significant differences between the groups for all four scales. For example, the mean problem recognition scale score was 28.6 for Drug Court cases and 23.3 for the Comparison group. For the follow-up motivation surveys, only the problem recognition scale evidenced significant differences (DC=29.2, C=27.1); while the desire for help showed close to significant differences. Overall, a greater percentage of Drug Court youth were terminated unsuccessfully relative to those in the comparison group (34.1% vs. 22.4%); successful completion was designated as finishing the probation term in the latter group. Lastly, youth in the Drug Court group had significantly more months at risk to recidivate on average (DC=26.1, C=22.0; calculated from the start date of drug court or probation).

Table 3. Full Sample Description

Variable	**Drug Court Group (n=686) Mean (sd)/%**	**Comparison Group (n=686) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Matching Variables				
Risk Level^				
Low	17.4	6.2	42.09 (2)*	3.0
Moderate	42.3	51.6		
High	40.2	42.3		
Gender				

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Table 3. Full Sample Description				
Variable	**Drug Court Group (n=686) Mean (sd)/%**	**Comparison Group (n=686) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Male	75.5	75.7	.00 (1)	0.0
Female	24.5	24.3		
Race				
White	59.3	56.1	5.87 (5)	2.3
Black	8.4	11.5		
Hispanic	28.8	29.2		
Other	3.4	3.2		
Alcohol Use Frequency				
Daily	4.6	5.7	10.13 (2)*	28.6
Once a week or more	28.3	19.5		
Less than once a week	67.2	74.7		
Drug Use Frequency				
Daily	31.7	24.3	12.14 (2)*	21.4
Once a week or more	41.8	40.4		
Less than once a week	26.4	35.3		
Other Baseline Variables				
Age	16.1 (1.12)	16.2 (1.31)	-2.89 (1337.60)	0.1
Highest Grade Completed	9.4 (1.55)	9.4 (1.81)	-.50 (1132.56)	13.8
Offense Level				
Felony	29.7	32.7	10.54 (2)*	0.2
Misdemeanor	52.4	55.7		
Status	17.9	11.7		
Offense Type				
Personal	8.4	21.7	68.68 (7)*	0.6
Property	24.1	25.0		
Drug/Alcohol	42.9	31.2		
Weapons	3.1	3.8		
Sex Offenses	.4	1.0		
Probation Violations	6.8	2.8		
Other	14.4	14.5		
Prior Adjudications (1=Yes)	50.8	53.4	.88 (1)	1.8
Previous Drug Charge (1=Yes)	35.4	23.6	22.59 (1)*	0.7
Gang Involvement (1=Yes)	12.7	17.2	5.24 (1)*	1.5
Runaway History (1=Yes)	23.2	24.3	.25 (1)	3.0
Rating of Family Disruption				
Frequent	23.5	26.9	2.44 (2)	13.8
Situational/minor	37.2	37.4		
None	39.4	35.7		
Prior Out-of-School Suspension (1=Yes)	46.1	39.9	5.05 (1)*	5.2
Truancy Record (1=Yes)	58.2	49.2	10.71 (1)*	4.4
Rating of School Disruption				
Frequent	34.8	32.3	1.05 (2)	13.8
Situational/minor	36.3	36.6		
None	28.9	31.2		

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Table 3. Full Sample Description				
Variable	**Drug Court Group (n=686) Mean (sd)/%**	**Comparison Group (n=686) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Drug of Choice				
Alcohol	23.5	22.4	8.39 (2)*	7.2
Marijuana	71.1	75.2		
Other	5.4	2.3		
Age of First Alcohol Use	13.4 (1.75)	13.5 (1.64)	-.61 (826)	39.7
Age of First Drug Use	13.5 (3.43)	13.5 (1.69)	-.32 (931)	32.0
Previous D/A Treatment (1=Yes)	23.5	17.3	7.88 (1)*	3.8
MH Treatment Ever (1=Yes)	37.6	28.7	10.66 (1)*	12.2
Court Process and Motivation				
Number of Case Hearings	15.3 (15.64)	5.1 (4.53)	15.42 (695.07)*	10.1
Number of Status Reviews	8.1 (9.88)	1.2 (3.25)	15.62 (674.02)*	17.9
Number of Treatment Referrals	3.2 (4.61)	1.4 (3.75)	8.27 (1315.98)*	0.0
Number of Drug Tests	42.2 (32.58)	9.6 (11.70)	16.62 (858.78)*	0.0
Number of Incentives	5.12 (6.69)	.33 (1.65)	18.22 (768.23)*	0.0
Number of Sanctions	3.6 (4.97)	1.6 (2.38)	9.90 (984.87)*	0.0
Motivation Scale Scores – Baseline				
Problem recognition scale	28.6 (8.97)	23.3 (8.82)	7.30 (731)*	46.6
Desire for help	32.7 (8.59)	27.3 (7.91)	8.08 (379.06)*	45.6
Treatment readiness	33.3 (8.76)	29.1 (7.52)	6.40 (407.12)*	44.5
Treatment pressure	32.7 (6.04)	30.1 (7.36)	4.34 (294.35)*	46.7
Motivation Scale Scores – 180 Day				
Problem recognition scale	29.2 (9.32)	27.1 (7.28)	.98 (299)*	78.1
Desire for help	33.0 (8.23)	29.2 (9.24)	1.91 (304)	77.7
Treatment readiness	32.3 (8.95)	31.3 (5.67)	.46 (310)	77.3
Treatment pressure	32.1 (6.56)	30.2 (6.52)	1.25 (300)	78.0
Termination Status				
Successful	60.4	63.0	63.67 (8)*	1.1
Unsuccessful	34.1	22.4		
Data collection ended	2.3	11.7		
Expiration of term	1.2	1.3		
Other	2.1	1.5		
Time at Risk (months)	26.1 (10.06)	22.0 (13.89)	6.12 (1248.80)*	0.2

Notes: *in t/X^2 indicates statistically significant difference at $p<.05$
t = t-statistic used for comparisons between scores or other continuous measures (e.g., age)
X^2= Chi Square statistic used for comparisons between categorical measures (e.g., any prior drug charges)
sd = standard deviation; df = degree of freedom
^One site did not use a risk assessment (Rhode Island); a proxy measure was used for these youth. Please refer to page 78 of this report. Seven different risk instruments were used across the remaining eight sites. Two Ohio sites also switched their assessment tool during the project. Common risk levels across all of these measures were combined into the ratings of low, medium, and high.

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Site-by-Site Descriptives and Results

Ada County, Idaho

Site Description

The juvenile drug court is considered a substance abuse and mental health program offered within the Clinical Services Division of the Ada County Juvenile Court. Referrals are made through judges, attorneys, and probation officers. The court operates as a pre-adjudication/disposition program. A total of 42 youth were enrolled in the Drug Court group and 42 youth were enrolled in the Comparison group. Comparison group youth were selected from traditional probation. Twenty-eight youth were enrolled in the Comparison group using a blanket consent process. Data collection for the study was performed by on-site contractors throughout the course of the study.

The Ada County Juvenile Drug Court has been in operation since 2003 and is funded by the state of Idaho. Youth range in age from 14 to 18 and must evidence drug abuse issues. Only Ada County residents are eligible for the program. The drug court requires clients to progress through four phases of treatment lasting a minimum of nine months. Phase 1 youth spend an average of seven to eight hours in drug court programming per week. Phase 2 youth average five to six hours in drug court programming per week. Phase 3 youth average four to five hours in drug court programming per week. Phase 4 youth average two to three hours in drug court programming per week. The drug court relies on the following techniques to supervise youth in the program: curfew, drug and alcohol testing, participation in school or work, and attendance at court. The drug court does not utilize any referral agencies; it provides all required treatment to drug court participants. The drug court employs five treatment staff that provide all group and individual treatment. The treatment consists of the following components: drug education, three

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substance abuse groups (Foundations of Recovery, Everyday Living, and Recovery Enhancement), a family education group, individual counseling, and family counseling.

Sample Description

Looking at the matching variables in Ada, there were no significant differences across the Drug Court (DC; n=42) and Comparison (C; n=42) groups. There was a roughly 60%-40% split in terms of males and females, and the vast majority of youth (over 90% in both groups) were white. Overall, the majority of youth fell in the moderate or high risk groups based on the risk assessment used by this site. There was a relatively greater prevalence of low risk youth in the Drug Court group (11.9%) than the Comparison group (2.4%), and there were some differences in the substance use frequency across groups. For example, more Comparison group youth used drugs daily (40.5%) than in the Drug Court group (22.0%). In general, the drug use frequency was far higher than alcohol use for Ada youth.

As shown in the second section of Table 4, marijuana was the overwhelming drug of choice for both the Drug Court (78.6%) and Comparison (83.3%) groups. The age of first use for alcohol (DC=13.1 years, C=13.8 years) and drugs (DC=12.8 years, C=13.6 years) are roughly comparable for both groups and indicate that these youth generally started using substances early in adolescence. A fairly sizeable minority of youth in both groups had previous drug abuse treatment (DC=41.5%, C=30.8%) and/or mental health treatment (DC=28.6%, C=38.7%).

Looking at other baseline variables, the average age was substantially higher for Comparison youth (17.0 vs. 16.0 for Drug Court group). The vast majority of cases in both groups were misdemeanor offenses and felonies comprised less than 10 percent of cases in both groups. The primary offense types were property (DC=33.3%, C=19.5%) and drug and alcohol offenses (DC=38.1%, C=43.9%) in both groups. Other offenses (public order, runaway, beyond

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control) were fairly prevalent in these groups as well. Although the differences were not statistically significant, Drug Court youth had a greater likelihood of prior adjudication (83.3% vs. 70.0%) and prior drug charges (57.1% vs. 51.2%) than Comparison youth. In addition, the Comparison group youth had a greater prevalence of gang involvement, running away, family disruption, school disruption, out-of-school suspension, and truancy than Drug Court youth. In some cases, such as the family and school disruption measures, these differences were statistically significant.

The last panel of Table 4 (see p. 48) shows measures for several key court process and motivation variables. Not surprisingly, there were significant differences in the mean number of case hearings (DC=27.9, C=6.5) and status reviews (DC=12.8, C=0.77) for the two groups. The respective standard deviation values (shown in parentheses in the table) suggest that there was a considerable amount of variation across cases for both groups. There were also significant differences in the number of treatment referrals, drug tests, incentives, and sanctions with greater mean values for the Drug Court group in each instance. Generally, the baseline motivation scores were significantly greater for the Drug Court group as compared to the Comparison group. For example, the mean problem recognition scale score was 34.2 for Drug Court cases and 23.4 for the Comparison group. Overall, a slightly greater percentage of Drug Court youth were terminated unsuccessfully relative to those in the Comparison group (50.0% vs. 35.0%); in the latter group successful completion was designated as finishing the probation term. Lastly, youth in the Drug Court group had almost double the time at risk to recidivate (DC=23.9, C=13.4 months).

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Table 4. Ada County Site Description

Variable	Treatment Group (n=42) Mean (sd)/%	Comparison Group (n=42) Mean (sd)/%	t /X^2 (df)	% Missing
Matching Variables				
Risk Level^				
Low	11.9	2.4	3.83 (2)	0.0
Moderate	78.6	92.9		
High	9.5	4.8		
Gender				
Male	57.1	59.5	.05 (1)	0.0
Female	42.9	40.5		
Race				
White	92.9	90.5	1.01 (4)	0.0
Black	2.4	2.4		
Hispanic	2.4	2.4		
Other	2.4	4.8		
Alcohol Use Frequency				
Daily	0.0	3.2	2.66 (2)	15.5
Once a week or more	40.0	25.8		
Less than once a week	60.0	71.0		
Drug Use Frequency				
Daily	22.0	40.5	3.45 (2)	7.1
Once a week or more	51.2	43.2		
Less than once a week	26.8	16.2		
Other Baseline Variables				
Age	16.0 (1.18)	17.0 (1.06)	-3.92 (82.0)*	0.0
Highest Grade Completed	9.2 (1.78)	8.4 (3.86)	1.131 (40.20)	17.9
Offense Level				
Felony	9.5	9.5	.11 (2)	0.0
Misdemeanor	78.6	76.2		
Status	11.9	14.3		
Offense Type				
Personal	9.5	7.3	4.23 (5)	1.2
Property	33.3	19.5		
Drug/Alcohol	38.1	43.9		
Probation Violations	2.4	0.0		
Other	16.7	29.3		
Prior Adjudications (1=Yes)	83.3	70.0	2.05 (1)	2.4
Previous Drug Charge (1=Yes)	57.1	51.2	.29 (1)	1.2
Gang Involvement (1=Yes)	0.0	10.0	4.42 (1)*	2.4
Runaway History (1=Yes)	38.1	47.5	.74 (1)	2.4
Rating of Family Disruption				
Frequent	14.6	63.2	19.82 (2)*	6.0
Situational/minor	43.9	21.1		
None	41.5	15.8		
Prior Out-of-School Suspension (1=Yes)	7.3	43.2	13.62 (1)*	7.1
Truancy Record (1=Yes)	50.0	67.6	2.50 (1)	6.0
Rating of School Disruption				

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Table 4. Ada County Site Description				
Variable	**Treatment Group (n=42) Mean (sd)/%**	**Comparison Group (n=42) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Frequent	22.0	60.5	14.05 (2)*	6.0
Situational/minor	34.1	26.3		
None	43.9	13.2		
Drug of Choice				
Alcohol	14.3	11.9	.35 (2)	0.0
Marijuana	78.6	83.3		
Other	7.1	4.8		
Age of First Alcohol Use	13.1 (2.07)	13.8 (1.96)	-1.33 (58)	28.6
Age of First Drug Use	12.8 (2.18)	13.6 (1.88)	-1.52 (70)	14.3
Previous D/A Treatment (1=Yes)	41.5	30.8	.99 (1)	4.8
MH Treatment Ever (1=Yes)	28.6	38.7	.76 (1)	21.4
Court Process and Motivation				
Number of Case Hearings	27.9 (16.97)	6.5 (7.12)	7.14 (47.51)*	8.3
Number of Status Reviews	12.8 (22.28)	.77 (2.25)	3.34 (39.16)*	22.6
Number of Treatment Referrals	3.6 (1.82)	1.4 (1.21)	6.42 (71.19)*	0.0
Number of Drug Tests	85.8 (46.65)	16.1 (15.28)	9.20 (49.70)*	0.0
Number of Incentives	15.9 (9.32)	1.4 (4.45)	9.10 (58.72)*	0.0
Number of Sanctions	6.9 (7.48)	.14 (.93)	5.78 (42.26)*	0.0
Motivation Scale Scores – Baseline				
Problem recognition scale	34.2 (8.92)	23.4 (8.63)	3.59 (42)*	47.6
Desire for help	37.8 (8.88)	28.8 (7.27)	3.03 (42)*	47.6
Treatment readiness	36.7 (6.95)	31.1 (6.47)	2.43 (44)*	45.2
Treatment pressure	35.5 (4.82)	32.9 (7.36)	1.15 (14.47)	45.2
Motivation Scale Scores – 180 Day				
Problem recognition scale	32.8 (9.78)	42.8 (.79)	-1.41 (20)	73.8
Desire for help	38.0 (5.89)	45.8 (3.54)	-1.82 (20)	73.8
Treatment readiness	36.7 (5.83)	44.4 (2.65)	-1.81 (21)	72.6
Treatment pressure	34.6 (5.65)	36.7 (4.71)	-.50 (21)	72.6
Termination Status				
Successful	47.6	57.5	7.67 (5)	2.4
Unsuccessful	50.0	35.0		
Data collection ended	0.0	2.5		
Expiration of term	2.4	0.0		
Other	0.0	5.0		
Time at Risk	23.9 (9.95)	13.4 (7.56)	5.47 (76.53)*	0.0

Notes: *in t/X^2 indicates statistically significant difference at probability<.05
t = t-statistic used for comparisons between scores or other continuous measures (e.g., age)
X^2= Chi Square statistic used for comparisons between categorical measures (e.g., any prior drug charges)
sd = standard deviation; df = degree of freedom
^Youth were screened using the YLS/CMI

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Clackamas County, Oregon

Site Description

The juvenile drug court operates as a subdivision within the Clackamas County Juvenile Department. Referrals are made through the probation department. The court operates as a pre-adjudication/disposition program. A total of 36 youth were enrolled in the Drug Court group and 36 youth were enrolled in the Comparison group. Comparison group youth were selected from traditional probation. Twenty-six youth were enrolled in the Comparison group using a blanket consent process. Data collection for the study was performed by on-site contractors throughout the course of the study.

The Clackamas County Juvenile Drug Court has been in operation since 2001. The drug court is funded by Clackamas County. Youth range in age from 14 to 18 and must evidence drug abuse issues. Only Clackamas County residents are eligible for the program. The drug court requires clients to progress through four phases of treatment designed to last seven to eight months. Phase 1 youth spend an average of seven to eight hours in drug court programming per week. Phase 2 youth average five to six hours in drug court programming per week. Phase 3 youth average four to five hours in drug court programming per week. Phase 4 youth average two to three hours in drug court programming per week. The drug court relies on the following supervision techniques to monitor youth in the program: curfew, drug and alcohol testing, participation in school or work, participation in substance abuse treatment, and attendance at court. Treatment for youth in the drug court is provided by both county employees and outside referral agencies. The Girls Skills Group is run by a county employee. Two referral agencies, Tim O'Brien, LPC and Wright Counseling and Consultation Services, LLC, provide parenting groups, family treatment, and youth substance abuse treatment to groups and individuals.

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Sample Description

Looking at the matching variables in Clackamas, there was one significant difference across the Drug Court (DC; n=36) and Comparison (C; n=36) groups; the frequency of their drug use. There was a roughly 86%-14% split in terms of males and females and, in both groups, the vast majority of youth (83.3%) were white. None of the youth in the Drug Court or Comparison groups were low risk, and there was almost an even split between moderate and high risk youth in the groups. Concerning the use of alcohol, drug court youth are more likely to use alcohol either daily or once a week or more. However, the groups were not significantly different concerning frequency of alcohol use. The one significant difference in the matching variables is evidenced in the frequency of drug use. For example, more youth in the Drug Court group used drugs once a week or more (41.2%) than the Comparison group (15%). In general, the drug use frequency was far higher than alcohol use for all of the Clackamas youth.

As shown in the second section of the table (labeled Other Baseline Variables), marijuana was the overwhelming drug of choice for both the Drug Court (66.8%) and Comparison (73.1%) groups. The age of first use for alcohol (DC=11.9 years, C=12.7 years) and drugs (DC=12.1 years, C=12.2 years) are comparable for both groups and indicate that these youth generally started using substances early in adolescence. A fairly sizeable minority of youth in both groups had previous drug abuse treatment (DC=30.6%, C=40.0%). Additionally, youth in the Comparison group were significantly more likely to have had prior mental health treatment (DC=40.6%, C=72.7%).

Looking at other baseline variables, the average age for these youth was roughly 16 years old with a significantly higher age for Comparison group youth (16.8 vs. 16.0 for Drug Court group). None of the youth in the Drug Court or Comparison group were referred for status

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offenses. Drug Court youth were significantly more likely to have felony level offenses than the Comparison group youth. For example, 83.3% of Drug Court youth were referred for felony offenses, while only 41.7% of Comparison youth were referred for felony offenses. Significant differences between the two groups are also observed in the type of offense committed. Youth in the Drug Court group had more referrals for property (DC=54.3%, C=30.6%) and drug and alcohol offenses (DC=40.0%, C=19.4%), while Comparison group youth had more personal offenses (DC=2.9%, C=33.3%) and other offenses (DC=0.0%, C=8.4%; these other offenses were mostly public order offenses). Youth in the Comparison group had a greater likelihood of prior adjudication (67.6% vs. 37.1%). Although nonsignificant, Drug Court group youth had more prior drug charges (63.6% vs. 45.7%) than Comparison youth. Other significant differences between the groups included a greater rate of family disruption and a higher number of out-of-school suspensions for Drug Court youth, and a more severe rating of school disruption for Comparison youth. In general, the two groups of youth evidenced little difference on other baseline variables such as gang involvement, running away, and truancy record.

The last panel of Table 5 (see p. 53) shows measures for several key court process and motivation variables. Not surprisingly, there were significant differences in the mean number of case hearings (DC=19.2, C=6.1) and status reviews (DC=18.6, C=0.0) for the two groups. The respective standard deviation values (shown in parentheses in the table) suggest that there was a considerable amount of variation across cases for both groups. There were also significant differences in the number of treatment referrals, drug tests, and incentives. However, no difference was found in the number of sanctions administered across the groups. In general, the baseline motivation scores were greater for the Drug Court group compared to the Comparison youth (statistical significance was reached only on the problem recognition scale). Clackamas

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County youth enrolled in the study varied greatly in their completion of either drug court or probation. A much greater percentage of Drug Court youth were designated as unsuccessful relative to those in the Comparison group (50.0% vs. 19.4%); successful completion was designated as finishing the probation term in the latter group. Concerning time at risk to recidivate, Drug Court youth had almost twice the number of months at risk in the community (DC=23.0; C=13.1).

Table 5. Clackamas County Site Description

Variable	Treatment Group (n=36) Mean (sd)/%	Comparison Group (n=36) Mean (sd)/%	t /X^2 (df)	% Missing
Matching Variables				
Risk Level^				
Medium	50.0	52.8	.06 (1)	0.0
High	50.0	47.2		
Gender				
Male	86.1	86.1	.00 (1)	0.0
Female	13.9	13.9		
Race				
White	83.3	83.3	1.14 (3)	0.0
Black	5.6	5.6		
Hispanic	11.1	8.3		
Other	0.0	2.8		
Alcohol Use Frequency				
Daily	6.1	0.0	4.67 (2)	26.4
Once a week or more	57.6	35.0		
Less than once a week	36.4	65.0		
Drug Use Frequency				
Daily	55.9	60.0	8.29 (2)*	25.0
Once a week or more	41.2	15.0		
Less than once a week	2.9	25.0		
Other Baseline Variables				
Age	16.0 (1.01)	16.8 (1.09)	-3.29 (70)*	0.0
Highest Grade Completed	7.9 (3.16)	9.3 (3.22)	-1.14 (27)	59.7
Offense Level				
Felony	83.3	41.7	13.33(1)*	0.0
Misdemeanor	16.7	58.3		
Offense Type				
Personal	2.9	33.3	17.76 (5)*	1.4
Property	54.3	30.6		
Drug/Alcohol	40.0	19.4		
Weapons	2.9	8.3		
Other	0.0	8.4		

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Table 5. Clackamas County Site Description				
Variable	**Treatment Group (n=36) Mean (sd)/%**	**Comparison Group (n=36) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Prior Adjudications (1=Yes)	37.1	67.6	6.43 (1)*	4.2
Previous Drug Charge (1=Yes)	63.6	45.7	2.20 (1)	5.6
Gang Involvement (1=Yes)	5.6	6.5	.02 (1)	6.9
Runaway History (1=Yes)	38.9	27.8	1.00 (1)	0.0
Rating of Family Disruption				
Frequent	52.8	50.0	6.89 (2)*	0.0
Situational/minor	47.2	33.3		
None	0.0	16.7		
Prior Out-of-School Suspension (1=Yes)	61.1	24.2	9.52 (1)*	4.2
Truancy Record (1=Yes)	52.8	52.9	.00 (1)	2.8
Rating of School Disruption				
Frequent	11.1	36.1	6.29 (2)*	0.0
Situational/minor	86.1	61.1		
None	2.8	2.8		
Drug of Choice				
Alcohol	8.3	19.2	4.03 (2)	13.9
Marijuana	66.8	73.1		
Other	25.0	7.7		
Age of First Alcohol Use	11.9 (2.42)	12.7 (2.08)	-1.25 (49)	29.2
Age of First Drug Use	12.1 (2.04)	12.2 (2.49)	-.21 (50)	27.8
Previous D/A Treatment (1=Yes)	30.6	40.0	.64 (1)	8.3
MH Treatment Ever (1=Yes)	40.6	72.7	5.40 (1)*	25.0
Court Process and Motivation				
Number of Case Hearings	19.2 (7.89)	6.1 (3.60)	9.07 (49.25)*	1.4
Number of Status Reviews	18.6 (8.46)	0.0 (0.00)	11.81 (28)*	48.6
Number of Treatment Referrals	18.2 (11.03)	11.7 (11.51)	2.44 (70)*	0.0
Number of Drug Tests	59.2 (26.30)	14.1 (21.81)	7.91 (70)*	0.0
Number of Incentives	8.67 (4.31)	4.17 (3.32)	4.97 (70)*	0.0
Number of Sanctions	4.1 (3.34)	5.6 (5.15)	-1.47 (70)	0.0
Motivation Scale Scores – Baseline				
Problem recognition scale	29.8 (7.26)	23.2 (8.92)	2.17 (34)*	50.0
Desire for help	32.6 (8.75)	27.1 (7.96)	1.60 (36)	47.2
Treatment readiness	33.0 (8.63)	23.1 (8.61)	2.89 (36)	47.2
Treatment pressure	36.4 (4.32)	33.1 (8.23)	1.09 (8.13)	50.0
Motivation Scale Scores – 180 Day				
Problem recognition scale	30.4 (5.50)	--	--	84.7
Desire for help	30.3 (3.81)	--	--	83.3
Treatment readiness	33.4 (7.78)	--	--	83.3
Treatment pressure	34.7 (8.96)	--	--	83.3
Termination Status				
Successful	44.4	66.7	17.6 (3)*	0.0
Unsuccessful	50.0	19.4		
Data collection ended	5.6	13.9		
Time at Risk	23.0 (11.40)	13.1 (7.98)	4.25 (62.67)*	NEED

Notes: *in t/X^2 indicates statistically significant difference at probability<.05
t = t-statistic used for comparisons between scores or other continuous measures (e.g., age)

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X^2= Chi Square statistic used for comparisons between categorical measures (e.g., any prior drug charges)
sd = standard deviation; df = degree of freedom
^Youth were screened using the Juvenile Crime Prevention Instrument (JCP)
--Motivation surveys were not distributed to comparison youth at the 180 day follow-up

Jefferson County, Ohio

Site Description

The juvenile drug court operates under the Jefferson County Juvenile Court. Referrals are made through judges, attorneys, and probation officers. The court operates as both a pre- and post-adjudication program. A total of 50 youth were enrolled in the Drug Court group and 50 youth were enrolled in the Comparison group. Comparison group youth were sampled from traditional probation. None of the youth in Jefferson were enrolled in the comparison group using a blanket consent process. Data collection for the study was performed by the University of Cincinnati CCJR staff.

The Jefferson County Juvenile Drug Court has been in operation since 2003. The drug court is funded through the Ohio Department of Youth Services Juvenile Accountability Incentive Block Grant (JAIBG) program. Youth range in age from 14 to 18 and must evidence drug abuse issues. Only Jefferson County residents are eligible for the program. The drug court has two different tracks for youth based upon their substance dependency level. Track I: Basic Education requires eight, hour long drug education/intervention classes, one AA/NA meeting per week, random urine drug screens, 90 consecutive clean days, acceptable academic performance, and gainful employment or other structured activity. Track I is designed to last three to six months, and youth spend an average of two hours per week in drug court programming. Track II: Intensive Outpatient requires clients to progress through three phases of treatment designed to last six to nine months. Phase 1 youth spend an average of nine hours in drug court programming

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per week. Phase 2 youth average four hours in drug court programming per week. Phase 3 youth average three hours in drug court programming per week.

The drug court relies on the following techniques to supervise youth in the program: weekly drug and alcohol testing, participation in school or work, participation in substance abuse treatment, school and home visits, and monthly attendance at court. Treatment for youth in the drug court is provided by four outside referral agencies. The referral agencies are Trinity Behavioral Medicine (group substance abuse treatment sessions), Family Services Association (individual counseling for boys, youth life skills, and family counseling), Jefferson Behavioral Health Services (individual counseling for girls, youth life skills, and family counseling), and Ezra Academy and Center for Treatment Services (residential substance abuse services).

Sample Description

In examining the matching variables in Jefferson, there were no significant differences across the Drug Court (DC; n=50) and Comparison (C; n=50) groups. There was a roughly 60%-40% split in terms of males and females, and the vast majority of youth were white. There were slightly more nonwhite youth in the Comparison group, a difference that was close to reaching statistical significance. Few of the youth in the Drug Court or Comparison groups were low risk (6.0% vs. 0%); and most youth in both groups had moderate risk to reoffend. Concerning the use of alcohol, both groups of youth predominantly used alcohol less than once a week and both groups evidenced much more frequent use of drugs. Daily drug use was more prevalent in the Drug Court versus the Comparison group (35.9% vs. 12.5%), while more Comparison youth used drugs at least once a week than the Drug Court youth (50.0% vs. 25.6%). In general, the drug use frequency was far higher than alcohol use for all of the Jefferson youth.

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As shown in the second section of the table (labeled Other Baseline Variables), marijuana was the overwhelming drug of choice for Drug Court youth (71.1%) while Comparison youth chose either alcohol (31.3%) or marijuana (56.3%). Youth in the two groups varied significantly in their drug of choice. The age of first use for alcohol (DC=13.5 years, C=14.0 years) and drugs (DC=13.5 years, C=13.3 years) are comparable for both groups and indicate that these youth generally started using substances early in adolescence. It was uncommon for any youth in Jefferson to have had previous drug abuse treatment (DC=14.6%, C=5.6%). However, a substantial portion of youth in both groups had prior mental health treatment (DC=40.5%, C=58.1%).

Looking at other baseline variables, the average age for youth was roughly 16 years old (DC=16.2, C=15.7). Few of the youth in the Drug Court or Comparison group were referred for status offenses (14.0% vs. 10%). Drug Court youth were more likely to have felony level offenses than the Comparison group youth, though this difference was not significant. Specifically, 46.0% of Drug Court youth were referred for felony offenses, while only 26.0% of Comparison youth were referred for felony offenses. Significant differences between the two groups were observed in the type of offense committed. Youth in the Drug Court group had more referrals for drug and alcohol offenses (DC=74.0%, C=20.0%), while Comparison group youth had more personal offenses (DC=4.0%, C=30.0%), and property offenses (DC=2.0%, C=34.0%). Both sets of youth had 16% of offenses labeled as other offenses. Examples of other offenses for these youth include public order, wayward, and truancy charges. Although nonsignificant, youth in the Comparison group had more prior adjudications (65.3% vs. 46.0%). Concerning the other baseline variables, few differences can be noted between the Drug Court and Comparison groups on prevalence of prior drug charges, gang involvement, running away, family disruption, and

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out-of-school suspensions. Youth in the Comparison group had higher rates of school disruption, which approached a statistical significance.

The last panel of Table 6 (see p. 59) shows measures for several key court process and motivation variables. Not surprisingly, there were significant differences in the mean number of case hearings (DC=5.1, C=3.4) and status reviews (DC=7.5, C=3.0) for the two groups. The respective standard deviation values (shown in parentheses in the table) suggest that there was a considerable amount of variation within the two groups in Jefferson. There were also significant differences between the groups in the number of treatment referrals, drug tests, and incentives. However, no statistical difference was found in the number of sanctions administered across the groups. In general, the baseline motivation scores were greater for the Drug Court group relative to the Comparison group. Statistically significant differences were identified in two of the four scales included in the motivation instrument. For example, the mean problem recognition scale score was 26.3 for Drug Court cases and 20.0 for the Comparison group. Jefferson County youth enrolled in the study did not vary greatly in their completion of either drug court or probation. Slightly more Drug Court youth were designated as successful relative to those in the comparison group (86.0% vs. 67.3%). Finally, youth in the Drug Court group had a substantially longer time at risk in the community than youth in the Comparison group.

Table 6. Jefferson County Site Description

Variable	**Treatment Group (n=50) Mean (sd)/%**	**Comparison Group (n=50) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Matching Variables				
Risk Level^				
Low	6.0	0.0	4.27 (2)	4.0
Moderate	70.0	63.0		
High	24.0	37.0		
Gender				
Male	66.0	60.0	.39 (1)	0.0
Female	34.0	40.0		

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Table 6. Jefferson County Site Description				
Variable	**Treatment Group (n=50) Mean (sd)/%**	**Comparison Group (n=50) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Race				
White	83.7	61.2	5.73 (2)	8.0
Black	11.6	26.5		
Other	4.7	12.2		
Alcohol Use Frequency				
Daily	3.2	0.0	.41 (2)	63.0
Once a week or more	3.2	0.0		
Less than once a week	93.5	100.0		
Drug Use Frequency				
Daily	35.9	12.5	2.46 (2)	53.0
Once a week or more	25.6	50.0		
Less than once a week	38.5	37.5		
Other Baseline Variables				
Age	16.2 (1.16)	15.7 (1.52)	1.34 (98)*	0.0
Highest Grade Completed	9.5 (1.29)	8.7 (1.55)	2.74 (80.96)*	15.0
Offense Level				
Felony	46.0	26.0	5.88 (2)	0.0
Misdemeanor	40.0	64.0		
Status	14.0	10.0		
Offense Type				
Personal	4.0	30.0	42.08 (5)*	0.0
Property	2.0	34.0		
Drug/Alcohol	74.0	20.0		
Probation Violation	4.0	0.0		
Other	16.0	16.0		
Prior Adjudications (1=Yes)	46.0	65.3	3.74 (1)	1.0
Previous Drug Charge (1=Yes)	6.0	4.1	.19 (1)	1.0
Gang Involvement (1=Yes)	0.0	2.0	1.01 (1)	0.0
Runaway History (1=Yes)	9.3	14.3	.51 (1)	15.0
Rating of Family Disruption				
Frequent	12.8	17.1	2.44 (2)	12.0
Situational/minor	34.0	46.3		
None	53.2	36.6		
Prior Out-of-School Suspension (1=Yes)	33.3	27.0	.36 (1)	24.0
Truancy Record (1=Yes)	46.2	48.6	.048 (1)	24.0
Rating of School Disruption				
Frequent	12.8	29.3	5.77 (2)	38.0
Situational/minor	29.8	36.6		
None	57.4	34.1		
Drug of Choice				
Alcohol	6.5	31.3	6.57 (2)*	38.0
Marijuana	71.7	56.3		
Other	21.7	12.5		
Age of First Alcohol Use	13.5 (1.75)	14.0 (.89)	-1.139 (13.86)	63.0
Age of First Drug Use	13.5 (1.90)	13.3 (1.98)	.39 (45)	53.0

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Table 6. Jefferson County Site Description				
Variable	**Treatment Group (n=50) Mean (sd)/%**	**Comparison Group (n=50) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Previous D/A Treatment (1=Yes)	14.6	5.6	1.75 (1)	16.0
MH Treatment Ever (1=Yes)	40.5	58.1	2.21 (1)	27.0
Court Process and Motivation				
Number of Case Hearings	5.1 (5.39)	3.4 (2.61)	1.98 (71.40)*	2.0
Number of Status Reviews	7.5 (3.87)	3.0 (4.36)	5.31 (92)*	6.0
Number of Treatment Referrals	2.3 (1.07)	.82 (1.02)	6.89 (98)*	0.0
Number of Drug Tests	8.7 (4.36)	.36 (.80)	13.37 (52.31)*	0.0
Number of Incentives	.10 (.30)	0.0 (.00)	2.33 (49.00)*	0.0
Number of Sanctions	1.10 (1.53)	1.4 (2.18)	-.85 (98)	0.0
Motivation Scale Scores – Baseline				
Problem recognition scale	26.3 (9.26)	20.0 (8.39)	2.69 (58)*	40.0
Desire for help	31.8 (8.25)	23.3 (7.74)	3.97 (57)*	41.0
Treatment readiness	32.9 (9.47)	29.3 (6.23)	1.61 (59)	39.0
Treatment pressure	32.8 (6.30)	32.0 (8.71)	.41 (35.97)	39.0
Motivation Scale Scores – 180 Day				
Problem recognition scale	25.3 (10.20)	--	--	87.0
Desire for help	32.3 (7.89)	--	--	87.0
Treatment readiness	33.2 (9.50)	--	--	87.0
Treatment pressure	33.5 (5.91)	--	--	87.0
Termination Status				
Successful	86.0	67.3	6.78 (3)	1.0
Unsuccessful	14.0	24.4		
Data collection ended	0.0	8.2		
Time at Risk	28.7 (9.53)	24.1 (8.93)	2.48 (98)*	0.0

Notes: *in t/χ^2 indicates statistically significant difference at probability<.05
t = t-statistic used for comparisons between scores or other continuous measures (e.g., age)
χ^2 = Chi Square statistic used for comparisons between categorical measures (e.g., any prior drug charges)
sd = standard deviation; df = degree of freedom
^Youth were screened using the SAVRY
-- Motivation surveys were not distributed to comparison youth at the 180 day follow-up

Lane County, Oregon

Site Description

The juvenile drug court, also known as the "Recovery and Progress (RAP)" court, operates as a subdivision within the Lane County Juvenile Court. Referrals are made through juvenile probation counselors. The court operates as a pre- and post-adjudication program. A total of 48 youth were enrolled in the Drug Court group and 48 youth were enrolled in the Comparison group. Four sets of matched cases had to be dropped from the data analysis due to

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data collector error. This resulted in 44 youth in both the Drug Court and Comparison groups. Comparison group youth were sampled from traditional probation. Thirty-six youth were enrolled in the comparison group using a blanket consent process. Data collection for the study was performed by on-site contractors throughout the course of the study.

The Lane County Juvenile Drug Court has been in operation since 2000. The drug court is funded through general funds from the county and donations from a foundation. Youth range in age from 13 to 17 and must evidence drug abuse issues. Violent and sex offenders are excluded from participation. The drug court requires clients to progress through four phases of treatment lasting a minimum of seven months, with an average of nine to 12 months. The focus in Phase 1 is behavior compliance; youth must attend weekly court hearings, complete an alcohol and drug assessment, and submit random drug screens. The focus in Phase 2 is treatment; youth must attend court hearings every other week, participate in treatment, and continue random drug screens. The focus in Phase 3 is on completing treatment requirements; youth must attend court hearings every two to three weeks, continue treatment, and begin working on an aftercare plan. The focus in the final phase is transition; youth must attend court every three weeks, complete and follow an aftercare plan, and complete a written assignment outlining their commitment to staying crime and substance free. The drug court relies on the following techniques to supervise youth in the program: curfew, drug and alcohol testing, and attendance at court. The drug court utilizes the following five treatment programs run by three separate referral agencies: Phoenix Program run by the county; a residential Program (Pathways) and an outpatient program run by Looking Glass Counseling Center; and an outpatient program and day treatment program run by Center for Family Development.

Sample Description

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There were no significant differences across matching variables for the Drug Court (DC; n=44) and Comparison (C; n=44) groups. There was a roughly 65%-35% split in terms of males and females, and the vast majority of youth were white. Youth in the Drug Court and Comparison groups split across three risk levels with 41.9% of youth in the Drug Court group identified as high risk and 57.1% of youth in the Comparison group identified as high risk. Concerning the use of alcohol, Comparison youth were more likely to use alcohol either daily or once a week or more. However, the groups were not significantly different concerning frequency of alcohol use. More youth in the Drug Court group used drugs at least once a week or more (daily=28.6% and once a week or more=50.0%) than the Comparison group (daily=25.8% and once a week or more=45.2%). In general, the drug use frequency was far higher than alcohol use for all of the Lane youth.

As shown in the second section of the table (labeled Other Baseline Variables), marijuana was the overwhelming drug of choice for both the Drug Court (71.4%) and Comparison (86.0%) groups. The age of first use for both alcohol and drugs is almost identical in both groups. These relatively young ages indicate that these youth started using substances early in their adolescent years. A minority of youth in both groups had received either previous drug abuse treatment (DC=36.1%, C=22.0%) or prior mental health treatment (DC=11.1%, C=23.1%).

Looking at other baseline variables, the average age for these youth was roughly 16 years old (DC=16.3 and C=16.1). None of the youth in the Drug Court or Comparison group were referred for status offenses. Drug Court youth were significantly more likely to have low severity offenses than the Comparison group youth. For example, 75.0% of Drug Court youth were referred for misdemeanor offenses, while only 52.3% of Comparison youth were referred for misdemeanor offenses. No significant differences were identified for the type of offense

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committed. A significant proportion of youth in both groups had referrals for property offenses (DC=40.9%, C=54.5%), while youth in the Drug Court group had more drug and alcohol offenses (DC=27.3%, C=15.9%). Prior adjudications were not significantly different between the groups at 15.9% for the Drug Court group and 20.5% for the Comparison group. The Drug Court group had a significantly higher percentage of previous drug charges (DC=40.9%, C=18.2%). Other significant differences between the groups include a greater rate of running away and a higher rate of family disruption for Comparison youth. Generally speaking, the two groups of youth evidenced little difference on other baseline variables such as gang involvement, prior out-of-school suspensions, truancy record, and rating of school disruption.

The last panel of Table 7 (see p. 64) shows measures for several key court process and motivation variables. For Lane, there were no significant differences in the mean number of case hearings (DC=2.5, C=2.6), status reviews (DC=0.10, C=0.20), or treatment referrals for the two groups.[6] Not surprisingly, there were significant differences in the number of drug tests, incentives, and sanctions. In general, the baseline motivation scores were greater for the Drug Court group relative to the Comparison youth, but these differences only reached significance on the desire for help scale (DC=30.5, C=26.3). Lane County youth enrolled in the study did not vary greatly in their completion of either drug court or probation. A slightly greater percentage of Drug Court youth were designated as successful relative to those in the Comparison group (65.1% vs. 57.1%). Lastly, youth in Lane did not differ significantly in their time at risk to recidivate (in months; DC=22.1, C=18.9).

[6] The similarities in case hearings, status reviews, and treatment referrals are most likely due to a data collection error (see the high percentage of missing data for two of the three variables). Based on the site visit at Lane County, Drug Court youth routinely went to court on average twice per month during their time in drug court and were involved in numerous treatment activities.

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Table 7. Lane County Site Description				
Variable	**Treatment Group (n=44) Mean (sd)/%**	**Comparison Group (n=44) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Matching Variables				
Risk Level^				
Low	27.9	19.0	2.04 (2)	3.4
Medium	30.2	23.8		
High	41.9	57.1		
Gender				
Male	63.6	68.2	.20 (1)	0.0
Female	36.4	31.8		
Race				
White	93.2	86.7	1.71 (4)	0.0
Black	2.3	4.4		
Hispanic	2.3	4.4		
Other	2.2	4.5		
Alcohol Use Frequency				
Daily	4.5	7.1	.47 (2)	47.7
Once a week or more	27.3	35.7		
Less than once a week	68.2	57.1		
Drug Use Frequency				
Daily	28.6	25.8	.45 (2)	33.0
Once a week or more	50.0	45.2		
Less than once a week	21.4	29.0		
Other Baseline Variables				
Age	16.3 (1.11)	16.1 (1.14)	.70 (86)	0.0
Highest Grade Completed	9.3 (1.31)	9.3 (1.17)	.074 (45)	46.6
Offense Level				
Felony	25.0	47.7	4.91 (1)*	0.0
Misdemeanor	75.0	52.3		
Offense Type				
Personal	22.7	22.7	3.17 (5)	0.0
Property	40.9	54.5		
Drug/Alcohol	27.3	15.9		
Weapons	2.3	2.3		
Other	6.8	4.5		
Prior Adjudications (1=Yes)	15.9	20.5	.31 (1)	0.0
Previous Drug Charge (1=Yes)	40.9	18.2	5.46 (1)*	0.0
Gang Involvement (1=Yes)	2.3	9.1	1.91 (1)	0.0
Runaway History (1=Yes)	31.0	61.4	7.99 (1)*	2.3
Rating of Family Disruption				
Frequent	22.0	44.2	6.82 (2)*	4.5
Situational/minor	51.2	46.5		
None	26.8	9.3		
Prior Out-of-School Suspension (1=Yes)	73.8	76.7	.10 (1)	3.4
Truancy Record (1=Yes)	81.4	84.1	.11 (1)	1.1
Rating of School Disruption				
Frequent	41.5	53.5	1.22 (2)	4.5

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Table 7. Lane County Site Description				
Variable	**Treatment Group (n=44) Mean (sd)/%**	**Comparison Group (n=44) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Situational/minor	43.9	34.9		
None	14.6	11.6		
Drug of Choice				
Alcohol	23.8	14.0	3.72 (2)	3.4
Marijuana	71.4	86.0		
Other	4.8	0.0		
Age of First Alcohol Use	13.2 (1.42)	13.5 (.93)	-.55 (25)	69.3
Age of First Drug Use	12.7 (1.49)	12.8 (1.37)	-.16 (31)	62.5
Previous D/A Treatment (1=Yes)	36.1	22.0	1.88 (1)	12.5
MH Treatment Ever (1=Yes)	11.1	23.1	1.35 (1)	39.8
Court Process and Motivation				
Number of Case Hearings	2.5 (3.25)	2.6 (2.72)	-.08 (14)	81.8
Number of Status Reviews	.10 (.30)	.20 (.45)	-.08 (14)	81.8
Number Treatment Referrals	1.0 (1.10)	1.4 (1.27)	-1.53 (86)	0.0
Number Drug Tests	22.8 (19.02)	2.8 (4.09)	6.80 (46.97)*	0.0
Number Incentives	1.5 (1.68)	0.0 (.00)	5.93 (43.0)*	
Number Sanctions	1.9 (2.40)	.43 (1.07)	3.62 (59.34)*	0.0
Motivation Scale Scores – Baseline				
Problem recognition scale	26.6 (7.89)	20.0 (4.94)	16.63 (39)	53.4
Desire for help	30.5 (6.52)	26.3 (7.85)	2.12 (41)*	51.1
Treatment readiness	32.0 (5.70)	32.3 (9.54)	.32 (41)	51.1
Treatment pressure	33.4 (6.38)	27.9 (8.32)	1.59 (40)	52.3
Motivation Scale Scores – 180 Day				
Problem recognition scale	25.8 (12.36)	--	--	77.3
Desire for help	29.7 (11.79)	--	--	77.3
Treatment readiness	32.5 (7.53)	--	--	77.3
Treatment pressure	28.6 (8.21)	--	--	78.4
Termination Status				
Successful	65.1	57.1	3.43 (4)	3.4
Unsuccessful	32.6	40.5		
Data collection ended	0.0	2.4		
Other	2.3	0.0		
Time at Risk	22.1 (11.42)	18.9 (9.21)	1.43 (82.30)	

Notes: *in t/X^2 indicates statistically significant difference at probability<.05
t = t-statistic used for comparisons between scores or other continuous measures (e.g., age)
X^2= Chi Square statistic used for comparisons between categorical measures (e.g., any prior drug charges)
sd = standard deviation; df = degree of freedom
^Youth were screened using the Juvenile Crime Prevention Instrument (JCP)
-- Motivation surveys were not distributed to comparison youth at the 180 day follow-up

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Lucas County, Ohio

Site Description

The juvenile treatment court operates as a subdivision of the Lucas County probation department. Referrals are made through the court intake department and probation officers. The court operates as both a diversion and post-adjudication program. A total of 60 youth were enrolled in the Drug Court group and 60 youth were enrolled in the Comparison group. Comparison group youth were sampled from traditional probation. One pair of matched cases had to be removed from the sample due to matching error. None of the Comparison group youth were enrolled via the blanket consent process. Data collection for the study was performed by the University of Cincinnati CCJR staff.

The Lucas County Juvenile Drug Court has been in operation since 2004. At the time of participation in the study, the drug court was largely funded by a Bureau of Justice Assistance (BJA) grant. Youth range in age from 14 to 17.5 and must evidence drug abuse issues. Parents are also court ordered to participate. The drug court requires clients to progress through three phases of treatment lasting a minimum of six months, with an average of eight to nine months. Throughout the drug court program, youth must attend two sober support group meetings per week, as well as any additional treatment to which they are referred. Additional components to the program follow a step-down approach. In Phase 1, youth and parents must attend weekly court hearings, and parents must attend weekly parenting groups. In Phase 2, youth and parents must attend court hearings every other week, and parents must attend parenting groups bimonthly. In the final Phase (3), youth and parents must attend court hearings every three weeks, and parents must continue to attend parenting groups bimonthly. The drug court relies on the following techniques to supervise youth in the program: curfew, drug and alcohol testing, home and school visits, and attendance at court. The drug court utilizes one referral agency for

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substance abuse counseling, Unison Behavioral Health Group. The drug court also provides the following treatment components: Parents Helping Parents, Parent Project, youth AA meetings, and various family counseling.

Sample Description

Considering the matching variables in Lucas, there were no significant differences across the Drug Court (DC; n=59) and Comparison (C; n=59) groups. In fact, only one baseline variable was significantly different (offense type) between the groups. There was a roughly 70%-30% split in terms of males and females, and the vast majority of youth were either white or black. There were slightly more nonwhite youth in the Comparison group, but this was a nonsignificant difference. Few of the youth in the Drug Court or Comparison groups were low risk (16.9% vs. 8.5%), and a majority of youth in both groups were at high risk to reoffend. Concerning the use of alcohol, both groups of youth predominantly used alcohol less than once a week and both groups evidenced much more frequent use of drugs. Daily drug use and at least weekly drug use was more prevalent in the Drug Court versus the Comparison group (daily=44.4% vs. 38.9%, and once a week or more=42.6% vs. 35.2%).

As shown in the second section of the table (labeled Other Baseline Variables), marijuana was the overwhelming drug of choice for both groups of youth (DC=91.5%, C=85.5%). The age of first use for alcohol is the same for both groups (13.7). Age of first use of drugs is lower for the comparison group (DC=14.3, C=13.1), but the difference is nonsignificant. Roughly a quarter of youth in Lucas had previous drug abuse treatment (DC=23.7%, C=22.4%). However, a fairly substantial portion of youth in both groups had prior mental health treatment (DC=62.5%, C=47.4%).

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Looking at the other baseline variables, the average age for these youth was almost equal between the groups (DC=15.7 years, C=15.8 years). Drug Court and Comparison youth varied on level of offense, but not significantly. Drug Court youth had more status and misdemeanor offenses (5.1% and 71.2%) than Comparison youth (0% and 61.0%), and youth in the Comparison group had more felony offenses than the Drug Court group youth (DC=23.7%, C=39.0%). Significant differences between the two groups were observed in the type of offense committed. Youth in the Drug Court group had more referrals for drug and alcohol offenses (DC=42.4%, C=27.1%), while Comparison group youth had more personal offenses (DC=5.1%, C=28.8%). Youth in both groups had a fair portion of offenses that fall into the other category. For Lucas youth, other offenses included obstruction of justice and safe school ordinance. No significant differences for other baseline variables are noted between the Drug Court and Comparison groups on prior adjudications, prior drug charges, gang involvement, running away, family disruption, out-of-school suspensions, truancy record, or school disruption.

The last panel of Table 8 (see p. 69) displays measures for several key court process and motivation variables. Not surprisingly, there were significant differences in the mean number of case hearings (DC=3.4, C=1.9) and status reviews (DC=18.7, C=2.8) for the two groups. There were also significant differences in the number of treatment referrals, drug tests, incentives, and sanctions. In general, the baseline motivation scores were all greater for the Drug Court group relative to the comparison youth (statistical significance was reached on the problem recognition scale and treatment pressure scale). Follow-up surveys were also distributed to both groups of youth at the six-month mark in the study, and significant differences were observed between the groups at the follow-up point in three of the four motivation scales. For example, the mean desire for help scale score was 34.7 for Drug Court cases and 24.3 for the Comparison group. Lucas

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County youth enrolled in the study varied in their completion of either drug court or probation. Slightly more Drug Court youth were terminated unsuccessfully relative to those in the Comparison group (39.6% vs. 16.4%). Drug Court and Comparison youth did not vary significantly in their time at risk to recidivate (DC=25.2, C=22.8).

Table 8. Lucas County Site Description

Variable	Treatment Group (n=59) Mean (sd)/%	Comparison Group (n=59) Mean (sd)/%	t /X^2 (df)	% Missing
Matching Variables				
Risk Level^				
Low	16.9	8.5	2.13 (5)	5.1
Moderate/Regular	37.7	42.4		
High	45.3	49.2		
Gender				
Male	76.3	72.9	.18 (1)	0.0
Female	23.7	27.1		
Race				
White	63.8	54.2	6.04 (4)	0.8
Black	25.9	39.0		
Hispanic	5.2	5.1		
Other	5.2	1.7		
Alcohol Use Frequency				
Daily	2.3	6.5	2.53 (2)	23.7
Once a week or more	29.5	17.4		
Less than once a week	68.2	76.1		
Drug Use Frequency				
Daily	44.4	38.9	2.91 (2)	8.5
Once a week or more	42.6	35.2		
Less than once a week	13.0	25.9		
Other Baseline Variables				
Age	15.7 (1.02)	15.8 (.88)	-.09 (116)	0.0
Highest Grade Completed	8.6 (.98)	8.6 (1.14)	-.01 (112)	3.4
Offense Level				
Felony	23.7	39.0	5.65 (2)	0.0
Misdemeanor	71.2	61.0		
Status	5.1	0.0		
Offense Type				
Personal	5.1	28.8	27.8 (6)*	0.0
Property	23.7	20.3		
Drug/Alcohol	42.4	27.1		
Weapons	0.0	6.8		
Probation Violation	10.2	0.0		
Other	18.7	17.0		
Prior Adjudications (1=Yes)	40.7	52.5	1.67 (1)	0.0
Previous Drug Charge (1=Yes)	31.0	17.2	3.01 (1)	1.7

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Table 8. Lucas County Site Description

Variable	Treatment Group (n=59) Mean (sd)/%	Comparison Group (n=59) Mean (sd)/%	t /X^2 (df)	% Missing
Gang Involvement (1=Yes)	10.2	20.3	2.36 (1)	0.0
Runaway History (1=Yes)	45.6	39.0	.52 (1)	1.7
Rating of Family Disruption				0.0
Frequent	32.2	30.5	1.18 (2)	
Situational/minor	45.8	54.2		
None	22.0	15.3		
Prior Out-of-School Suspension (1=Yes)	69.5	78.0	1.09 (1)	0.0
Truancy Record (1=Yes)	62.7	62.7	.00 (1)	0.0
Rating of School Disruption				
Frequent	32.8	42.4	1.53 (2)	.8
Situational/minor	51.7	40.7		
None	15.5	16.9		
Drug of Choice				
Alcohol	6.8	12.7	1.16 (2)	3.4
Marijuana	91.5	85.5		
Other	1.7	1.8		
Age of First Alcohol Use	13.7 (1.13)	13.7 (1.31)	-.09 (80)	30.5
Age of First Drug Use	14.3 (9.58)	13.1 (1.57)	.89 (104)	10.2
Previous D/A Treatment (1=Yes)	23.7	22.4	.03 (1)	0.8
MH Treatment Ever (1=Yes)	62.5	47.4	2.61 (1)	4.2
Court Process and Motivation				
Number of Case Hearings	3.4 (3.95)	1.9 (1.28)	2.54 (61.32)*	10.2
Number of Status Reviews	18.7 (8.78)	2.8 (3.86)	11.48 (64.77)*	19.5
Number Treatment Referrals	4.7 (1.51)	2.1 (1.75)	8.62 (116)*	0.0
Number Drug Tests	39.6 (16.73)	7.6 (8.41)	13.13 (85.53)*	0.0
Number of Incentives	9.68 (5.32)	.07 (.31)	13.85 (58.41)*	0.0
Number Sanctions	9.1 (7.54)	1.1 (1.83)	7.85 (64.82)*	0.0
Motivation Scale Scores – Baseline				
Problem recognition scale	28.0 (8.33)	20.9 (9.75)	3.42 (77)*	33.1
Desire for help	31.1 (8.49)	27.4 (8.40)	1.91 (77)	33.1
Treatment readiness	29.9 (9.52)	28.3 (8.72)	.76 (80)	30.5
Treatment pressure	34.4 (4.76)	28.3 (8.13)	3.82 (45.76)*	33.9
Motivation Scale Scores – 180 Day				
Problem recognition scale	30.2 (8.60)	25.1 (3.36)	2.82 (28.31)*	58.5
Desire for help	34.7 (7.64)	24.3 (8.86)	3.26 (45)*	60.2
Treatment readiness	33.9 (7.43)	30.2 (2.05)	1.42 (41.30)*	58.5
Treatment pressure	32.5 (5.46)	28.8 (8.03)	1.54 (43)	61.9
Termination Status				
Successful	55.2	72.7	13.42 (5)*	4.2
Unsuccessful	39.6	16.4		
Data collection ended	3.4	7.3		
Expiration of term	0.0	3.6		
Other	1.7	0.0		
Time at Risk	25.2 (12.73)	22.8 (12.34)	1.04 (116)	0.0

Notes: *in t/X^2 indicates statistically significant difference at probability<.05
t = t-statistic used for comparisons between scores or other continuous measures (e.g., age)

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X^2= Chi Square statistic used for comparisons between categorical measures (e.g., any prior drug charges)
sd = standard deviation; df = degree of freedom
^84 youth were screened using a site specific instrument referred to as the "Toledo" and 28 youth were screened using the OYAS; similar risk scores were combined

Medina County, Ohio

Site Description

The juvenile drug court operates under the Probate and Juvenile Division within the Medina County Common Pleas Court. Referrals are made through juvenile court intake services. The court operates as both a diversion and pre- and post-adjudication program. A total of 64 youth were enrolled in the Drug Court group and 64 youth were enrolled in the Comparison group. Comparison group youth were sampled from traditional probation. A total of seven youth were enrolled in the Comparison group using a blanket consent process. Data collection for the study was performed by the University of Cincinnati CCJR staff.

The Medina County Juvenile Drug Court has been in operation since 2004. At the time of the CPC-DC assessment, the drug court was funded by the state of Ohio (through the state legislature initiative RECLAIM Ohio) and a Medina County Drug Abuse Commission grant. Youth range in age from 13 to 18 and must have a drug-related case or charge or test positive for drug use. Only Medina County residents are eligible for the program. Drug trafficking, violent, and sex offenders are excluded from participation. The drug court has two separate tracks: the Non-Intensive Component (NIC) and the Intensive Component (IC). NIC requires clients to progress through three phases of treatment lasting an average of four months. Phase 1 includes individual counseling and four hours weekly of group counseling, as specified by an individual service plan. Phase 2 includes individual counseling and two hours weekly of group counseling, as specified by an individual service plan. In Phase 3, Graduation Phase, youth have no formal counseling schedule, but counseling is available. IC clients progress through three phases,

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averaging 11 total months. Phase 1 youth spend an average of five hours in drug court programming per week, plus family involvement in parent classes. Phase 2 youth average three hours in drug court programming per week, plus parental involvement. In Phase 3, Graduation Phase, youth are not required to attend counseling of any kind (unless otherwise specified). Youth in both components must complete an aftercare interview three months after graduation. The drug court relies on the following techniques to supervise youth in the program: curfew, drug and alcohol testing, participation in school or work, and attendance at court. Treatment for youth in the drug court is provided by outside referral agencies. The referral agencies included in this report are Solutions Behavior Healthcare – Outpatient Services (substance abuse and mental health treatment), Solutions Equine Therapy (equine-assisted psychotherapy), and Camp Integrity (after-school program serving at-risk youth).

Sample Description

There were no significant differences across the Drug Court (DC; n=64) and Comparison (C; n=64) groups on the matching variables. There was a roughly 75%-25% split in terms of males and females, and the vast majority of youth were white. There were slightly more nonwhite youth in the Comparison group, but this was a nonsignificant difference. A small percentage of the youth in the Drug Court and Comparison groups were low risk (18.8% vs. 13.1%), and a majority of youth in both groups were at moderate risk to reoffend. Concerning the use of alcohol, both groups of youth predominantly used alcohol less than once a week, and both groups evidenced more frequent use of drugs. Daily drug use was slightly more prevalent in the Drug Court versus the Comparison group (23.4% vs. 21.1%), while use of drugs at least once a week was more prevalent in the Comparison group (31.6% vs. 19.1%).

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As shown in the second section of the table (labeled Other Baseline Variables), marijuana was the drug of choice for both groups of youth (DC=68.9%, C=74.5%). The age of first use for alcohol (DC=13.7, C=13.0) and drugs (DC=14.3, C=13.6) were comparable for both groups and indicate that these youth generally started using substances early in adolescence and used alcohol before they used drugs. Few youth in Medina had previous drug abuse treatment (DC=11.5%, C=11.7%). However, a fairly substantial portion of youth in both groups had prior mental health treatment (DC=61.0%, C=65.0%).

Looking at other baseline variables, the average age for youth was almost equal between groups (DC=16.1, C=16.0). Drug Court and Comparison youth had significant differences concerning the severity of their offense. Drug Court youth had more misdemeanor offenses (93.8%) than Comparison youth (71.9%), and youth in the Comparison group had more felony offenses than the Drug Court group youth (DC=6.3%, C=21.9%). Significant differences between the two groups were also observed in the type of offense committed. Youth in the Drug Court group had more referrals for drug and alcohol offenses (DC=82.8%, C=32.8%), while Comparison group youth had relatively more personal offenses (DC=1.6%, C=23.4%). Other offenses make up a fairly sizable portion of all offenses for both groups. Other offenses in Medina included truancy, disobedient child, and unruly charges. Other baseline variables with no significant differences included prior adjudications, prior drug charges, gang involvement, running away, family disruption, out-of-school suspensions, or truancy. There were significant differences concerning school disruption, with many more youth in the Drug Court group displaying frequent school disruption.

The last panel of Table 9 (see pp. 74-75) shows measures for several key court process and motivation variables. Not surprisingly, there were significant differences in the mean

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number of case hearings (DC=9.8, C=4.2) and in status reviews (DC=11.9, C=1.4) for the two groups. There were also significant differences in the number of treatment referrals, drug tests, incentives, and sanctions. The baseline motivation scores were all greater for the Drug Court group, but none of these reached statistical significance. Medina County youth enrolled in the study varied in their completion of drug court or probation. Slightly more Drug Court youth were designated as successful relative to those in the Comparison group (75.0% vs. 67.2%). Drug Court youth in Medina had substantially longer period of time to reoffend (DC=32.1, C=24.8).

Table 9. Medina County Site Description

Variable	Treatment Group (n=64) Mean (sd)/%	Comparison Group (n=64) Mean (sd)/%	t /X^2 (df)	% Missing
Matching Variables				
Risk Level^				
Low	18.8	13.1	4.460 (5)	2.3
Moderate	60.9	62.3		
High	20.4	24.6		
Gender				
Male	75.0	76.6	.04 (1)	0.0
Female	25.0	23.4		
Race				
White	98.4	96.5	1.14 (2)	5.5
Black	1.6	1.8		
Other	0.0	1.8		
Alcohol Use Frequency				
Daily	0.0	5.0	2.33 (2)	36.7
Once a week or more	9.8	12.5		
Less than once a week	90.2	82.5		
Drug Use Frequency				
Daily	23.4	21.1	1.77 (2)	33.6
Once a week or more	19.1	31.6		
Less than once a week	57.4	47.4		
Other Baseline Variables				
Age	16.1 (1.13)	16.0 (1.33)	.36 (126)	0.0
Highest Grade Completed	9.1 (1.17)	9.1 (1.60)	-1.05 (93.31)	9.4
Offense Level				
Felony	6.3	21.9	11.41 (2)*	0.0
Misdemeanor	93.8	71.9		
Status	0.0	6.3		
Offense Type				

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Table 9. Medina County Site Description				
Variable	**Treatment Group (n=64) Mean (sd)/%**	**Comparison Group (n=64) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Personal	1.6	23.4	36.28 (5)*	0.0
Property	6.3	18.8		
Drug/Alcohol	82.8	32.8		
Sex	0.0	1.6		
Other	9.4	23.4		
Prior Adjudications (1=Yes)	40.6	56.3	3.13 (1)	0
Previous Drug Charge (1=Yes)	4.8	11.1	1.74 (1)	1.6
Gang Involvement (1=Yes)	0.0	3.2	1.97 (1)	3.1
Runaway History (1=Yes)	14.5	26.3	2.57 (1)	7.0
Rating of Family Disruption				
Frequent	26.2	23.0	1.38 (2)	4.7
Situational/minor	26.2	36.1		
None	47.5	41.0		
Prior Out-of-School Suspension (1=Yes)	47.5	54.5	.57 (1)	9.4
Truancy Record (1=Yes)	24.2	37.5	2.46 (1)	7.8
Rating of School Disruption				
Frequent	27.9	6.6	9.80 (2)*	4.7
Situational/minor	31.1	37.7		
None	41.0	55.7		
Drug of Choice				
Alcohol	27.9	23.5	.51 (2)	12.5
Marijuana	68.9	74.5		
Other	3.3	2.0		
Age of First Alcohol Use	13.7 (2.04)	13.0 (1.47)	1.33 (54)	56.3
Age of First Drug Use	14.3 (1.75)	13.6 (15.9)	1.83 (71)	43.0
Previous D/A Treatment (1=Yes)	11.5	11.7	.00 (1)	5.5
MH Treatment Ever (1=Yes)	61.0	65.0	.16 (1)	22.7
Court Process and Motivation				
Number of Case Hearings	9.8 (9.19)	4.2 (3.76)	4.05 (65.89)*	13.3
Number of Status Reviews	11.9 (9.74)	1.4 (2.20)	7.95 (61.44)*	8.6
Number of Treatment Referrals	3.0 (1.96)	1.3 (1.14)	5.78 (101.10)*	0.0
Number of Drug Tests	31.3 (25.23)	7.9 (6.01)	7.20 (70.12)*	0.0
Number of Incentives	5.56 (5.43)	.22 (.72)	7.81 (65.24)*	0.0
Number of Sanctions	4.8 (7.04)	1.9 (2.10)	3.13 (74.06)*	0.0
Motivation Scale Scores – Baseline				
Problem recognition scale	25.8 (9.49)	25.2 (10.97)	.20 (51)	58.6
Desire for help	30.6 (8.63)	28.3 (9.40)	.77 (54)	56.3
Treatment readiness	30.2 (11.49)	29.9 (6.60)	.10 (56)	54.7
Treatment pressure	31.9 (7.00)	29.3 (4.59)	1.10 (51)	58.6
Motivation Scale Scores – 180 Day				
Problem recognition scale	32.9 (11.76)	--	--	91.4
Desire for help	34.3 (10.24)	--	--	90.6
Treatment readiness	30.8 (11.86)	--	--	90.6
Treatment pressure	35.0 (6.10)	--	--	91.4
Termination Status				

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Table 9. Medina County Site Description				
Variable	**Treatment Group (n=64) Mean (sd)/%**	**Comparison Group (n=64) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Successful	75.0	67.2	6.31 (4)	10.0
Unsuccessful	25.0	25.0		
Data collection ended	0.0	3.1		
Other	0.0	4.7		
Time at Risk	32.1 (9.19)	24.8 (10.50)	4.21 (126)*	0.0

Notes: *in t/X^2 indicates statistically significant difference at probability<.05
t = t-statistic used for comparisons between scores or other continuous measures (e.g., age)
X^2= Chi Square statistic used for comparisons between categorical measures (e.g., any prior drug charges)
sd = standard deviation; df = degree of freedom
^64 youth were screened using the YLS/CMI and 64 youth were screened using the OYAS; similar risk scores were combined
-- Motivation surveys were not distributed to comparison youth at the 180 day follow-up

Rhode Island

Site Description

The juvenile drug court is considered a "Special Problem Solving Court" under the Family Court division of the Judiciary of Rhode Island. Referrals are made through the court intake services department at three locations across the state. The court operates as both a pre-adjudication/diversion and post-adjudication program. A total of 131 youth were enrolled in the Drug Court group and 131 youth were enrolled in the Comparison group. Comparison group youth were sampled from traditional probation and from diversion. Youth in the Drug Court diversion program were matched with juveniles who participated in a non-drug court diversion program. One matched-pair case from Rhode Island could not be included in the data analysis due to data collector error. Twenty-six youth were enrolled in the comparison group using a blanket consent process. Data collection for the study was performed by on-site contractors throughout the course of the study.

The Rhode Island County Juvenile Drug Court has been in operation since 2000. The drug court is funded by the state and operates out of several locations across the state. Youth

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range in age from 13 to 17 and must be charged with a drug related offense or another non-violent offense and have known substance abuse issues. The drug court has both a post-adjudication and a pre-adjudication/diversion program. Graduation from drug court depends on the successful completion of all recommended treatment, which varies on a case-by-case basis. Post-adjudication drug court participants must have clean urine screens for six months in order to successfully graduate. Diversion drug court youth must have clean urine screens for three months in order to successfully graduate. An additional distinction between the two types of drug court programs is that diversion youth will have their records sealed upon successful graduation. The drug court relies on the following techniques to supervise youth in the program: curfew, drug and alcohol testing, home and school visits, and attendance at court. The drug court also has the option to assess and provide services to youth through the Rhode Island Juvenile Mental Health Clinic. Approximately one-quarter of youth in the drug court are referred to the Rhode Island Juvenile Mental Health Clinic. In these cases, the clinic assists the drug court in determining a treatment plan.

The drug court utilizes several referral agencies for treatment. The following agencies were evaluated as part of the CPC-DC assessment: Providence Center (Multi-Systemic Therapy); All Things Considered (individual outpatient substance abuse treatment); Phoenix Houses of New England (outpatient substance abuse treatment, residential substance abuse treatment, and shelter care); Providence Community Action (ProCAP; outpatient substance abuse treatment); Thompson Resources Limited (individual substance abuse treatment); Robert O'Neil (individual mental health and substance abuse counseling); and Nicole Hebert, LICSW (individual mental health and substance abuse counseling).

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Sample Description

Looking at the matching variables in Rhode Island, there were three significant differences across the Drug Court (DC; n=130) and Comparison (C; n=130) groups. There was a roughly 80%-20% split in terms of males and females, and the vast majority of youth in both groups (83.9%) were white. At the time the study took place, Rhode Island was not assessing their youth with a standardized risk assessment tool. As such, a proxy measure based on criminal history was provided to the site in order to assist with matching. Four variables (prior charges, level of current charge, age at first referral, and the number of prior adjudications) were used to calculate a score between zero to six. Actual scores for youth in Rhode Island ranged from zero to four. As evidenced in the table, there were significant differences in scores between groups, with Drug Court youth appearing to be less risky. For example, 40.7% of Drug Court youth scored zero while 0% of Comparison youth scored zero. Further, Drug Court youth were significantly more likely to use alcohol and other drugs frequently than Comparison youth. In general, the drug use frequency was far higher than alcohol use for all of the Rhode Island youth.

As shown in the second section of the table (labeled Other Baseline Variables), marijuana was the overwhelming drug of choice for both the Drug Court (93.8%) and Comparison (100%) groups. The difference in the age of first use of alcohol (DC=14.4, C=16.0) almost reached significance, and the difference in the age of first use of drugs (DC=14.1, C=15.5) did reach significance. These ages indicate that Rhode Island youth started using alcohol and drugs at a later age than youth from the other sites. Very few youth had previous drug abuse treatment (DC=9.4%, C=0.0%), and few youth had previous mental health treatment (DC=26.9%, C=11.0%). Both of these differences are statistically significant.

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Looking at other baseline variables, the average age for Rhode Island youth was roughly 16 years old with a slightly higher age for Comparison group (16.3 vs. 16.1 for the Drug Court group). This difference is not significant. Drug Court youth were significantly more likely to have been referred for status offenses (DC=55.9%, C=20.0%), while Comparison youth were more likely to have been referred for misdemeanor offenses (DC=42.5%, C=80.0%). Significant differences between the two groups were also observed for the type of offense committed, with Comparison youth having a higher likelihood of having been referred for drug and alcohol offenses than youth in the drug court (DC=66.1%, C=80.0%). A fair number of youth in both groups were referred for "other" charges. In Rhode Island, these other charges include truancy, public order, and disobedient charges. Although nonsignificant, Comparison group youth had a higher rate of prior adjudications (6.2% vs. 2.6% for the Drug Court group). Other significant differences between the groups include a greater frequency of prior drug charges, family disruption, out-of-school suspensions, truancy record, and school disruption for Drug Court youth. The two groups of youth evidenced little difference on other baseline variables such as gang involvement and running away.

The last panel of Table 10 (see p. 80) shows measures for several key court process and motivation variables. Not surprisingly, there were significant differences in the mean number of case hearings (DC=5.4, C=2.0) and status reviews (DC=4.8, C=0.62) for the two groups. There were also significant differences in the number of treatment referrals, drug tests, incentives, and sanctions. For Rhode Island, motivation surveys were not distributed to Comparison youth. As such, only Drug Court youth scores are presented in the following table. Rhode Island youth enrolled in the study varied greatly in their completion of either drug court or probation. A much

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greater percentage of Comparison youth were designated as successful relative to those in the Drug Court group (94.6% vs. 73.4%).

Table 10. Rhode Island Site Description

Variable	Treatment Group (n=130) Mean (sd)/%	Comparison Group (n=130) Mean (sd)/%	t /X^2 (df)	% Missing
Matching Variables				
Risk Level^				
0	40.7	0.0	67.4 (4)*	4.6
1	48.3	87.7		
2	6.8	6.2		
3	1.7	3.1		
4	2.5	3.1		
Gender				
Male	76.9	78.5	.09 (1)	0.0
Female	23.1	21.5		
Race				
White	83.9	83.9	.66 (3)	4.6
Black	4.8	6.5		
Hispanic	9.7	8.9		
Other	1.6	.8		
Alcohol Use Frequency				
Daily	1.0	0.0	9.15 (2)*	45.0
Once a week or more	17.2	0.0		
Less than once a week	81.8	100.0		
Drug Use Frequency				
Daily	34.1	14.0	15.85 (2)*	30.8
Once a week or more	51.2	47.4		
Less than once a week	14.6	38.6		
Other Baseline Variables				
Age	16.1 (1.25)	16.3 (1.46)	-1.63 (256)	0.0
Highest Grade Completed	9.1 (1.73)	9.4 (1.53)	-1.42 (213)	17.3
Offense Level				
Felony	1.6	0.0	38.67 (2)*	1.2
Misdemeanor	42.5	80.0		
Status	55.9	20.0		
Offense Type				
Personal	3.1	9.2	41.35 (5)*	1.2
Property	3.1	5.4		
Drug/Alcohol	66.1	80.0		
Sex	0.0	0.8		
Other	27.6	4.6		
Prior Adjudications (1=Yes)	2.6	6.2	1.86 (1)	5.8
Previous Drug Charge (1=Yes)	23.1	3.8	20.64 (1)*	0.0
Gang Involvement (1=Yes)	1.6	0.8	.37 (1)	2.3
Runaway History (1=Yes)	5.5	7.0	.23 (1)	1.5
Rating of Family Disruption				

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Table 10. Rhode Island Site Description				
Variable	**Treatment Group (n=130) Mean (sd)/%**	**Comparison Group (n=130) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Frequent	26.8	10.2	16.79 (2)*	1.9
Situational/minor	36.2	30.5		
None	37.0	59.4		
Prior Out-of-School Suspension (1=Yes)	43.2	22.5	12.39 (1)*	2.3
Truancy Record (1=Yes)	52.8	15.6	39.10 (1)*	1.9
Rating of School Disruption				
Frequent	63.0	31.8	25.38 (2)*	1.5
Situational/minor	18.9	38.8		
None	18.1	29.5		
Drug of Choice				
Alcohol	6.2	0.0	7.63 (1)*	4.6
Marijuana	93.8	100.0		
Age of First Alcohol Use	14.4 (1.25)	16.0 (1.41)	-1.81 (90)	64.6
Age of First Drug Use	14.1 (1.35)	15.5 (1.20)	-4.28 (127)*	50.4
Previous D/A Treatment (1=Yes)	9.4	0.0	12.89 (1)*	1.2
MH Treatment Ever (1=Yes)	26.9	11.0	10.17 (1)*	5.4
Court Process and Motivation				
Number of Case Hearings	5.4 (7.69)	2.0 (1.66)	4.49 (116.45)*	8.1
Number of Status Reviews	4.8 (4.50)	.62 (1.48)	9.30 (127.63)*	8.1
Number Treatment Referrals	1.5 (.95)	.40 (.60)	11.45 (218.86)*	0.0
Number Drug Tests	13.1 (12.05)	.55 (1.98)	11.69 (135.99)*	0.0
Number Incentives	.46 (.60)	0.0 (.00)	8.78 (129.00)*	0.0
Number Sanctions	1.9 (4.39)	0.0 (.12)	5.01 (129.20)*	0.0
Motivation Scale Scores – Baseline				
Problem recognition scale	21.9 (7.98)	--	--	72.3
Desire for help	26.2 (8.02)	--	--	71.2
Treatment readiness	27.8 (8.51)	--	--	70.4
Treatment pressure	29.4 (6.05)	--	--	71.2
Motivation Scale Scores – 180 Day				
Problem recognition scale	21.5 (9.45)	--	--	97.7
Desire for help	28.3 (5.89)	--	--	98.1
Treatment readiness	29.0 (7.05)	--	--	97.7
Treatment pressure	32.5 (5.94)	--	--	97.7
Termination Status				
Successful	73.4	94.6	19.97 (6)*	1.9
Unsuccessful	18.7	4.6		
Expiration of term	.8	0.0		
Data collection ended	2.3	0.0		
Other	4.8	.8		
Time at Risk	26.3 (9.25)	30.6 (15.76)	-2.67 (208.47)*	0.0

Notes: *in t/X^2 indicates statistically significant difference at probability<.05
t = t-statistic used for comparisons between scores or other continuous measures (e.g., age)
X^2= Chi Square statistic used for comparisons between categorical measures (e.g., any prior drug charges)

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sd = standard deviation; df = degree of freedom
^The Rhode Island drug court did not use a risk instrument; youth were scored on the number of prior charges, the level of their current charge, their age at first referral, and the number of prior adjudications
-- Motivation surveys were not distributed to comparison youth at baseline or at the 180 day follow-up

San Diego County, California

Site Description

The juvenile drug court operates under the Superior Court of California, County of San Diego. Referrals come from judges and probation officers. The court operates as a pre-adjudication program. A total of 148 youth were enrolled in the Drug Court group and 148 youth were enrolled in the Comparison group. Comparison group youth were selected from traditional probation. None of the youth enrolled in the Comparison group were enrolled via a blanket consent process. Data collection for the study was performed by on-site contractors throughout the course of the study.

The San Diego County Juvenile Drug Court has been in operation since 1998. Youth range in age from 13 to 17.5 and must evidence drug abuse issues. The drug court requires clients to progress through three phases of treatment designed to last nine months. However, the average time in drug court is 11 to 12 months. Throughout the drug court program, youth must attend drug treatment for up to nine hours per week. Additional components to the program follow a step-down approach. In Phase 1, youth must attend weekly court hearings, submit random drug screens at least twice per week, and have weekly contact with their probation officer. Youth must attain 90 days sobriety, and any relapse will send them back to the beginning of Phase 1. In Phase 2, youth must attend court hearings every other week and continue the same level of drug screenings and probation officer contact. Youth must attain 180 days sobriety, and any relapse will send them back to the beginning of Phase 1. An application, interview, and assessment are necessary for advancement to Phase 3. In Phase 3, youth must

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attend court hearings once per month, submit random drug screens at least once per week, meet with their probation officer at least every other week, and complete aftercare.

The drug court relies on the following techniques to supervise youth in the program: drug and alcohol testing, home and school visits, and attendance at court. The drug court utilizes several referral agencies for substance abuse counseling. The following were evaluated for this report: South Bay Community Services; Palavra Tree, Inc.; Mental Health Systems; Phoenix Houses of California; San Diego Youth Services; and McAlister Institute.

Sample Description

There were no significant differences in the matching variables across the Drug Court (DC; n=148) and Comparison (C; n=148) groups in San Diego. There was a roughly 85%-15% split in terms of males and females, and the vast majority of youth were nonwhite, with the majority of youth being Hispanic. Almost no youth in the Drug Court and Comparison groups were low risk, and the remainder of youth were split between medium, high, and intensive risk, with a majority of youth in both groups categorized as intensive risk (i.e., very high). Concerning the use of alcohol, both groups of youth predominantly used less than once a week, and both groups evidenced much more frequent use of drugs. Daily drug use was slightly more prevalent in the Drug Court versus the Comparison group (30.5% vs. 21.3%), while use of drugs at least once a week was higher in the Comparison group (42.5% vs. 33.6%).

As shown in the second section of the table (labeled Other Baseline Variables), marijuana was the drug of choice for both groups of youth (DC=63.6%, C=50.7%). Although nonsignificant, Drug Court youth first used alcohol and drugs at an earlier age than Comparison youth (alcohol: DC=13.2, C=13.6; drugs: DC=13.1, C=13.4). Approximately one-quarter of

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youth from each group in San Diego had previous drug abuse treatment (DC=27.0%, C=25.0%) and/or mental health treatment (DC=29.7%, C=23.0%).

Looking at other baseline variables, there was a statistically significant difference in age between the groups (DC=15.8 years, C=16.3 years). Drug Court and Comparison youth did not differ on their level of offense with a roughly 55%-45% split between felony offenses and misdemeanor offenses. Significant differences between the two groups were observed in the type of offense committed. Youth in the Drug Court group had more referrals for property (DC=42.9%, C=37.4%) and drug and alcohol offenses (DC=21.1%, C=10.9%), while Comparison group youth had more personal offenses (DC=14.3%, C=23.8%). Other offenses were prevalent in both groups. Examples of these offenses include public order, resisting/evading, false information, and truancy. Concerning the other baseline variables, only two other significant differences were identified; Drug Court youth had greater frequencies of prior adjudications and prior drug charges. Drug Court youth and Comparison youth did not differ in gang involvement, running away, family disruption, out-of-school suspensions, truancy, or school disruption.

The last panel of Table 11 (see pp. 85-86) shows measures for several key court process and motivation variables. Not surprisingly, there were significant differences in the mean number of case hearings (DC=31.6, C=8.0), status reviews (DC=1.8, C=0.01), treatment referrals (DC=2.3, C=0.30), drug tests (DC=56.7, C=18.9), incentives (DC=8.2, C=0.0), and sanctions (DC=3.4, C=2.0). In general, the baseline motivation scores were all greater for the Drug Court group as compared to the Comparison youth, with three scales reaching statistical significance at baseline. San Diego County youth enrolled in the study varied in their completion of either drug court or probation. While approximately 58% of youth in both groups successfully completed

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drug court or probation, more youth in the Comparison group were terminated unsuccessfully. In San Diego, youth in the Comparison group had a longer time at risk to reoffend than youth in the Drug Court (DC=24.8, C=28.2 months).

Table 11. San Diego County Site Description

Variable	Treatment Group (n=148) Mean (sd)/%	Comparison Group (n=148) Mean (sd)/%	t /X^2 (df)	% Missing
Matching Variables				
Risk Level^				
Low	0.0	.7	4.35 (3)	1.4
Medium	19.7	23.4		
High	23.1	29.7		
Intensive	57.1	46.2		
Gender				
Male	84.5	84.5	.00 (1)	0.0
Female	15.5	15.5		
Race				
White	23.1	25.0	2.81 (5)	.3
Black	13.6	14.9		
Hispanic	59.2	56.1		
Other	4.1	4.1		
Alcohol Use Frequency				
Daily	2.9	4.5	1.28 (2)	9.1
Once a week or more	27.0	22.0		
Less than once a week	70.1	73.5		
Drug Use Frequency				
Daily	30.5	21.3	3.49 (2)	12.8
Once a week or more	33.6	42.5		
Less than once a week	35.9	36.2		
Other Baseline Variables				
Age	15.8 (.94)	16.3 (1.35)	-3.63 (263)*	0.0
Highest Grade Completed	9.5 (1.29)	9.8 (1.52)	-1.99 (283)*	3.7
Offense Level				
Felony	54.1	53.4	1.84 (2)	0.0
Misdemeanor	45.3	43.9		
Status	0.7	2.7		
Offense Type				
Personal	14.3	23.8	14.34 (6)*	.7
Property	42.9	37.4		
Drug/Alcohol	21.1	10.9		
Weapons	8.2	8.2		
Sex	0.7	2.7		
Other	12.9	17.0		
Prior Adjudications (1=Yes)	64.9	43.9	13.09 (1)*	0.0
Previous Drug Charge (1=Yes)	31.1	20.9	3.95 (1)*	0.0
Gang Involvement (1=Yes)	4.1	6.8	1.06 (1)	0.0

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Table 11. San Diego County Site Description				
Variable	**Treatment Group (n=148) Mean (sd)/%**	**Comparison Group (n=148) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Runaway History (1=Yes)	12.8	10.1	0.53 (1)	0.0
Rating of Family Disruption				
Frequent	8.9	12.5	5.63 (2)	53.0
Situational/minor	26.8	0.0		
None	64.2	87.5		
Prior Out-of-School Suspension (1=Yes)	48.0	48.0	.00 (1)	0.0
Truancy Record (1=Yes)	72.1	65.5	1.48 (1)	0.3
Rating of School Disruption				
Frequent	35.8	25.0	2.60 (2)	53.0
Situational/minor	22.8	12.5		
None	41.5	62.5		
Drug of Choice				
Alcohol	35.7	47.1	5.36 (2)	4.4
Marijuana	63.6	50.7		
Other	.7	2.1		
Age of First Alcohol Use	13.2 (1.59)	13.6 (1.78)	-1.61 (240)	18.2
Age of First Drug Use	13.1 (1.56)	13.4 (1.60)	-1.37 (235)	19.9
Previous D/A Treatment (1=Yes)	27.0	25.0	.16 (1)	0.0
MH Treatment Ever (1=Yes)	29.7	23.0	1.74 (1)	0.0
Court Process and Motivation				
Number of Case Hearings	31.6 (16.89)	8.0 (4.54)	16.42 (168.26)*	0.3
Number of Status Reviews	1.8 (5.80)	.01 (.12)	3.26 (106.07)*	17.6
Number Treatment Referrals	2.3 (1.52)	.30 (.59)	15.32 (190.38)*	0.0
Number Drug Tests	56.7 (33.46)	18.9 (10.67)	13.10 (176.61)*	0.0
Number Incentives	8.2 (7.80)	.00 (.00)	12.85 (147)*	0.0
Number Sanctions	3.4 (2.80)	2.0 (2.10)	4.83 (272.82)*	0.0
Motivation Scale Scores – Baseline				
Problem recognition scale	30.6 (9.06)	24.7 (8.30)	4.91 (222)*	24.3
Desire for help	35.1 (8.46)	28.4 (7.34)	6.27 (199.12)*	23.0
Treatment readiness	35.8 (7.58)	29.9 (7.04)	5.88 (230)*	21.6
Treatment pressure	31.9 (6.07)	30.9 (6.60)	1.15 (219)	25.3
Motivation Scale Scores – 180 Day				
Problem recognition scale	28.6 (8.82)	24.4 (5.56)	.81 (101)	65.2
Desire for help	32.6 (7.88)	31.1 (6.74)	.32 (105)	63.9
Treatment readiness	31.9 (7.90)	33.8 (1.25)	-.40 (106)	63.5
Treatment pressure	31.5 (6.53)	32.2 (2.55)	-.20 (105)	63.9
Termination Status				
Successful	57.4	58.8	15.2 (6)*	0.0
Unsuccessful	30.4	39.2		
Data collection ended	4.1	0.7		
Expiration of term	4.1	0.0		
Other	4.1	1.4		

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Table 11. San Diego County Site Description				
Variable	**Treatment Group (n=148) Mean (sd)/%**	**Comparison Group (n=148) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Time at Risk	24.8 (9.53)	28.2 (10.99)	-2.81 (288.23)*	0.0

Notes: *in t/X^2 indicates statistically significant difference at probability<.05
t = t-statistic used for comparisons between scores or other continuous measures (e.g., age)
X^2= Chi Square statistic used for comparisons between categorical measures (e.g., any prior drug charges)
sd = standard deviation; df = degree of freedom
^Youth were screened using the San Diego Risk and Resilience Check-Up (SDRRC)
-- Motivation surveys were not distributed to comparison youth at the 180 day follow-up

Santa Clara County, California

Site Description

The juvenile drug court operates under the Superior Court of California, County of Santa Clara. Referrals for the court come from judges, attorneys, and probation officers. The court operates as a post-adjudication program. A total of 115 youth were enrolled in the Drug Court group and 115 youth were enrolled in the Comparison group. Two pairs of matched cases had to be excluded from the data analysis, resulting in 113 youth in both groups. These lost cases are a result of data collector error. Comparison group youth were selected from traditional probation. Seventy-three youth were enrolled in the comparison group using a blanket consent process. Data collection for the study was performed by on-site contractors throughout the course of the study.

The Santa Clara County Juvenile Drug Court has been in operation since 1996. Youth are all under 18 years of age and must have a history of substance abuse and engaging in delinquent behavior. Youth with a history of selling drugs, firearm possession or a felony sexual offense were not considered for drug court (the court developed new policies shortly after the assessment which allow for consideration of some of these offenses on a case-by-case basis). The drug court requires clients to progress through three phases of treatment lasting a minimum

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of six month, with an average of about one year. As a phase system, components of the program follow a step-down approach. In Phase 1, youth must attend a minimum of four hours of treatment per week, submit two random drug screens per week, meet with their probation officer at least twice per week, and attend court hearings once per week. In Phase 2, youth must continue the same level of treatment and urine screens, meet with their probation officer at least once per week, and attend court hearings three times per month. Additionally, parents/guardians must participate in one parent workshop. In the final Phase (3), youth must continue with a lower level of treatment, submit random urine screens at least once per week, and meet with their probation officer and attend court hearings at least twice per month. The drug court relies on the following techniques to supervise youth in the program: curfew, drug and alcohol testing, home and school visits, and attendance at court. The drug court utilizes several referral agencies for substance abuse counseling. The following four agencies were evaluated as part of the CPC-DC report: Advent Group Ministries; Asian American Recovery Services (AARS), Santa Clara County Department of Alcohol and Drug Services (DADS); and Community Health Awareness Council (CHAC – New Outlooks).

Sample Description

Examining the matching variables in Santa Clara, there were two significant differences across the Drug Court (DC; n=113) and Comparison (C; n=113) groups. There was a roughly 75%-25% split in terms of males and females, and the vast majority of youth were Hispanic. Approximately one-quarter of youth in the Drug Court and Comparison groups were low risk, and the other youth were split between regular and maximum risk (i.e., moderate and high). Significant differences between the groups were identified for the use of alcohol and drugs. Drug Court youth evidenced higher rates of using alcohol and drugs than the Comparison group. For

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example, 15.3% of the Drug Court group used alcohol daily, while 11.8% of the Comparison youth used alcohol daily.

As shown in the second section of the table (labeled Other Baseline Variables), marijuana was the drug of choice for the Comparison group (C=70.9%, DC=43.4%), while alcohol was the drug of choice for the Drug Court group (DC=49.6%, C=26.4%). Drug Court youth tended to use alcohol or drugs at an earlier age than Comparison youth. Drug Court youth had a mean starting age of 13.1 for alcohol and 13.2 for drugs, while Comparison youth first used alcohol at 13.4 years and drugs at 13.9 years. The difference is significant for age of first drug use. There were also significant differences between the groups in previous drug or alcohol treatment (DC=32.4%, C=18.9%) and mental health treatment (DC=42.6%, C=15.5%).

Looking at other baseline variables, the average age for these youth was almost equal between the groups (DC=16.4 years, C=16.2 years). Significant differences between the two groups were observed in the level of offense and type of offense committed. Youth in the Drug Court group had more referrals for misdemeanor offenses, and the Comparison group had more referrals for felony offenses (C=48.7%, DC=31.0%). More so than the other sites, youth were placed into drug court or put on formal probation based on violating court orders (DC=32.7%, C=17.0%). Comparison group youth had more personal offenses than the Drug Court group (DC=9.7%, C=25.9%). Other offenses were prevalent in both groups; these were mostly due to public order violations. Concerning the other baseline variables, several other significant differences are noted between the Drug Court and Comparison groups on the following variables: prior adjudications, prior drug charges, out-of-school suspensions, truancy record and school disruption. Drug Court youth and Comparison youth did not differ concerning gang involvement, running away, or family disruption.

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The last panel of Table 12 (see pp. 90-91) shows measures for several key court process and motivation variables. Not surprisingly, there were significant differences in the mean number of case hearings (DC=11.5, C=6.9), status reviews (DC=7.5, C=2.3), treatment referrals (DC=2.2, C=0.5), drug tests (DC=16.5, C=12.7), and incentives (DC=2.3, C=0.0). The groups did not differ concerning the number of sanctions issued (DC=2.9, C=2.5). The baseline motivation scores were all greater for the Drug Court group as compared to the Comparison youth, with all four scales reaching statistical significance. For example, the mean score for the treatment readiness scale for the Drug Court group was 36.5 as opposed to 27.7 for the Comparison group. Follow-up motivation surveys were distributed to both groups of youth after six months of either drug court or probation. These results did not reach statistical significance, but the mean scores remained higher for the Drug Court group. Santa Clara County youth enrolled in the study also varied in their completion of either drug court or probation. This is most likely due to the fact that the Comparison youth were matched later in the study and many of them had not yet completed probation at the time data collection ended (DC=1.8%, C=57.1%).

Table 12. Santa Clara County Site Description

Variable	**Treatment Group (n=113) Mean (sd)/%**	**Comparison Group (n=113) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Matching Variables				
Risk Level^				
Low	23.9	17.3	1.64 (2)	4.0
Regular	33.6	33.7		
Max	42.5	49.0		
Gender				
Male	74.3	74.3	.00 (1)	0.0
Female	25.7	25.7		
Race				
White	11.7	11.5	5.54 (4)	0.9
Black	4.5	4.4		
Hispanic	76.6	82.3		
Other	7.2	1.8		

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Table 12. Santa Clara County Site Description				
Variable	**Treatment Group (n=113) Mean (sd)/%**	**Comparison Group (n=113) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Alcohol Use Frequency				
Daily	15.3	11.8	11.05 (2)*	11.5
Once a week or more	41.8	22.5		
Less than once a week	42.9	65.7		
Drug Use Frequency				
Daily	23.1	14.9	7.57 (2)*	7.5
Once a week or more	50.9	41.6		
Less than once a week	25.9	43.6		
Other Baseline Variables				
Age	16.4 (1.16)	16.2 (1.17)	1.02 (224)	0.0
Highest Grade Completed	10.5 (1.09)	10.2 (1.41)	1.33 (221)	1.3
Offense Level				
Felony	31.0	48.7	10.51 (2)*	0.0
Misdemeanor	38.0	20.4		
Status	31.0	31.0		
Offense Type				
Personal	9.7	25.9	18.43 (7)*	0.4
Property	23.9	22.3		
Drug/Alcohol	17.7	12.5		
Weapons	6.2	5.4		
Sex	1.8	0.9		
Probation violation	32.7	17.0		
Other	8.1	16.1		
Prior Adjudications (1=Yes)	92.7	75.2	12.42 (1)*	1.8
Previous Drug Charge (1=Yes)	69.0	54.0	5.40 (1)*	0.0
Gang Involvement (1=Yes)	62.2	71.4	2.16 (1)	1.3
Runaway History (1=Yes)	42.6	34.2	1.62 (1)	3.1
Rating of Family Disruption				
Frequent	28.3	25.7	.22 (2)	0.0
Situational/minor	41.6	42.5		
None	30.1	31.9		
Prior Out-of-School Suspension (1=Yes)	36.5	14.3	13.67 (1)*	7.5
Truancy Record (1=Yes)	63.2	43.9	7.26 (1)*	5.8
Rating of School Disruption				
Frequent	25.7	24.8	12.15 (2)*	0.0
Situational/minor	50.4	31.0		
None	23.9	44.2		
Drug of Choice				
Alcohol	49.6	26.4	17.43 (2)*	1.3
Marijuana	43.4	70.9		
Other	7.1	2.7		
Age of First Alcohol Use	13.1 (1.59)	13.4 (1.48)	-.96 (179)	19.9
Age of First Drug Use	13.2 (1.70)	13.9 (1.39)	-2.92 (182)*	18.6
Previous D/A Treatment (1=Yes)	32.4	18.9	5.31 (1)*	1.8
MH Treatment Ever (1=Yes)	42.6	15.5	18.49 (1)*	9.7

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Table 12. Santa Clara County Site Description				
Variable	**Treatment Group (n=113) Mean (sd)/%**	**Comparison Group (n=113) Mean (sd)/%**	**t /X^2 (df)**	**% Missing**
Court Process and Motivation				
Number of Case Hearings	11.5 (7.40)	6.9 (4.44)	5.58 (176.29)*	2.2
Number of Status Reviews	7.5 (4.01)	2.3 (5.34)	8.24 (217)*	3.1
Number Treatment Referrals	2.2 (1.21)	0.5 (1.30)	10.68 (222.92)*	0.0
Number Drug Tests	16.5 (11.43)	12.7 (9.22)	2.75 (224)*	0.0
Number Incentives	2.3 (1.49)	0.0 (.09)	16.25 (112.89)*	0.0
Number Sanctions	2.9 (2.33)	2.5 (1.75)	1.45 (224)	0.0
Motivation Scale Scores – Baseline				
Problem recognition scale	32.0 (7.32)	23.8 (8.98)	4.81 (122)*	
Desire for help	35.3 (6.35)	26.3 (8.77)	5.87 (122)*	
Treatment readiness	36.5 (6.77)	27.7 (8.45)	5.42 (123)*	
Treatment pressure	33.3 (5.36)	25.9 (6.54)	5.63 (117)*	
Motivation Scale Scores – 180 Days				
Problem recognition scale	30.2 (8.53)	26.0 (7.23)	1.24 (64)	70.8
Desire for help	32.7 (8.29)	28.6 (6.12)	1.28 (66)	69.9
Treatment readiness	30.4 (11.70)	27.3 (3.83)	.65 (67)	69.5
Treatment pressure	31.8 (6.35)	28.8 (6.06)	1.20 (64)	70.8
Termination Status				
Successful	40.2	25.9	99.66 (5)*	4.0
Unsuccessful	58.1	12.5		
Data collection ended	1.8	57.1		
Expiration of term	0.0	2.7		
Other	0.0	1.8		
Time at Risk	26.8 (8.05)	8.5 (10.19)	14.93 (212.65)*	0.0

Notes: *in t/X^2 indicates statistically significant difference at probability<.05
t = t-statistic used for comparisons between scores or other continuous measures (e.g., age)
X^2= Chi Square statistic used for comparisons between categorical measures (e.g., any prior drug charges)
sd = standard deviation; df = degree of freedom
^Youth were screened using the Classification and Reclassification Tool (CRT); a variation of the Wisconsin Risk and Needs (WRN) that was normed to Santa Clara
-- Motivation surveys were not distributed to comparison youth at the 180 day follow-up

CPC-DC Results

A full description of the CPC-DC can be found on page 34 of this report. Of the nine drug courts, two were categorized as "effective" on the CPC-DC, four were categorized as "needs improvement", and three were categorized as "ineffective." None of the courts were categorized as "highly effective." The breakdown of scores can be found in Table 13. In

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examining the areas and domains that make up the CPC-DC, courts performed similarly on two of the domains. On Quality Assurance, all of the courts scored in the "ineffective" range. Similarly, on Treatment, all of the courts were rated as either "ineffective" or "needs improvement." In the domain of Development, Coordination, Staff, and Support, ratings were spread across three of the ratings. Two of the courts were categorized as "ineffective", two as "effective", and five as "highly effective." In looking at Assessment Practices, five of the courts were rated as either "highly effective" or "effective" and four were rated as either "needs improvement" or "ineffective."

Table 13. CPC-DC Scores*

Court	% Overall	% Development, Coordination, Staff & Support	% Quality Assurance	% Capacity	% Assessment Practices	% Treatment	% Content
Ada	55.8	66.7	28.6	50.0	88.9	44.4	59.3
Clackamas	46.5	66.7	42.9	56.3	55.6	33.3	40.7
Jefferson	46.5	77.8	42.9	62.5	44.4	33.3	37.0
Lane	44.2	77.8	0.0	43.8	33.3	50.0	44.4
Lucas	37.2	55.6	0.0	31.3	44.4	38.9	40.7
Medina	60.5	77.8	28.6	56.3	88.9	50.0	63.0
Rhode Island	25.6	22.2	28.6	25.0	22.2	27.8	25.9
San Diego	51.2	55.6	42.9	50.0	66.7	44.4	51.9
Santa Clara	46.5	44.4	42.9	43.8	55.5	44.4	48.1

* Each area and all domains are scored and rated as either "highly effective" (65% to 100%); "effective" (55% to 64%); "needs improvement" (46% to 54%); or "ineffective" (less than 45%).

As part of the CPC-DC assessment, the most common referral agencies for each Drug Court were assessed using the CPC-DC: RA. Across the nine drug courts, 35 agencies were assessed. On the CPC-DC: RA overall, four referral agencies were rated as "highly effective", six as "effective", 12 as "needs improvement", and 13 as "ineffective." The scores have been averaged per drug court for the purpose of the report. The average percentage for the referral agencies is provided by court, along with the range in scores (where applicable) in Table 14. Of note is that Lane County, with five referral agencies has the highest overall average in the CPC-

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DC: RA. The five referral agencies in Lane average 65.7%, falling in the "highly effective" category.

As demonstrated in the table, San Diego had the largest range on overall program rating (range is 33.3). However, there is not a lot of variation on overall program score in four of the seven sites that used multiple referral agencies. In looking at the other CPC-DC: RA areas (capacity and content), there is more variation within sites. For example, in Rhode Island, San Diego, and Santa Clara, capacity scores were separated by about 33 percentage points. For content, San Diego referral agency scores ranged by roughly 50 percentage points. Lastly, in the domains that make up the areas, further variation in scores is seen with scores being separated by 75 points in one site and by 50 points in three sites in Quality Assurance. A range of 50 was also noted for two sites for Assessment Practices.

Table 14. CPC-DC: RA Scores*

Court	% (range) Overall	% (range) Development, Coordination, Staff & Support	% (range) Quality Assurance	% (range) Capacity	% (range) Assessment Practices	% (range) Treatment	% (range) Content
Ada (n=1)	35.3	50.0	50.0	50.0	75.0	20.7	27.3
Clackamas (n= 2)	38.6 (7.5)	75.0 (0)	0.0 (0.0)	56.3 (0.0)	0.0 (0.0)	32.6 (13.4)	29.4 (12.2)
Jefferson (n=4)	47.5 (29.2)	75.0 (35.8)	37.5 (25.0)	66.7 (27.8)	12.5 (25.0)	39.9 (30.8)	37.5 (30.0)
Lane (n=5)	65.7 (12.0)	75.7 (28.6)	50.0 (50.0)	71.1 (27.7)	65.0 (25.0)	63.3 (23.1)	63.5 (23.4)
Lucas (n=1)	60.8	78.6	75.0	77.8	25.0	55.2	51.5
Medina (n=3)	42.7 (14.7)	64.3 (21.4)	25.0 (50.0)	55.6 (22.3)	58.3 (50.0)	32.0 (17.1)	35.4 (14.8)
Rhode Island (n=9)	48.2 (26.5)	72.0 (21.4)	38.9 (75.0)	63.9 (33.3)	5.6 (25.0)	45.5 (37.1)	40.5 (35.5)
San Diego (n=6)	54.1 (33.3)	75.0 (28.6)	37.5 (50.0)	65.8 (33.3)	8.3 (25.0)	53.1 (55.2)	47.7 (51.5)
Santa Clara (n=4)	47.0 (7.9)	69.7 (35.7)	56.3 (25.0)	66.7 (33.3)	25.0 (50.0)	37.7 (7.8)	36.2 (10.5)

* Each area and all domains are scored and rated as either "highly effective" (65% to 100%); "effective" (55% to 64%); "needs improvement" (46% to 54%); or "ineffective" (less than 45%).

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In comparing the overall scores for the drug courts and referral agencies with the national averages (Table 15), we see that three of the drug courts surpass the national average for the overall score (Ada, Medina, and San Diego) and three are almost equal (Clackamas, Jefferson, and Santa Clara) to the average score (47%). Three of the drug courts fall below the national average (Lane, Lucas, and Rhode Island). For the referral agencies, the average score by drug court is evenly split as well with three of the mean scores being above average (Lane, Lucas, and San Diego), three almost equal to the average (Jefferson, Rhode Island, and Santa Clara), and three below average (Ada, Clackamas, and Medina). The results of these CPC-DC evaluations approximate what we typically find in completing any CPC assessments. Past research conducted by CCJR indicates that programs which score in either the "highly effective" or "effective" categories of the CPC have better recidivism outcomes than programs that score in the "ineffective" or "needs improvement" categories.

Table 15. National Average Scores for all CPC evaluations

	% Overall	% Capacity	% Content
National Average	47	53	40

* Each area and all domains are scored and rated as either "highly effective" (65% to 100%); "effective" (55% to 64%); "needs improvement" (46% to 54%); or "ineffective" (less than 45%).

Major Outcomes

The figures that follow show the results of analysis of the major outcomes for youth assigned to Drug Court versus those who were used as Comparison cases. The results are presented as comparative prevalence values across the two groups. Except where noted, all of the hypothesis tests associated with these comparisons were conducted with binary logistic regression models that included controls for months at risk of a new offense (calculated as date of entry into program to date of official record collection),[7] youth age, youth gender, youth race

[7] This was the date of termination in the analyses focused only on outcomes following program involvement.

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(coded as white/nonwhite), and risk level (coded as low, moderate, high). Although frequency of substance use (alcohol, other drugs) was collected for the majority of youth (n=1060), it was not included in the main models due to the data loss associated with it (particularly among Comparison youth). Given that it is a relevant covariate, however, the main outcome analysis was repeated using frequency of substance use, and the results were found to be similar to those reported here.

Full regression models for the main outcomes are presented in Appendix F. The covariates included in these models generally had significant effects on the outcomes in the analysis of the full sample. The likelihood of recidivism tended to increase with the level of risk and months elapsed since youth intake. The odds of recidivism generally decreased for youth as they got older, and females and white youth had significantly lower likelihoods of new referrals or adjudications.

The main analyses for all sites are shown in Figure 1. The sample sizes for these analyses range from 1292 to 1320 with a roughly even split in Drug Court and Comparison cases.[8] These results for official recidivism—(a) while the youth was still in Drug Court or on standard probation, (b) after termination, and (c) both—suggest that Drug Court youth had worse outcomes than those in the Comparison group. The type of referral of most interest was the new drug or alcohol-related referral. Analyses were conducted that parallel those shown in Figure 1. In each of the three possible outcomes (new referral during program, referral following termination, and any new referral), the effects suggest that those in Drug Court had a greater likelihood of recidivism. The effect sizes tend to be similar to those in the overall analysis.

[8] Given some data loss, the main models were also run using a Full Information Maximum Likelihood estimator to limit the impact of missing values as much as possible (Schafer & Graham, 2002). The results of those analyses were similar to those shown in the regression models in Appendix F.

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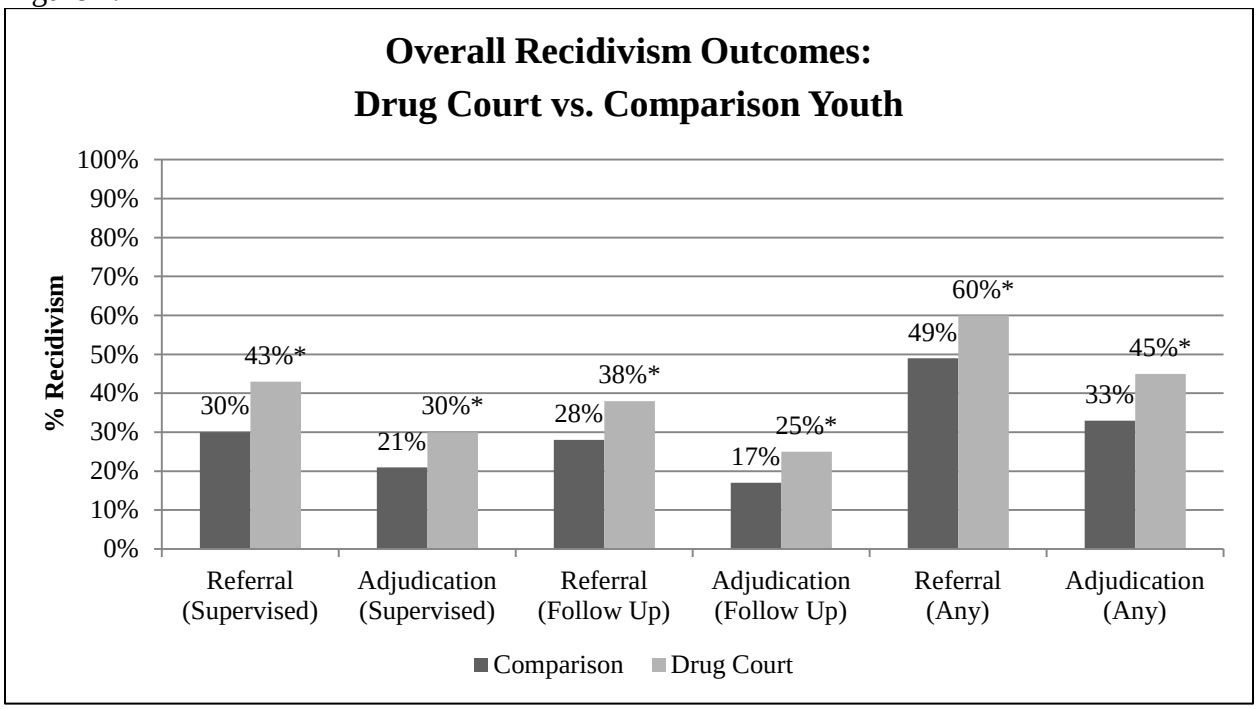
Not surprisingly, the overall prevalence of a new adjudication was lower than that of referral. Given that a new adjudication requires a more stringent level of evidence than arrest or referral, new adjudication can be considered the primary benchmark for a new offense. In this case there was a difference of 12 percentage points in the prevalence of new adjudication for the two groups. During follow up, there was a significant difference between Drug Court and Comparison youth with a likelihood of a new adjudication of 25% for the former and 17% for the latter. These findings suggest that Drug Court did not have an impact in line with its objectives and, instead, actually had an effect suggesting greater risk of new referral and adjudication.

Figure 1.



*p<.05

Technical violations in the form of positive drug screens and violations of a court order can also be used to evaluate Drug Court outcomes. In those cases, the results largely track the main findings reported above. Youth in the Drug Court group had significantly greater odds of a

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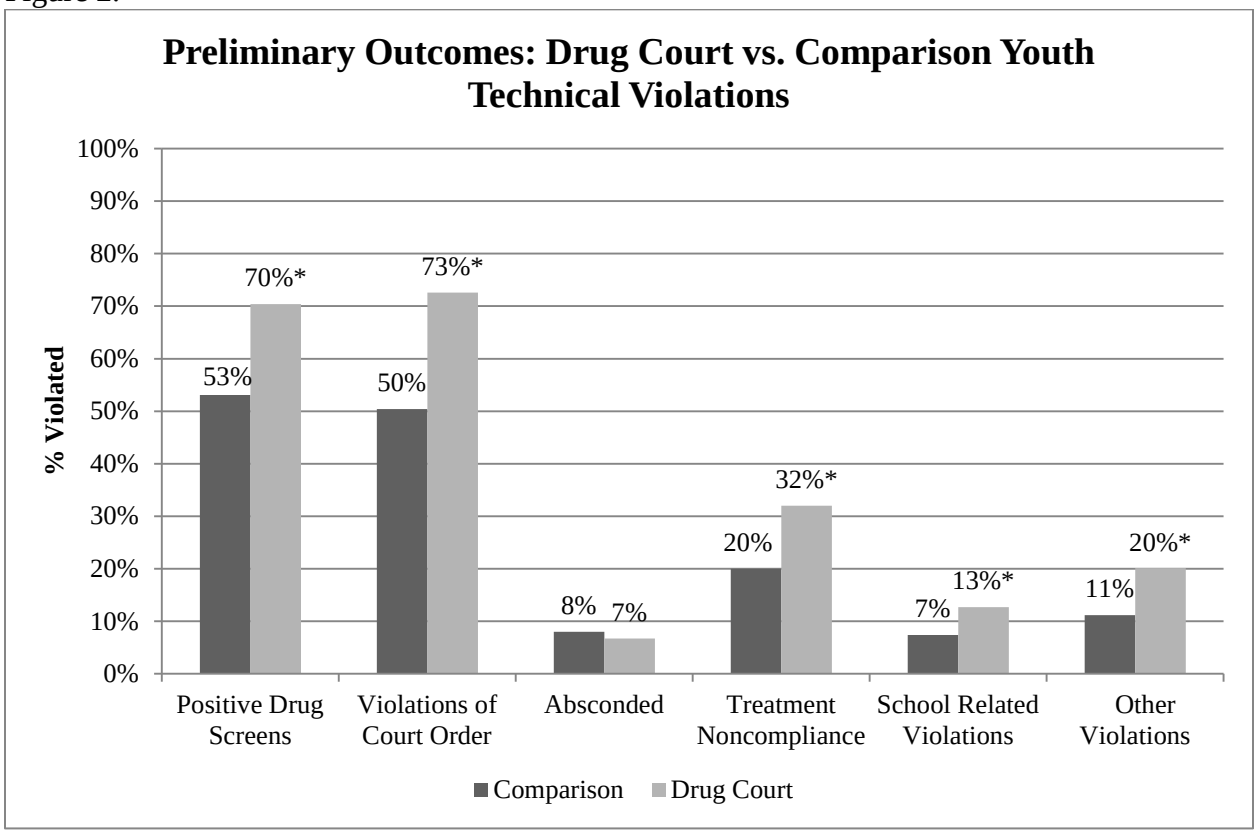
positive drug screen relative to those in the Comparison group. Similarly, the prevalence of violations of court orders was greater among those in the Drug Court group. The treatment effects for both of these outcomes were statistically significant in the multivariate logistic regression model with controls for relevant variables. Odds Ratio values were 2.43 and 3.28, respectively, suggesting that Drug Court youth had greater odds of recidivism than those in the Comparison group. These results are shown in Figure 2.

Figure 2.



*p<.05

Additional violations may stem from absconding while under supervision or during Drug Court involvement, treatment noncompliance, school-related violations (e.g., truancy), and other violations (e.g., curfew, no contact orders). Like positive drug tests and violations of court order, the Drug Court group tended to have significantly worse outcomes than the Comparison group. For example, the odds of a Drug Court youth failing to comply with treatment were twice as high

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(OR=2.04) as those in the Comparison group, and school-related violations show a pattern where youth in the Drug Court group had 70% greater odds of such violations than those in the Comparison group. In general, new technical violations or issues of noncompliance were quite prevalent among the Drug Court participants, and they were significantly more so than in the Comparison group. The frequency of these violations was also comparatively higher among those youth in the Drug Court group. For example, though both groups show a good deal of variance, when aggregating across the different types, youths in the Drug Court group had 10.15 violations (sd=12.22) on average compared to a mean of 4.86 (sd=6.41) for those in the Comparison group. Like the general prevalence of these violations shown in the figure above, the frequency of different types of violations for the two groups tend to exhibit the same pattern (e.g., Drug Court youth had 4.5 positive drug tests and 3.6 violations of court orders on average relative to 2.4 and 1.6 for the Comparison group).

Self-Reported Outcomes at Follow-Up

As noted in the methodology section, a follow-up mail survey was sent to the majority of study youth. The response rate for this survey was low, suggesting caution in interpreting any results obtained from this component of the study. Significantly more Drug Court than Comparison youth returned the survey for at least one of the follow-up periods (~26% vs. 11%), which is likely due in part to the fact that some of the Comparison group comprised record-review only (blanket consent) cases. The level of survey completion for successful and unsuccessful cases in terms of program discharge was roughly similar (17.2% noncompleters and 19.1% completers). Given that, these data were used to provide a basic sense of some outcomes that could not be ascertained from official record data. These outcomes included (a) substance use, (b) self-reported delinquency, (c) school attendance, (d) employment, and (e) running away

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from home. The results are presented in Figure 3. The overall level of completion (21%) coupled with missing data on certain items led to low sample sizes in these analyses.

The self-report results suggest that the vast majority of youth in both the Drug Court and Comparison groups engaged in alcohol or substance use during the follow-up period. For alcohol use, the Drug Court group had lower prevalence of use (78%) relative to the Comparison group (86%). The Drug Court group had a significantly lower prevalence on the self-report drug use measure (63%) compared to the Comparison group (83%). The associated Odds Ratio value in the multivariate model was 0.24, suggesting that those youth in the Drug Court group had significantly lower odds of substance use at follow up relative to those in the Comparison group. Although the remaining comparisons were nonsignificant in both multivariate and bivariate analysis, they all tend to suggest parity in outcomes for Drug Court and Comparison youth. A couple of comparisons, while nonsignificant, do favor the Drug Court group (e.g., self-reported delinquency, ran away). Again, given the low response rate and associated sample sizes, it is important that these results are interpreted with caution.

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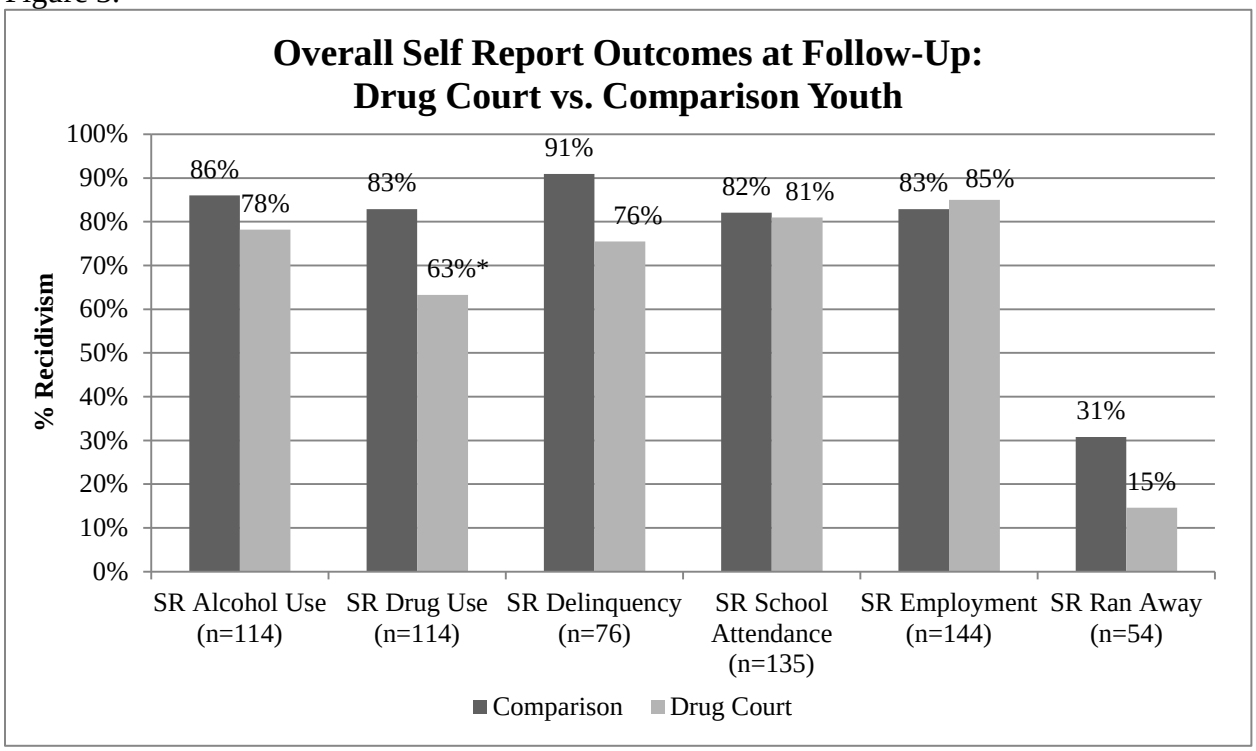
Figure 3.



p<.05

Drug Court Outcomes by Site

Although the overall effect for treatment was statistically significant and positive across each of these analyses, a site-by-site examination of the descriptive outcomes for these measures and formal modeling suggests that there are differences across sites in the relationship between treatment in the Drug Court or Comparison conditions and recidivism. For example, after removing the sites with statistically significant disparities between groups (Ada and Santa Clara) the multivariate model suggests that, although the analysis still favors the Comparison group youth in terms of their having a lesser likelihood of recidivism, the treatment effect is nonsignificant (accounting for control variables).

Variation across sites was confirmed using a multilevel logistic regression model to assess the degree of variation in the likelihood of a new referral or new adjudication (Raudenbush & Bryk, 2002; see Appendix F). Both the model for the new referrals and new

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adjudications indicated substantial variance around the overall likelihood of recidivism (significant for adjudication), suggesting that it varied across the nine study sites. The direction and size of the effects was generally the same as in Figure 1, and the Drug Court/Comparison indicator was statistically significant and positive in both analyses. Specifically, the odds ratio estimates for the "Treatment" variable were 1.61 and 1.70 for new referral and new adjudication, respectively. This suggests that those in the Drug Court group had significantly higher odds of recidivism than those youth in the Comparison group while controlling for risk level, length of time at risk of a new offense, age, sex, and race and adjusting for any shared effects experienced by youth at the same site. Although it was nonsignificant, there was some variation in the effect of Drug Court participation across sites. This might be attributable to the low sample size (n=9) in the context of these models (Snijders & Bosker, 1999).

The site-by-site comparisons for adjudication and referral following program entry are shown in Figures 4a and 4b. The effects shown are generally similar across all outcome variables. As was the case in the full sample models, the significant effects are based on hypothesis tests conducted within a multivariate logistic regression model. While there was variation across sites in terms of the significance and direction of the treatment-recidivism relationship, the majority of sites show outcomes favoring the Comparison group. In particular, Ada (27% vs. 62% for referral; 10% vs. 51% for adjudication) and Santa Clara (39% vs. 88% for referral; 22% vs. 78% for adjudication) show large, statistically significant differences in the prevalence of recidivism for Comparison and Drug Court youth. Those were the only two sites that had statistically significant effects once appropriate control measures were included in the analysis. Although nonsignificant, Clackamas (17 percentage points), Rhode Island (10 points), Lucas (5 points), Medina (4 points), and San Diego (3 points) showed effects more favorable to

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youth in the Comparison group in terms of percent with new referrals. Clackamas (12 points), Lucas (7 points), Medina (7 points), and San Diego (4 points) showed effects more favorable to youth in the Comparison group in terms of the relative prevalence of youth with new adjudications after program entry.

Of the nine sites, only Jefferson and Lane show effects that favor the Drug Court for both new referrals and new adjudications. Specifically, in Jefferson, which had a total sample size of 91 cases, Drug Court youth had a lower level of post-program entry referral (42%) than Comparison youth (52%). The two groups had similar levels of new adjudication, however, with a one percentage point difference favoring the Drug Court group. In Lane (n=85), the Drug Court group had a 50% rate of new referral after program entry compared to 75% for those in the Comparison group. Drug Court youth also had a lower prevalence of new adjudication (27%) than youth in the Comparison group (46%). Although Rhode Island Drug Court youth had higher levels of new referral, they had lower prevalence of new adjudication following program entry relative to the Comparison group (7% vs. 12%). While the group differences are sizeable in some cases, none of the effects described in this paragraph were statistically significant in the multivariate model that accounted for the control variables mentioned above.

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Figure 4a.

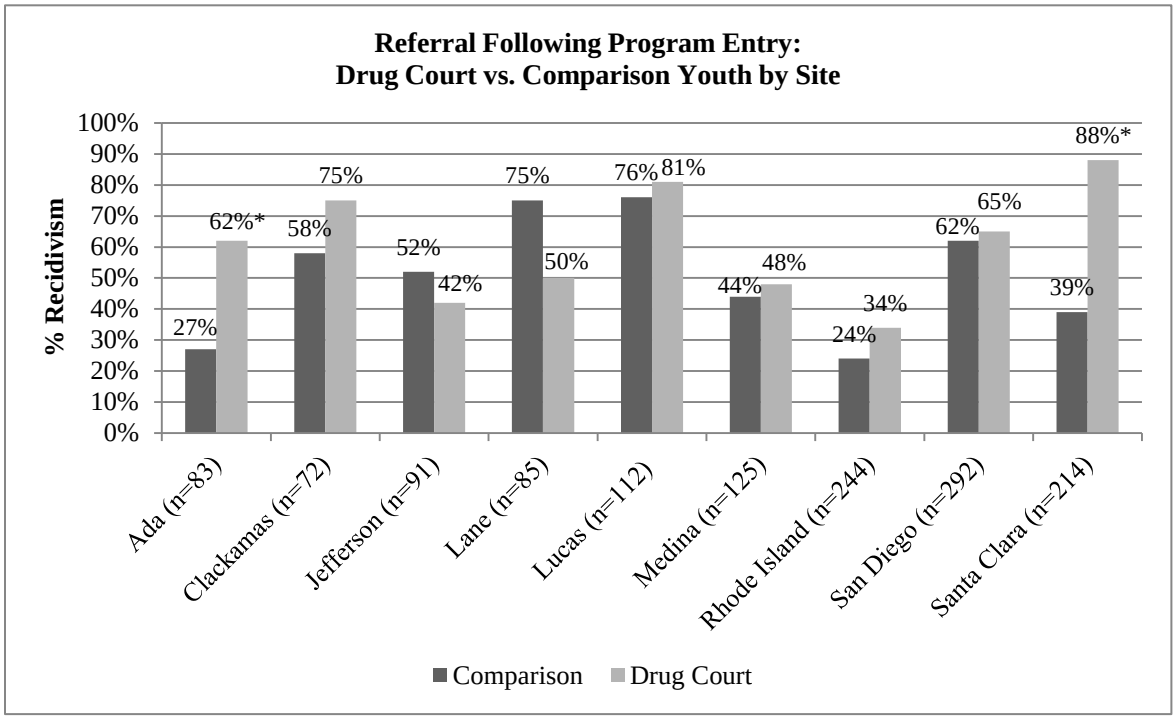

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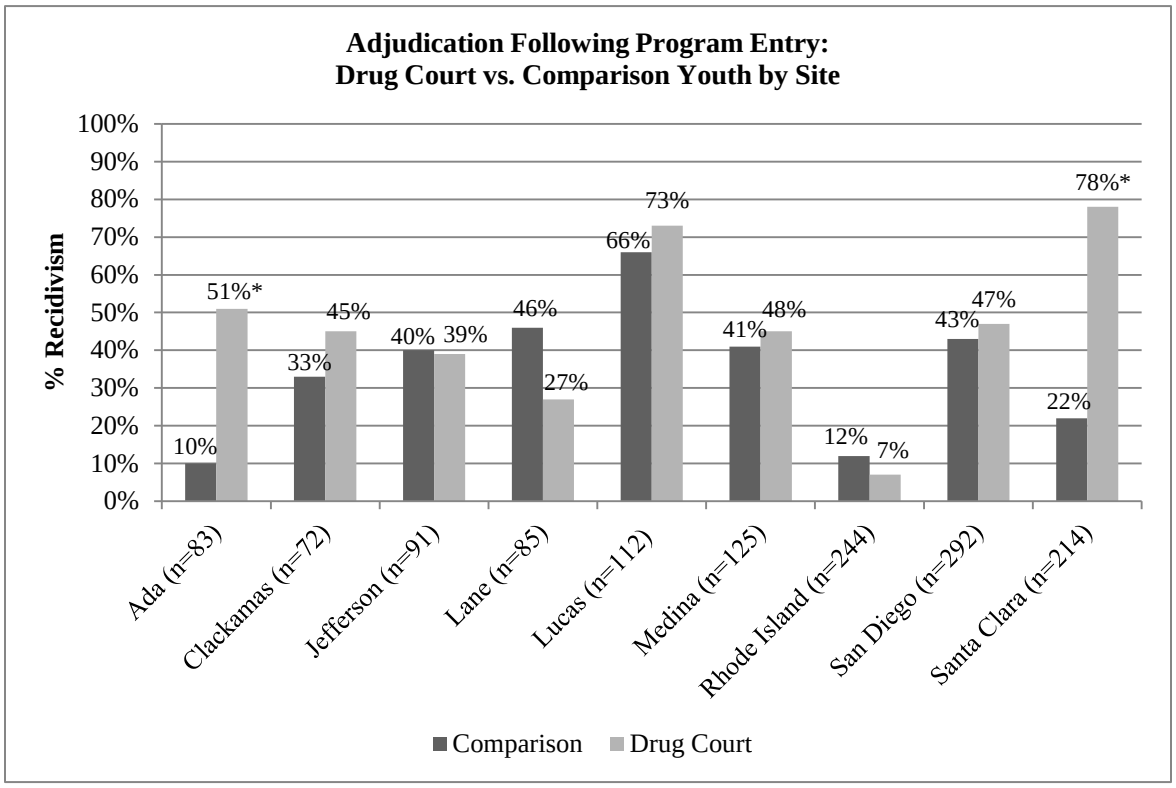
Figure 4b.



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Outcomes by Risk Level

Given the initial results just reported, it is important to consider factors that may moderate the treatment-outcome relationships. Figures 5a and 5b present the referral and adjudication outcome variables arrayed by the designated risk level for each youth. The multivariate models included all variables mentioned above with the exception of risk, which was used as a stratification measure in this case. As can be seen in the sample size figures shown on the x-axis, the majority of youth included in the study were designated as moderate or high risk according to personnel in each court and a standardized risk instrument. Among those designated as low risk, the Drug Court youth had higher levels of recidivism for both new referral (51%) and adjudication (33%), respectively. Low risk Comparison youth had prevalence levels of 39% and 25% for those outcomes. These differences are not statistically significant.

There were statistically significant differences in the likelihood of a new referral or adjudication for the moderate and high risk strata. Moderate-risk youth in the Drug Court group had a new referral prevalence of 55% compared to 39% in the Comparison group. Similarly, 43% of moderate-risk youth in the Drug Court group had a new adjudication following entry into the program compared to 24% of moderate-risk youth who were adjudicated while on probation supervision. The difference in prevalence of referral and adjudication for high-risk youth was slightly smaller than for moderate risk cases, but is statistically significant as well. Specifically, 71% of high-risk Drug Court youth had a new referral compared to 60% of those in the Comparison group. The difference between the high-risk Drug Court and Comparison groups was 10 percentage points for new adjudication (54% vs. 44%).

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Figure 5a.

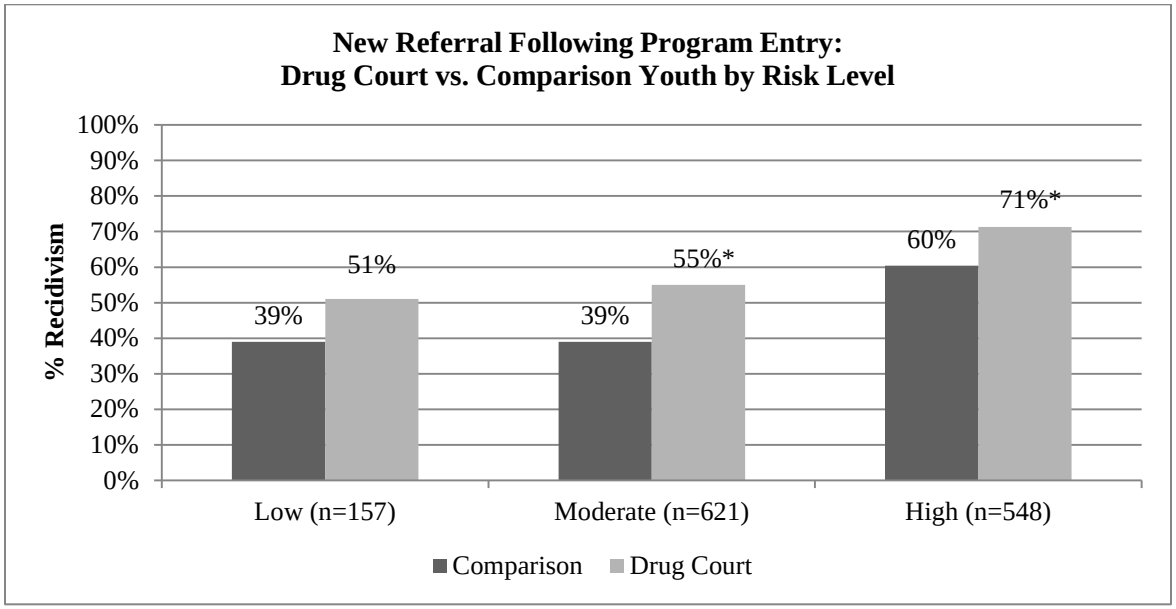
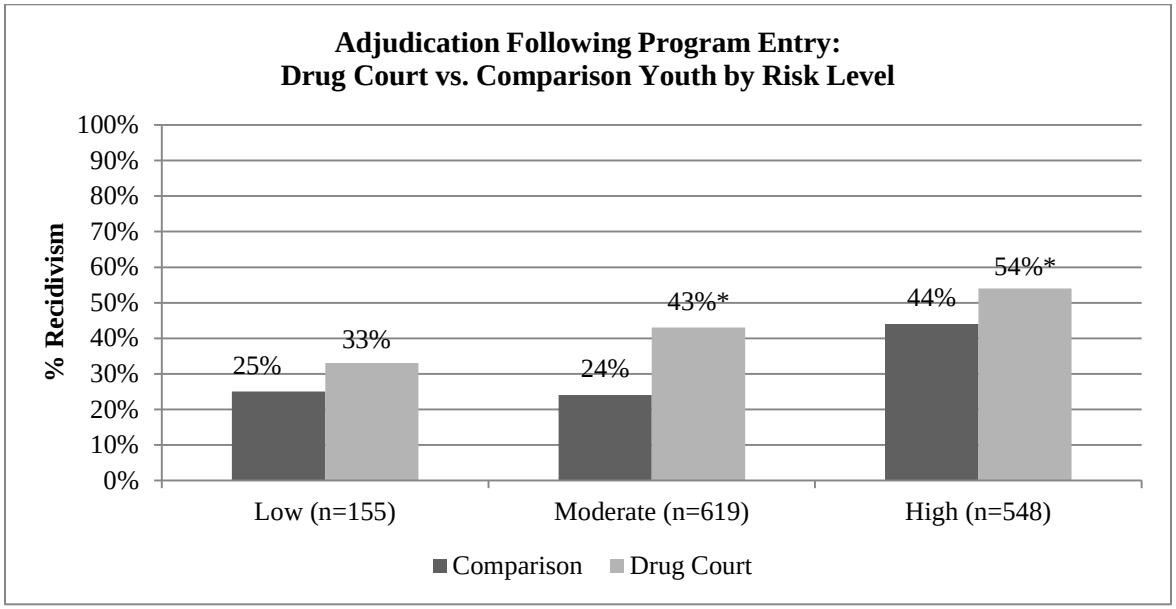


Figure 5b.



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Outcomes and Time of Program Entry

Given that youth had varying times of entry into the drug court or probation supervision, it is necessary to control for the "time at risk" for recidivism in assessing the outcomes from official records. As noted above, all multivariate models included such a variable. The bivariate

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comparisons show that there were group differences in overall time at risk that make it difficult to achieve balance on that measure—even after including that measure in the regression analysis. Given that there were some differences across groups and that those differences were sometimes particularly pronounced in sites with large effects favoring the Comparison group, results for the main outcome measures (new referral, new adjudication) were examined after stratifying for short, moderate, and long lengths of time at risk.[9] For the short duration, which included 467 cases, the results of the logistic regression models suggest that the Drug Court group had twice the odds of a new referral compared to those in the Comparison Group (Odds Ratio [OR]=2.05, $p<.05$). A similar odds ratio of 2.18 was observed for the new referral outcome for the moderate duration of time at risk (n=332). This was statistically significant as well. The effect for those with greater length of time at risk (n=517) also favored the Comparison group in that Drug Court youth had 34% greater odds of a new referral; this effect was not statistically significant when accounting for the important control variables. The results for new adjudications largely parallel those for new referrals. In the short duration group, Drug Court youth had nearly three times greater odds of a new adjudication (OR=2.99, $p<.05$). For the moderate duration group the odds ratio for new adjudication for Drug Court and Comparison youth is 2.06 ($p<.05$), and for those youth with a greater amount of time at risk, the odds ratio is 1.17 (nonsignificant). Generally, this suggests that the main conclusions are not contingent on the amount of time that youths have to accumulate new referrals or adjudications. Still, there is some variation in the effect size depending on how long the youth has for a potential new offense. In an ancillary analysis of the

[9] This measure was created by dividing the distribution of time at risk of a new offense into roughly three parts based on percentile values of the time difference between the first date (entry into the program) and the date that data were collected from agency records. The first strata cut point was up to 33 months (short), the second strata comprised those youth who had observation periods from 33 to 40 months (moderate), and the long risk time strata captured cases that had greater than 40 months to accumulate a new arrest.

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two sites that had a strong impact on the overall results, Santa Clara and Ada, both tend to show the same pattern of findings regardless of the specific degree of time at risk for committing a new offense.

Sociodemographics and Drug Court Outcomes

While there are some indicators that must be emphasized in fully contextualizing the main outcomes of interest (e.g., risk level, time at risk for new offense), there are a number of factors identified in the literature that may be correlated with successful drug court outcomes. For example, race/ethnicity and gender are variables that are frequently identified as important in the context of juvenile justice decisions and outcomes (e.g., Feld, 2009; Kempf-Leonard, 2007). Furthermore, some have investigated differences in Drug Court outcomes depending on gender (e.g., Polakowski et al., 2008) and race (Barnes et al., 2009) with mixed conclusions. The need for further examination of these variables here is also borne out in the multivariate regression models described earlier, which suggested significant relationships between race and sex and the likelihood of recidivism. Figures 6a and 6b provide the comparative outcomes for race and Drug Court versus Comparison groups. The descriptive race measure described earlier was collapsed for the purposes of subgroup analysis. The effect was statistically significant in each of the comparisons—even after controlling for other key covariates. In general, as suggested by the relationship between race and recidivism, nonwhite youth had significantly greater likelihood of new referrals or adjudications. This is apparent in looking at the relative height of the bars in each of the figures as well. Coefficient comparison tests were used to determine whether the effect for the treatment variable was significantly different across the two groups, which would suggest that Drug Court works better or worse for white or nonwhite youth (see Brame et al. 1998, Clogg et al., 1995). Though the difference between the Drug Court and Comparison cases

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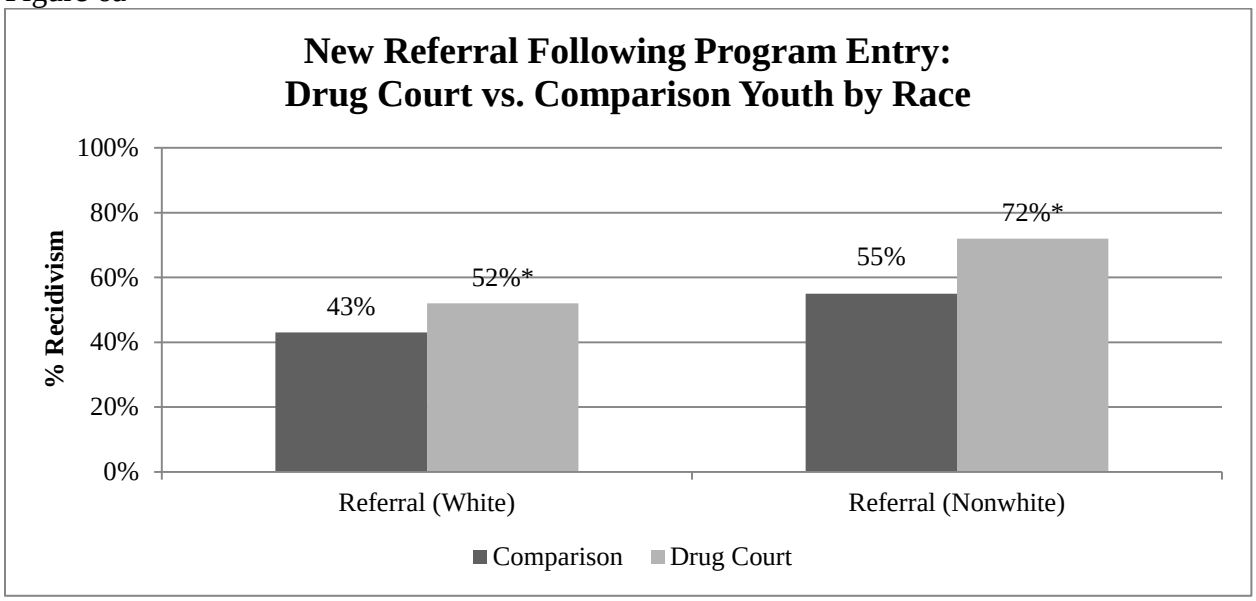
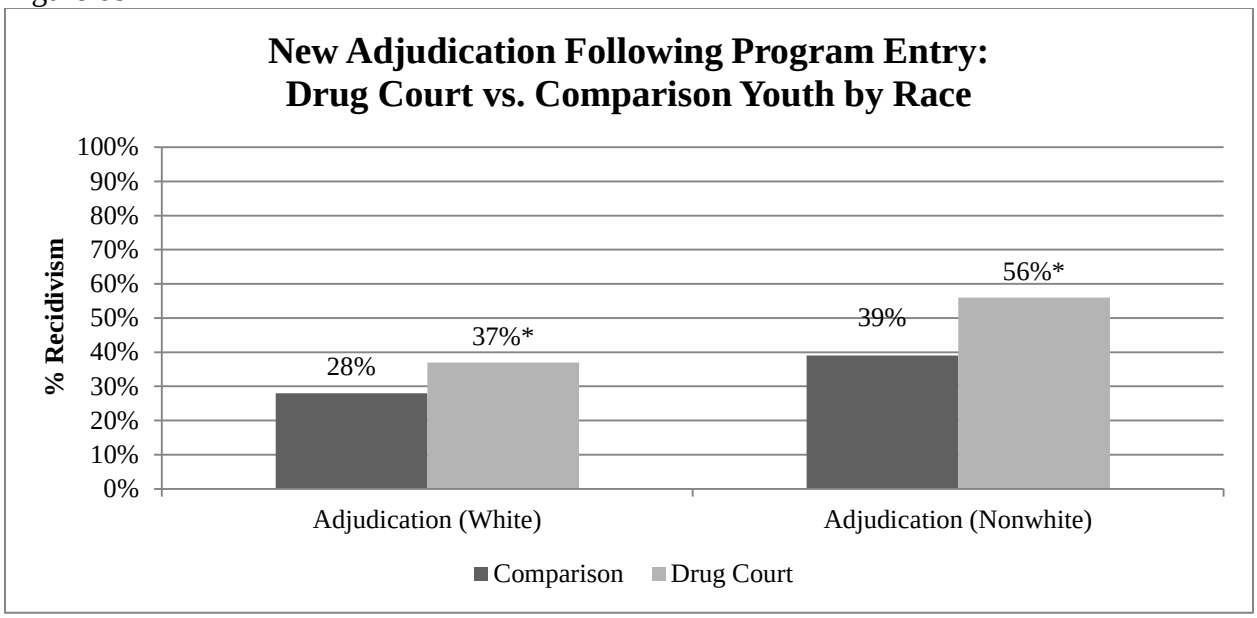
is larger for nonwhite youth for both new referrals and new adjudications, the formal test of coefficients suggests that the differences across the race subgroups are not statistically significant.

Figure 6a



*p<.05

Figure 6b



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Similar subgroup comparisons for males and females are summarized in Figures 7a and 7b. Females had a lower likelihood of recidivism than males—regardless of whether they were in the Drug Court or Comparison group. The figures illustrate that the treatment effect was statistically significant in each condition. In each case, the Drug Court group was significantly more likely to have a new offense relative to Comparison cases. The difference was 10 percentage points for males for both referral and adjudication. The differences for females were 20 and 18 percentage points for referral and adjudication, respectively. Though they are clearly somewhat divergent, these differences were nonsignificant using formal coefficient comparison tests.

Figure 7a

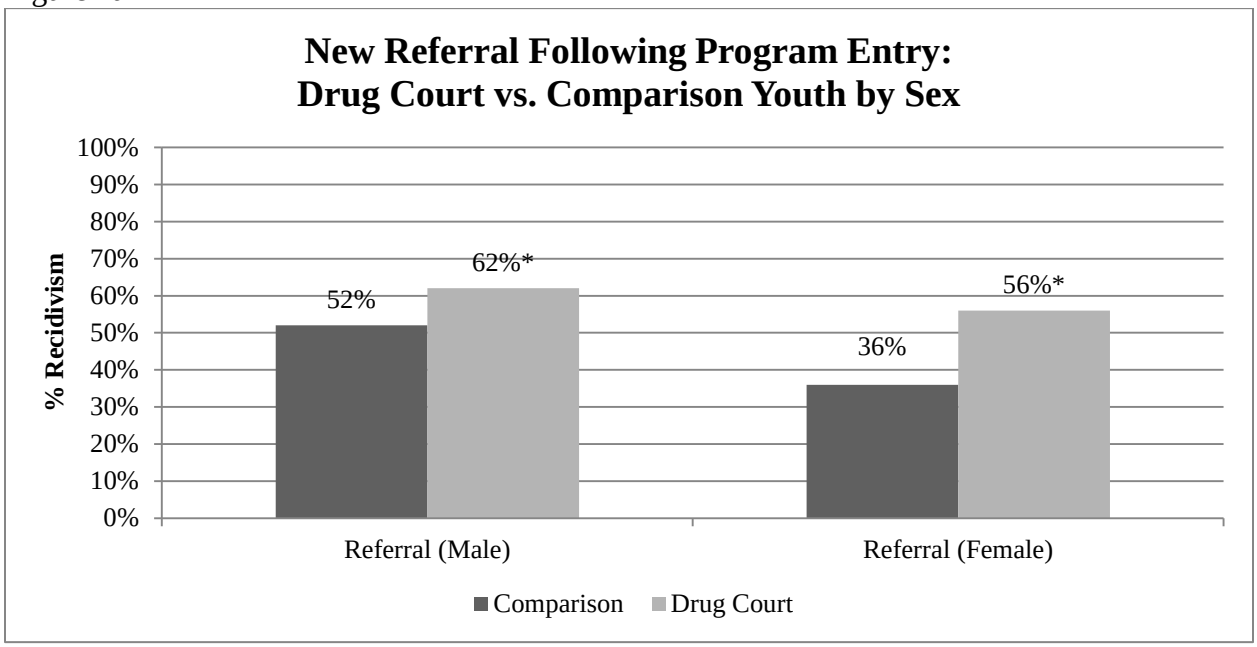

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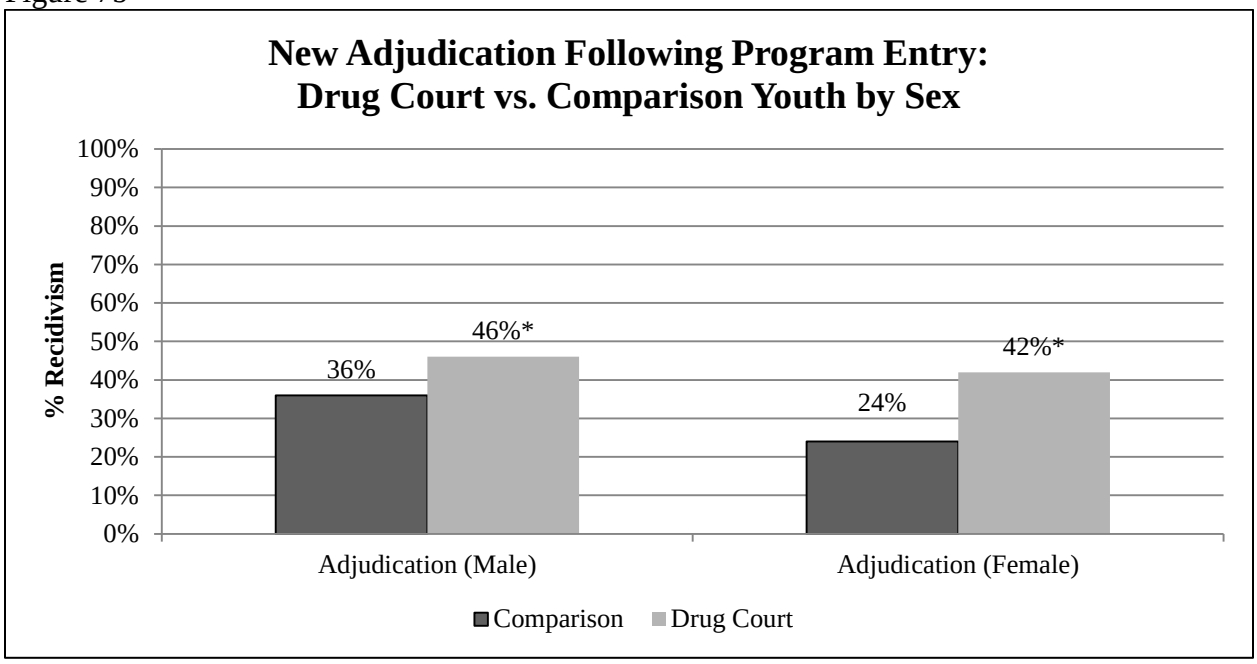
Figure 7b



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Age and Drug Court Outcomes

Previous studies have also considered whether Drug Court may be differentially effective for adolescents of different age groups (Polakowski et al., 2008). In order to investigate this contention, a treatment by age interaction term was first added to the multivariate models. The effect was not statistically significant for the new referral outcome (OR=1.13). It was, however, statistically significant for the new adjudication outcome variable. The odds ratio (1.27) suggested increasingly poor outcomes in terms of new adjudication for Drug Court group youth as they got older. Given these preliminary findings, the analysis of the main outcome variables was repeated after stratifying across three age groups (Under Age 15, Ages 15-16, Age 17 and over). The results of this analysis are shown in Figures 8a and 8b. In general, these figures confirm the age gradient identified in the interaction term models. In the youngest age group (under 15), the two groups are closer in terms of their recidivism rates following program entry, with the Drug Court youth showing a slightly lower, but nonsignificant, level of new referrals

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than Comparison youth (45% versus 48%). The effects for those in the Age 15-16 group and the Age 17 and over group tend to follow the general results presented earlier. Youth in the Drug Court group have significantly greater odds of new referrals and adjudications relative to those in the Comparison group. The effects are slightly stronger for youth in the 17 and over age group than the age 15-16 group for both new referrals (OR=2.31 vs. 1.58) and new adjudications (OR=2.60 vs. 1.79). They are not, however, significantly different in a formal coefficient comparison test.

Figure 8a

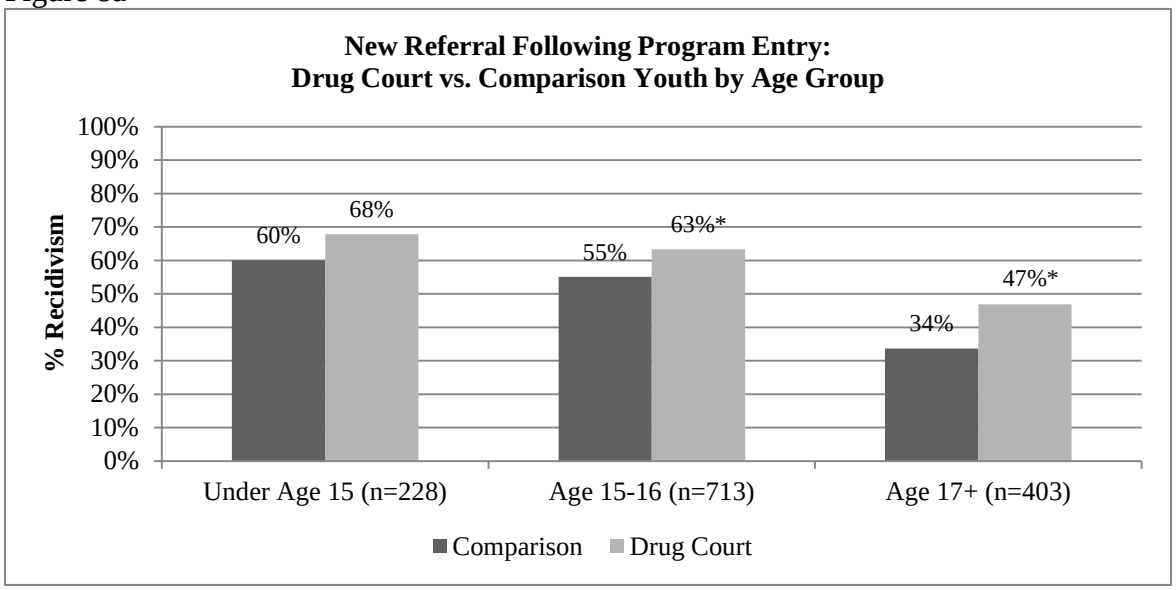

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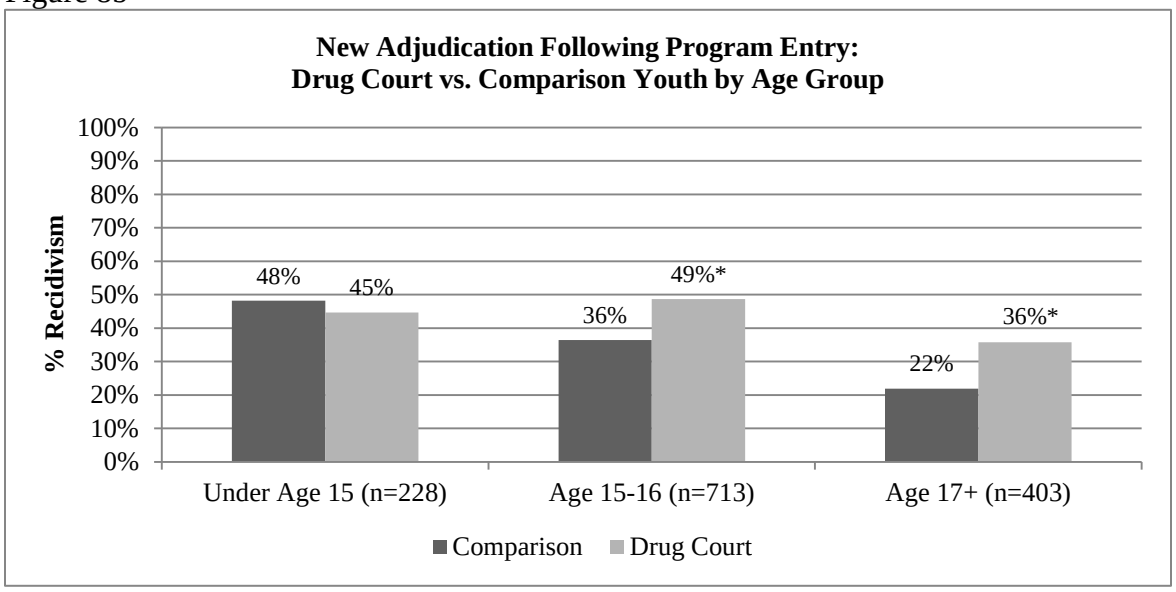
Figure 8b



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Other Possible Correlates of Drug Court Outcomes

While gender, race, and age are frequently looked at in the context of juvenile justice outcomes generally and Drug Court results specifically, there are several other factors that have been identified as possible correlates of success/failure in previous studies. Specifically, the (a) main substance of choice, (b) frequency of substance use, (c) previous treatment, (d) parental substance use, and (e) mental health problems are factors that have been identified as possible influences in prior literature that are also available in the data set used here.[10]

Table 16 shows the relationships between these possible influences and successful completion of treatment, new referral following entry into the Drug Court program, and new adjudication following entry into the Drug Court program. In general, there were few significant associations between these indicators and the three key measures presented in the table. None of the five measures had a significant association with successful completion of the Drug Court

[10] Other influences that have been identified in recent studies, such as Polakowski and colleagues (2008), are examined in different phases of the analyses presented here (e.g., performance in drug court such as positive drug screens, termination status).

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program, for example. There was a difference that approached significance for those youth who had evidence of a mental health problem versus those who did not (χ^2 = 2.78, p=.095). Similar associations were seen for the prevalence of new referrals and new adjudications. Looking at the recidivism indicators, those who primarily used alcohol tended to have a significantly greater likelihood of new referral (69.6%) and adjudication (55.5%), which were both greater than for youth who primarily used marijuana (58.3 and 42.1%) or other substances (52.8 and 38.1%). This suggests that Drug Court youth who primarily used alcohol fared worse in terms of outcomes. A similar pattern is seen for those youth who have had previous drug or alcohol treatment. For both outcomes, those youth who had not been in treatment previously had significantly lower levels of new referrals and/or new adjudications (58 and 43.5%, respectively) compared to those who had prior treatment (70.1 and 52.6%, respectively). Although there were some observable differences in terms of recidivism, particularly for frequency of use and adjudication, neither frequency of substance use nor having a family member with substance use issues was significantly associated with new referrals or adjudications.

Table 16. Outcomes for Drug Court Youth Across Possible Influences on Success

	% Successful Completion N=587 to 643	**% New Referral N=625 to 686**	**% New Adjudication N=613 to 674**
Primary Substance Used			
Alcohol	59.6	69.6*	55.5*
Marijuana	64.7	58.3	42.1
Other	63.6	52.8	38.2
Frequency of Substance Use			
<Once per week	68.6	57.2	39.9
Once per week or more	60.8	60.8	44.6
Daily	60.4	66.7	52.2
Previous Drug or Alcohol Treatment			
No	63.7	58.0*	43.5*
Yes	62.8	70.1	52.6
Family Member with Substance Abuse			

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Table 16. Outcomes for Drug Court Youth Across Possible Influences on Success			
	% Successful Completion N=587 to 643	**% New Referral N=625 to 686**	**% New Adjudication N=613 to 674**
No	64.1	59.7	44.3
Yes	63.2	61.8	47.5
Evidence of MH Problem			
No	67.0	57.7	41.5
Yes	60.6	63.1	48.8

*p<.05 using χ^2 test of independence

Program Completion, Duration of Participation, and Drug Court Outcomes

Successful completion status could be ascertained for the majority of youth in the Drug Court and Comparison conditions (n=1218 with 68% successful). Unsuccessful cases (32%) were considered to be those where the youth was terminated but (a) did not complete requirements, (b) absconded, or (c) were committed while in the Drug Court or under probation supervision (for Comparison cases). As a first step, an indicator for successful completion was added to the multivariate models for the new referral and adjudication outcome measures (post-termination only).[11] The results of those models continue to suggest an effect favoring the Comparison youth in terms of new referrals or adjudications. In both cases the odds of recidivism were more than 40% greater for the Drug Court youth. Still, the successful completion variable was statistically significant in both models. Those who were successfully terminated from either Drug Court or probation had significantly lower odds of a later referral and/or adjudication than those who did not successfully complete each of those processes. For referral, completers had odds roughly half as large as those who failed (OR=.51). Similarly, completers had 60% lower odds of a new adjudication relative to those who were unsuccessful in Drug Court or the Comparison condition.

[11] The overall referral or adjudication variables could not be used in this case as those would likely affect completion status. Consequently, this analysis draws only on those offenses that would have occurred after termination, whether successful or not.

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Figures 9a and 9b look specifically at the relationship across the treatment and comparison conditions for completers and noncompleters. First, the effects just described can be seen visually in these figures: those who successfully complete Drug Court or probation do better than those who do not. Second, the main effects described earlier remain the same for both completers and noncompleters. In three of the four possible comparisons shown here, there is a statistically significant difference between the Drug Court and Comparison groups—suggesting that Drug Court participants had a significantly greater likelihood of recidivism after controlling several key covariates. Coefficient comparison tests were used to determine whether there was a significant difference in the treatment effect across completers and noncompleters. These differences were small and nonsignificant for both outcome variables suggesting that there was no interaction between Drug Court or Comparison and successful completion.

The duration of participation or time in program was evaluated for each group as well. In the case of the comparison group, the interpretation of a potential effect is less meaningful as the "treatment as usual" scenario mainly consisted of probation supervision. For the Drug Court group, time in treatment had a negative impact on new referrals and adjudications/convictions, with odds ratios suggesting 1% (nonsignificant) and 3% ($p<.05$) reductions in recidivism respectively for each additional month in the program. Moreover, there was a significant differential in the effect of time in program across the Drug Court and Comparison groups for new adjudication ($z=2.53$, $p<.05$). The difference in effects on the referral outcome measure was sizeable as well but not statistically significant. These results suggest that maximizing time in the Drug Court and facilitating successful completion should be primary intermediate goals in achieving later desirable outcomes.

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Figure 9a

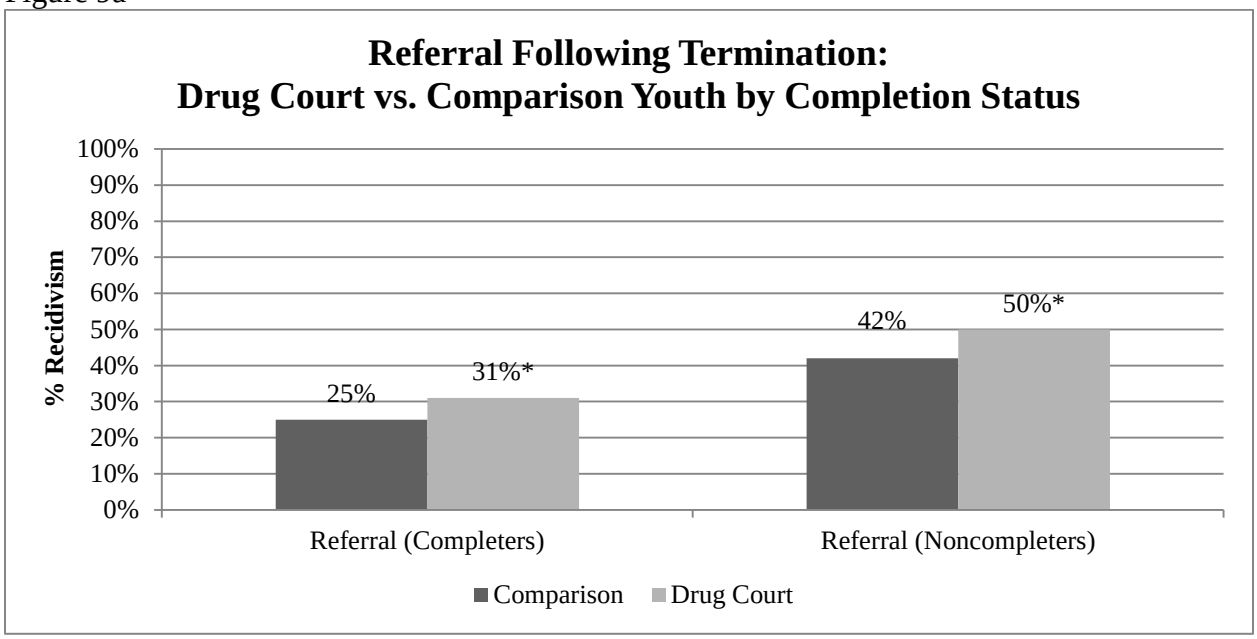
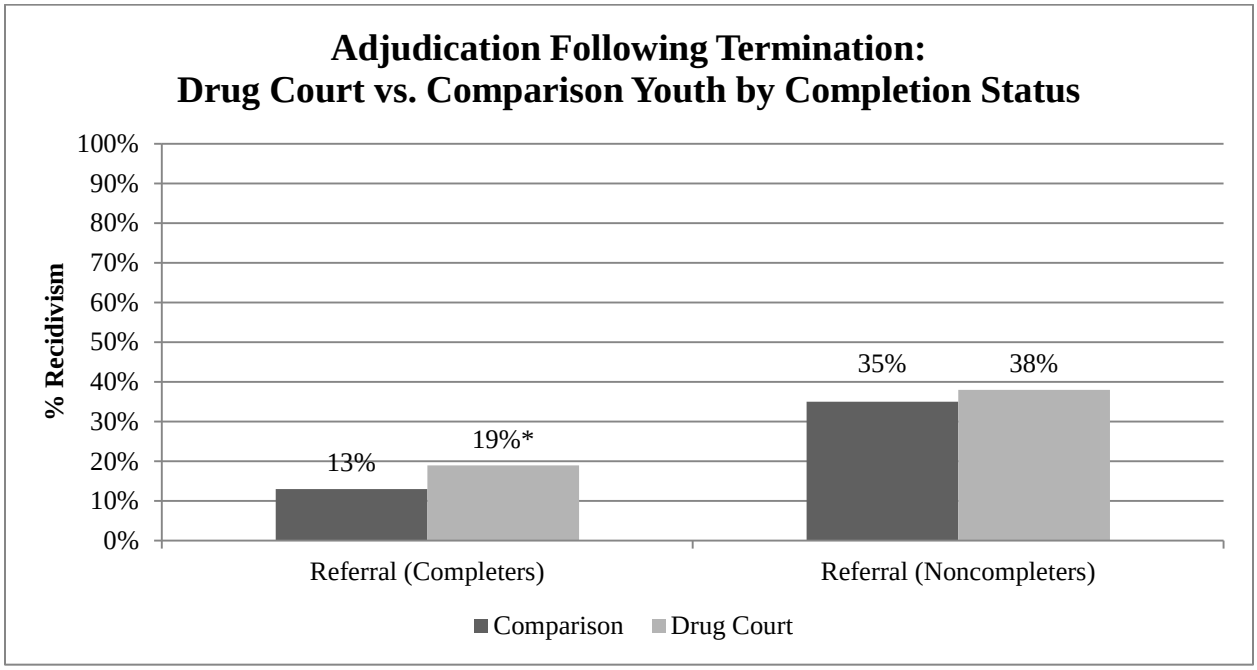


Figure 9b



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16 strategies for Juvenile Drug Courts

The 16 key strategies recommended by the NDCI are listed in Table 17. Each strategy contains certain Recommendations for Implementation. It is important to note that this seventh goal was added after the CPC-DC site visits had already taken place, and CCJR did not collect data on some of these strategies. Therefore, we are not able to fully confirm the importance of all 16 of these strategies. The proportion of Recommendations for Implementation that we can speak to are listed next to each strategy. For example, on Collaborative Planning, we have data that speaks to five of the 11 recommendations. The third column provides the specific Recommendations for Implementation that we have data on. Finally, in the last column, the number of CPC-DC indicators that speak to each strategy are listed. For instance, under Collaborative Planning, we have seven CPC-DC indicators that inform the practice. As is evident in Table 17, the overwhelming majority of recommendations do not correspond to any CPC-DC items. In fact, only 25 of the 152 Recommendations for Implementation parallel CPC-DC indicators.

Table 17. Correspondence of NDCI Strategies to CPC-DC

Strategy	Coverage	Recommendations Covered	CPC Items
1.Collaborative Planning	5 of 11	Written Policies, Operational Team, Participant Monitoring, Program Management, and Evaluation	7
2. Teamwork	0 of 11	--	--
3. Clearly Defined Population, Eligibility Criteria	2 of 6	Determine Criteria, Written and Formal Criteria	2
4. Judicial Involvement & Supervision	2 of 8	Staffing, Advance Notice to Judge	1
5. Monitoring & Evaluation	2 of 14	Ongoing Monitoring, Outcome Evaluation	6
6. Community Partnerships	0 of 8	--	--
7. Comprehensive Treatment Planning	5 of 11	SA Assessment, Phases, Reassessment, Treatment Continuum, Case Manager Coordinates	8
8. Developmentally Appropriate Services	3 of 10	Assessment of Developmental Level, Responsivity Issues for Each Client, Involve Family	3
9. Gender-	0 of 7	--	--

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Table 17. Correspondence of NDCI Strategies to CPC-DC			
Strategy	**Coverage**	**Recommendations Covered**	**CPC Items**
Appropriate Services			
10. Cultural Competence	0 of 10	--	--
11. Focus on Strengths	0 of 8	--	--
12. Family Engagement	0 of 8	--	--
13. Educational Linkages	0 of 8	--	--
14. Drug Testing	1 of 13	Frequency	1
15. Goal-Oriented Incentives and Sanctions	2 of 7	Individualized, Treatment Not used as Punishment	2
16. Confidentiality	1 of 12	Staffing Planning	1

As shown in the table above, a number of recommendations were not readily operationalized in the process evaluation. Overall, there are 152 specific recommendations within the 16 strategic points. Data were available on only 25 of them. Still, a number of CPC-DC indicators did address the strategies and recommendations. For example, the CPC-DC indicator for offender reassessment speaks to the recommendation of Ongoing Monitoring, Reassessment, and Treatment Continuum for Family-Based Services. As such, while there are 25 recommendations, there are 31 total instances of a match to a CPC-DC indicator. The prevalence of the nine courts that adhere to these recommendations is provided in the table below (Table 18).

As can be seen in Table 18, the nine courts included in this study are only somewhat adhering to these strategies. For instance, of the 31 CPC-DC indicators which correspond with the strategies, only 22 of them are being met by a majority of the courts. Some of the areas where the courts are meeting these recommendations include the following: these courts tended to select appropriate clients, staffed clients regularly, involved the correct team members in the staffings, and required the recommended level of participation and length of time in the drug court. The drug courts also provided sufficient case management and supervision of participants, used drug tests appropriately, and rewarded progress in the drug court. The participating drug courts struggled to

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meet other recommendations. In particular, the courts struggled with many of the quality assurance practices. For example, only one court (11.1%) had ever completed an outcome evaluation that included a comparison group. Concerning treatment practices, none of the courts required official aftercare. Additionally, only one court provided sufficient training to family/caregivers to assist the youth in making long term behavioral changes. Finally, staff training on the drug court model and effective practices in changing offender behavior was lacking. In fact, none of the courts met the CPC-DC indicator for staff training.

In sum, the courts in this study are not adhering to many of the recommended strategies. Since only two of the nine drug courts were effective in reducing recidivism, this may be a result of their lack of adherence to these strategies.

Table 18. Number of Drug Courts Adhering to Recommendations for Implementation

Strategy Number	Recommendation	CPC-DC Item	Number of Drug Courts
1	Written policies	Ethical guidelines	4
1	Written policies	Appropriate clients	8
1	Written policies	Violent offenders excluded	8
1	Operational team	Program coordinator	7
1	Operational team	Staff meetings	8
1	Operational team	Assessments shared	5
1	Participant monitoring, program management, evaluation	Staff meetings	8
1	Participant monitoring, program management, evaluation	DC evaluation	2
1	Participant monitoring, program management, evaluation	DC evaluation – methodology	1
1	Participant monitoring, program management, evaluation	Program evaluator	2
1	MIS/Data	Recidivism tracked	6
1	Training	Staff training	0
3	Determine criteria	Appropriate clients	8
3	Determine criteria	Violent offenders excluded	8
3	Written and formal criteria	Appropriate clients	8
3	Written and formal criteria	Violent offenders excluded	8
4	Staffings	Staff meetings	8
4	Advance notice to judge	Staff meetings	8
5	Ongoing monitoring	Quality assurance	1
5	Ongoing monitoring	Participant satisfaction	3
5	Ongoing monitoring	Offender reassessment	3

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Table 18. Number of Drug Courts Adhering to Recommendations for Implementation			
Strategy Number	**Recommendation**	**CPC-DC Item**	**Number of Drug Courts**
5	Ongoing monitoring	Recidivism tracked	6
5	Ongoing monitoring	DC evaluation	2
5	Ongoing monitoring	DC evaluation – methodology	1
5	Ongoing monitoring	Program evaluator	2
5	Outcome evaluation	DC evaluation	2
7	SA assessment	Need assessment	6
7	Phases	Length of treatment	7
7	Phases	DC involvement	7
7	Reassessment	Offender reassessment	3
7	Treatment continuum for A/D	Aftercare	0
7	Treatment continuum for A/D	Aftercare quality	0
7	Treatment continuum for family-based services	Offender reassessment	3
7	Engage family support	Family trained	1
7	Case manger coordinates services	Case management/supervision	9 (all)
8	Developmental level assessment	Responsivity assessed	2
8	Developmental level assessment	Matching	0
8	Specific responsivity issues for each client	Responsivity assessed	2
8	Specific responsivity issues for each client	Matching	0
8	Involve family	Family trained	1
14	Frequency (Drug Testing)	Drug tests	8
15	Individualized	Reward structure	7
15	Treatment not used as punisher	Reward structure	7
16	Staffing planning	Staff meetings	8

CPC-DC Results and Youth Outcomes

The process evaluation component of the study yielded a set of percentage values based on the scoring system described above. This was then examined in relation to the treatment outcomes presented earlier in this section (see Figure 1). Table 19 summarizes this analysis. The overall CPC-DC scores range from a potential low of zero to a high of 100. The Effect columns represent the Drug Court effect size in Odds Ratio form; values below one favor the Drug Court and those above one indicate that youth in the Drug Court condition had higher levels of recidivism than Comparison youth. Table 19 demonstrates that there is no clear pattern of association between the overall CPC-DC score and the main effect size values for new referral or adjudication. At a

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bivariate level the CPC-DC scores did not help to discern between sites in terms of their relative ranking of Drug Court effects.

Table 19. Comparison of Overall CPC-DC Score and Odds Ratio for Drug Court vs. Comparison by Site

Site	Overall CPC Score (0 to 100)	Effect on Referral	Effect on Adjudication
Ada	55.8	3.68	10.62
Clackamas	46.5	1.93	1.80
Jefferson	46.5	0.98	1.70
Lane	44.2	0.44	0.48
Lucas	37.2	2.58	2.06
Medina	60.5	1.30	1.28
Rhode Island	25.6	1.54	1.89
San Diego	46.5	1.07	0.86
Santa Clara	51.2	15.75	14.37

To further assess the possible link between programs and youth outcomes, the multilevel models described above were used as a base for integrating some of the information from the CPC-DC assessment into the consideration of new referrals and new adjudications. The results of a model that incorporates the overall CPC-DC score for each site along with a CPC-DC score by treatment group interaction term are presented in the final column of the multilevel results tables shown in Appendix F. In general, those results, along with others that incorporated the various domain scores for the CPC-DC (e.g., treatment, capacity, quality assurance), suggest that there were no significant effects on individual recidivism outcomes as reflected in new referral and new adjudication. Furthermore, any possible differences in the effectiveness (or lack thereof) across the nine sites did not interact with the site CPC-DC scores. Other measures that have been considered in previous studies (e.g., whether family treatment was part of the process, training in the drug court model) were considered for possible inclusion in these analyses, but had very limited variation across the nine sites and would not have been effective covariates—even putting aside low sample size.

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Section 5: Summary and Discussion

In looking at the full sample (n=1372), youth were predominantly moderate and high risk and 16 years of age. Males comprised three-fourths of the sample. Approximately 60% of the sample was white and 40% nonwhite. Youth in the study sample frequently used alcohol and drugs, with greater frequency of use seen with drugs, overwhelmingly marijuana. These youth started using both alcohol and drugs early in adolescence, around 13.5 years of age on average. Youth were predominately involved in the juvenile justice system for misdemeanor offenses related to property and drug and alcohol offenses. Approximately half of the youth had prior adjudications.

The Drug Court and Comparison groups were matched fairly well. A greater prevalence of low-risk youth with higher rates of both alcohol and drug use were found in the Drug Court group, however. Drug Court youth preferred alcohol and other drugs to marijuana at greater rates than youth in the Comparison group. Drug Court youth also were more likely to have had prior drug charges, prior drug and alcohol treatment, and prior mental health treatment. Not unexpectedly, youth in the Drug Court group differed significantly on some intermediary variables related to processing and supervision. For example, youth in the Drug Court group had a higher frequency of status reviews, treatment referrals, drug tests, incentives, and sanctions than youth on probation. Youth in the Drug Court group also had significantly greater motivation levels than youth in the Comparison group at baseline. Fewer youth in the Drug Court group completed successfully than youth in the Comparison group.

The nine study sites varied in terms of their programming, processing, and the composition of the groups of youth whom they treated. Sites varied in the number of youth enrolled in the study. This ranged from a low of 72 in Clackamas County to a high of 296 in San Diego County. Overall, the matching on key variables within sites was good. Six of the nine drug courts had no significant differences between the groups on the other key baseline variables. One site differed significantly

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on one matching variable, and two sites differed significantly on two matching variables. The nine sites had more variation on the other key baseline variables. Of 17 other key variables (e.g., age, offense level and type, prior adjudications, gang involvement, truancy), the number of significant differences within sites ranged from one to 11.

The results presented above provide useful insight on the questions driving this study and the performance of juvenile drug courts more generally. In this section of the report, key findings are discussed in relation to the research goals, limitations are considered, and policy recommendations and conclusions are presented. There were seven main goals in the research project. Each goal is discussed in relation to important findings. The seven goals are as follows:

1) To determine if there is a reduction in recidivism and substance abuse associated with participation in a juvenile drug court program, as compared to comparison groups.

2) To determine if there are increases in social functioning related to participating in juvenile drug court programs when compared to comparison groups.

3) To identify the characteristics of successful juvenile drug court participants.

4) To determine if juvenile drug courts are operating in a manner consistent with an evidence-based approach.

5) To identify the programmatic characteristics of effective juvenile drug courts.

6) To provide policymakers with information about the effectiveness of juvenile drug courts.

7) To determine if the 16 strategies for Juvenile Drug Courts recommended by the National Drug Court Institute (NDCI) are effective practices.

Goal 1: To determine if there is a reduction in recidivism and substance use associated with participation in a juvenile drug court program, as compared to comparison groups.

Drug Court youth recidivated at significantly higher rates than the Comparison group in the full sample analysis. The key recidivism measures were: new referral while in drug court or on probation, new adjudication while in drug court or on probation, new referral after completion of drug court or probation, new adjudication after completion of drug court or probation, and any referral or adjudication (in program and post-program combined). These results indicate that

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overall, the youth on probation had better outcomes than youth in drug court. Formal modeling results, which included several important control variables (e.g., risk level, age, gender, time at risk for a new offense) confirmed these findings, and show that when the two sites with the highest failure rates are removed (Ada and Santa Clara), results still favor the comparison group (although the results were not statistically significant). When these analyses are broken down by site, outcomes continued to favor Comparison youth. Two of the sites, Jefferson and Lane, evidenced lower rates of post-program referrals and post-program adjudications for Drug Court youth, however.

File review data was used to examine the frequency of use of alcohol and drugs at the time of intake to drug court or probation (these results are provided in the Site-by-Site Descriptives and Results starting on page 44). Self-report survey data was then used to examine the frequency of use of alcohol and drugs post-termination. As previously noted (see pages 34 and 98), there are significant limitations to the use of this self-report data. Still, even noting those limitations, the results from the self-report survey indicate that alcohol and drug use was highly prevalent for youth in both the Drug Court and Comparison groups during the follow-up time period. Youth in Drug Court did have lower rates of reported alcohol use (nonsignificant) and lower rates of reported drug use (significant) when compared to youth in the Comparison Group, however.

- Overall, the drug courts did not result in reductions in recidivism for drug court participants as compared to the control group.
- Only two of the nine drug courts evidence consistent reductions in recidivism.
- Based on the self-report data, some outcomes, including substance use, showed improvement for drug court youth relative to comparison youth.

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Goal 2: To determine if there are increases in social functioning related to participating in juvenile drug court programs when compared to comparison groups.

Given the limitations with the self-report data, there were some shortcomings in fully exploring this goal. Analyses were performed which examined youths' reports of any criminal activity, whether they attended school the majority of the time over the month preceding the survey, whether they were employed, and whether the youth had run away from home. All of these tests indicated nonsignificant differences between groups in both multivariate and bivariate analysis. Drug Court youths reported lower rates of engaging in criminal behavior, higher rates of employment, and lower rates of running away from home. Youth were almost equal in school attendance across the two groups. Based on the self-report data, some outcomes showed improvement for Drug Court youth relative to Comparison youth.

Goal 3: To identify the characteristics of successful juvenile drug court participants.

Several potential "moderators" of treatment effects were examined in the analytic process. Some of these were standard factors that may be important in assessing gender, culture, or age responsivity. Other moderators were drawn from previous studies of drug treatment or drug court effectiveness. Although there were some differential effect sizes for the main outcomes by risk level (low, moderate, high) there was little evidence that Drug Court youth at particular risk levels did considerably better than those at others. Race and gender were both determining factors in post-program referrals and adjudications. Nonwhite youth were significantly more likely to have post-program referrals and adjudications, although the assessment of a race-treatment interaction effect was not statistically significant. Similarly, while the gender interaction was nonsignificant, female drug court participants evidenced a greater prevalence of post-program referrals and adjudications than female Comparison youth, and the relative gaps appear to be wider for females than males. In general, the relevant analyses suggest that older youth tended to have worse outcomes than younger ones.

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In examining the recidivism indicators, youth who primarily used alcohol fared worse concerning recidivism. Youth with alcohol as the drug of choice had higher rates of new referrals and adjudications than youth who used marijuana or other substances. Similarly, those who had previous drug or alcohol treatment appeared to be more likely to recidivate. This suggests the importance of considering the nature of the youth's substance use problem and prior treatment history in drug court entry and the intervention plan.

Goal 4: To determine whether juvenile drug courts are operating in a manner consistent with an evidence-based approach.

The CPC-DC results shed light on this goal. Of the nine drug courts, two were categorized as "effective" on the CPC-DC, four were categorized as "needs improvement," and three were categorized as "ineffective." None of the courts were categorized as "highly effective." Across the nine drug courts, 35 referral agencies were assessed. On the CPC-DC: RA overall, four referral agencies were rated as "highly effective," six as "effective," 12 as "needs improvement", and 13 as "ineffective." The capacity area of the CPC-DC and CPC-DC: RA is designed to capture the ability of the drug court or referral agency to deliver effective treatment. Three of the nine courts and 29 of the referral agencies scored "effective" or "highly effective" in the capacity area. For the drug courts, this indicates that the majority of the courts assessed for this project were not in a good position to deliver effective services (e.g., lacked appropriate staff training, did not use sufficient quality assurance checks with the program or with the referral agencies, and did not evaluate the outcomes of the drug court). For the referral agencies, most had set the groundwork for having the ability to deliver evidence-based practices.

The results for the content area of the CPC-DC and CPC-DC: RA suggest that the sites are not adhering to risk, need, and responsivity principles in a way that would be consistent with evidence-based practice. Only two of the drug courts and 10 of the referral agencies scored in the "effective" or "highly effective" categories in terms of their adherence to best practices. This is

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cause for concern as assessment and treatment practices are the foundation for delivering evidence-based practices. In particular, drug courts struggled with assessing responsivity, screening low risk youth out of the drug court, targeting youth with a clear need in substance abuse, ensuring that referral agencies were providing cognitive-behavioral approaches, matching clients to appropriate treatment agencies, varying the intensity of drug court services to the risk and need level of each youth, ensuring that youth completed the drug court program, using an appropriate ratio of rewards to sanctions, responding to noncompliance appropriately, training family to assist youth with long-term behavioral change, and providing quality aftercare services.

The referral agencies also did not perform well in the content area. For example, they did not impose selection criteria, did not adequately assess youth, did not use cognitive-behavioral approaches, did not provide separate treatment groups for males and females, did not use homework to further learning, did not use sanctions to discourage negative behavior, and did not develop risk and relapse prevention plans. All of these factors surely contribute to the ability of the drug courts to reduce recidivism and drug use and increase social functioning.

Goal 5: To identify the programmatic characteristics of effective juvenile drug courts.

The fifth goal of this study relates to the "black box" of drug courts. In essence: what distinguishes a successful court from an unsuccessful court? Only two of the drug courts evidenced better outcomes compared to youth on probation, Jefferson and Lane. Jefferson scored in the “needs improvement” category and Lane scored in the “ineffective” category on the CPC-DC. Obviously, these findings in the process portion of the study contradict some expectations from the outcome analysis. Results presented earlier also highlight that there is no clear association between the CPC-DC scores and the official recidivism data more generally. As such, the CPC-DC scores for Jefferson and Lane were broken down further in order to unpack the noted discrepancies. Looking at these two courts, there are certain factors that they excel at that may explain the

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findings. For example, both courts were developed in adherence to core drug court practices (e.g., having a program coordinator and providing sufficient case management/supervision) and were sufficiently funded. Both courts offered an adequate length of treatment and had set completion criteria which ensured that youth progressed through the courts accordingly. The Lane drug court also provided exceptional treatment services to youth, with the average category of the CPC-DC: RA rated as "highly effective." This suggests that, while the structure of the drug court and its processes matter considerably, the referral agencies with whom they contract for services are likely essential in affecting individual youth outcomes.

The two courts that exhibited strong effects around increased recidivism for drug court participants were Ada and Santa Clara. Ada scored in the "effective" category and Santa Clara in the "needs improvement" category on the CPC-DC. With Ada, while the court was using good practices, the treatment was not high quality (scoring only 35.5% on the CPC-DC: RA). This may have resulted in the poor outcomes evidenced for Drug Court youth in Ada. For Santa Clara the combination of "needs improvement" for both the court and the referral agencies likely led to the disappointing outcomes.

Overall, tying the CPC results to the impact evaluation results did not provide a great deal of insight in connecting the processes and outcomes. This is likely due in part to the limited range in adherence across the sites, the fact that the sites tended to score low within that range, and, finally, that there were only nine sites from which to draw conclusions.

Goal 6: To provide policymakers with information about the effectiveness of juvenile drug courts.

An observation of the key results of this study as well as the area of research more generally suggests that policymakers, practitioners, and researchers need to seriously consider the question of whether drug court programs should be used with juveniles—at least as presently constituted. Belenko (1998, 2001) indicates that past research on juvenile drug courts has had methodological

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limitations including inadequate comparison groups, excluding unsuccessful cases from their outcomes, failing to follow participants post-program completion, and not examining whether the courts adhered to evidence-based practices. Mitchell et al.'s recent meta-analysis (2012) found that only the studies of low methodological quality indicated that juvenile drug courts significantly reduce recidivism. This multi-site study used comparable groups of justice-involved youth, which allowed us to overcome some of the methodological limitations highlighted in those reviews. Further, the results of this study also bring into question the effectiveness of juvenile drug courts in ways that are consistent with other studies that have reached mixed conclusions around the effectiveness of juvenile drug courts (e.g., Hartmann and Rhineberger, 2003; Wright and Clymer, 2001).

The intensity and inherent structure of drug courts may be resulting in the poor outcomes identified in this study. Youth in drug court had considerably more status reviews, case hearings, and drug tests than youth on probation. As such, they had much more opportunity to fail. The Drug Court group had greater prevalence of technical violations related to substance use, treatment noncompliance, and school-related problems as well. That group also had a far greater volume of these violations. While those measures clearly reflect the performance of individual youth, the findings may also require some thinking about whether the philosophy and processes inherent in drug courts are a good fit to the target population of adolescent drug users. One result of the current study is that youths who use substances other than alcohol and marijuana tended to show better outcomes, but the majority of youth included in the study sample comprise those who use the latter substances. It is possible that this population may be using substances in more temporary ways that may not be amenable to drug court practices that were designed for addicts who form the target population for drug courts in the adult justice system. This presents a question with respect to whether youth who only use alcohol or marijuana should be placed in intensive services modeled

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after treatment regimens given to criminal addicts in the adult system. Certainly, a lack of intervention may be unwarranted, but this study suggests that the drug court structure may be problematic for these youth.

The treatment approaches used by the agencies providing services to the drug court youth were predominantly talk therapy and education based. These two approaches have been proven ineffective in changing offender behavior. The body of research on juvenile offender rehabilitation overwhelmingly supports cognitive-behavioral treatment approaches for offenders (for a review, see Lipsey, 2009). This may be another reason why such high failure rates were evidenced by the majority of drug courts in this study.

In general, adult drug courts have been shown to be effective. However, this study finds little evidence that juvenile drug courts are effective. These results may be related to the nature of substance abuse in general. Adult offenders are much more ingrained in their use (i.e., longer duration of use, a larger variation in the substances used). For example, in a study of multiple adult drug courts in the state of Ohio (Lowenkamp et al., 2005), the average age of adult offenders was 32 and the offenders averaged 12 years of substance use. The juveniles in this study average 16 years of age and three years of substance use. These youth also overwhelmingly used only alcohol and marijuana. As such, we speculate that our results stem from the fact that adult offenders are further along in their substance abuse and have likely received more negative consequences for their substance use and associated criminal behavior. Therefore, adults are likely at a different stage in their amenability to treatment.

Goal 7: To determine if the 16 strategies for Juvenile Drug Courts recommended by the National Drug Court Institute (NDCI) are effective practices.

The seventh goal was added toward the end of the study and CCJR did not collect data on many of these strategies. Overall, drug courts met only about half of the recommendations. These included: selected appropriate clients, reviewed client progress regularly, involved the correct team

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members in the staffings, and required the recommended level of participation and length of time in the drug court. The drug courts also provided sufficient case management and supervision of participants, used drug tests appropriately, and rewarded progress in the drug court. However, the drug courts failed to meet many of the recommendations including quality assurance measures, aftercare provision, training for caregivers, and staff training (both concerning drug courts and evidence-based treatment approaches). In sum, the drug courts in this study are not adhering to many of the recommended strategies. Since only two of the nine drug courts showed positive outcomes on the main outcome measures, this lack of success may be partly a result of lack of adherence to NCDI suggested strategies.

Study Limitations

This study mainly relied on a comparison of outcomes for youth who participated in drug courts versus those on regular juvenile probation. Without random assignment, there is likely to be some imbalance between groups in terms of unobserved factors that might influence outcomes. Comparison groups can never be constructed with perfect fidelity in a quasi-experimental design. Still, the groups used here tended to be quite similar on a number of important factors. Overall in looking at Drug Court and Comparison groups, there were significant differences in two of the matching variables and seven other key baseline variables. Still, even in those cases where differences were identified, a number of relevant controls were utilized in the main analyses and sensitivity checks were carried out as needed to determine whether the findings were robust to some possible methodological/analytic problems. In general, the consistency in the main findings across various analyses and subgroups within the larger sample suggests that the overall conclusions reached here are an accurate reflection of the data collected for the study.

This study relied on self-report data to determine improvements in social process outcomes. The rate of return for this survey was only 21% across the three follow-up periods. This suggests

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that there may be some response bias associated with the respondents. A comparative analysis of those youth who completed the survey and noncompleters did not identify striking differences in the two groups that might affect responses to the main items of interest in the analysis. Furthermore, in examining these data, those who did respond showed no proclivity to hide problem behavior. For example, the vast majority of youth self-disclosed use of substances during the follow-up period, and slightly higher levels of youth indicated that they had engaged in delinquent behavior.

Limitations in the self-report data also point to some constraints associated with reliance on official record measures for recidivism. All the findings suggest that Drug Court youth fared worse on officially recorded outcomes. While there is likely to be a good deal of concordance between official records and actual rates of offending, the Drug Court youth were monitored to a greater degree than those in the probation-only group, which may have some impact on the observed results for officially recorded recidivism and technical violations. Thus, some of the overall difference in the two groups may be attributable to the degree of contact with the system and treatment providers on the part of Drug Court youth. Still, the main study findings emerged even after youth were terminated from drug court or probation supervision, suggesting that this "monitoring effect" would only be a partial explanation for the observed differential between the two groups.

Goal seven of this study was added midway through the study. As such, data were not specifically collected to address this goal. Nevertheless, it appears that there was limited adherence to identified best practices in the CPC-DC in general and the 16 specific strategies and associated recommendations promulgated by NDCI. Furthermore, while attempts were made to link data about the drug courts to youths at each site in multilevel analyses, there was limited variation in terms of some of the key indicators of Drug Court processes, and the sample size of nine sites limited the degree to which formal hypothesis tests could be used to study key questions requiring tying process results to outcome results.

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Conclusion

Despite some important limitations, this study provides valuable insight regarding juvenile drug court practices and performance with respect to individual youth outcomes. On the whole, the key study findings raise important questions about the effectiveness of drug court for juveniles. It is clear that youth in Drug Court fared poorly relative to those in the Comparison group. This finding showed up across the vast majority of sites, and the core results hold up to a variety of different checks and subgroup analyses. Notably, similar findings have emerged in other recent studies of juvenile drug courts (e.g., Hartmann and Rhineberger, 2003; Mitchell et al, 2012; Wright and Clymer, 2001). Given the findings of the outcome analysis and results from the CPC-DC assessment of the courts involved in the current study, it is clear that there is a need for further discussion around the underlying theory and actual practice of juvenile drug courts in terms of potential effectiveness with the target population.

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Appendix A: Data Collection Forms

I. STANDARDIZED INTAKE FORM

Identifying Data

1.1) ____ ____ - ____ ____ - ____ ____ ____ CLIENT ID

1.2) ____ ____ SITE ID

01=Ada County	05=Lucas County	08=Rhode Island County
02=Clackamas County	06=Medina County	09=San Diego County
03=Jefferson County	07=Polk County	10=Santa Clara County
04=Lane County		

1.3) _____/_____/_____Date form is initiated

1.4) _____Name of data collector

1.5) _____ Case number

1.6) _____ Last name

1.7) _____ First name

1.8) _____ Middle initial

1.9) ____ ____ ____ - ____ ____ - ____ ____ ____ ____ SSN

1.10) _____
Mailing Address: Street, City, State; Telephone Number

1.11) _____
Mailing Address: Zip Code

1.12) _____/_____/_____ Date of Birth

1.13) _____ Is this offender in the drug court group or the comparison group?
1=drug court
2=comparison

1.14) _____/_____/_____ Date Screened for Drug Court or Probation

1.15) _____ Is this a "restored" case?
1=Yes
2=No

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3=Not Applicable

1.16) _____ Is this an active case?
1=Yes
2=No

1.17) _____ Race
1=White
2=Black
3=Hispanic
4=Native American
5=Asian
6=Other
7=Unknown

1.18) _____ Sex
1=Male
2=Female

1.19) _____ Marital Status
1=Married
2=Not Married

1.20) _____ Highest Grade Completed
0=GED
99999=Unknown

1.21) _____Was the offender employed prior to referral?
1=Yes
2=No
3=Unknown

1.22) _____ How many hours does the offender typically work per week (prior to referral)?
1=35 hours or more/week
2=15 to 34 hours/week
3=Less than 15 hours
4=Zero, does not work
5=Unknown

1.23) _____ Number of child dependents (under 18 years of age); 99999=Unknown

1.24) _____ Offender pregnant
1=Yes
2=No
3=Not Applicable

1.25) _____ Has the offender moved during the past 12 months?
1=Yes
2=No
3=Unknown

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1.26) _____ How many times has the offender moved during the past 12 months?
99999=Unknown

1.27) _____ What is the youth's primary residence?
1=parent(s)/guardian(s)' home
2=outside placement
3=secure placement

Offense

1.28) _____/_____/_____ Date of referral

1.29) _____ Level of offense at the time of referral

1.30) _____ Charge (most serious)

1.31) _____ Number of pretrial days served as a result of the instant offense

1.32) _____/_____/_____ Date of first court appearance

1.33) _____ Were the charges reduced as a result of acceptance to drug court?
1=Yes
2=No
3=Not Applicable

1.34) _____ Legal Status
1= Adjudicated
2=Pre Adjudication

1.35) _____ What was the sentence for the current charge?
1=Community supervision
2=Secure placement
3=Residential
4=Diversion

1.36) _____/_____/_____ Disposition date

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1.37 – 1.47) Did the offender receive the following special conditions and sanctions?
1=Yes
2=No

37. _____ Community Service
38. _____ Court Costs & Fines
39. _____ Restitution
40. _____ Fees
41. _____ License Suspension
42. _____ Parental/Family Participation
43. _____ Drug Testing
44. _____ Electronic Monitoring
45. _____ Work Detail
46. _____ Intensive Supervision
47. _____ Drug Treatment

Criminal History

1.48) _____/_____/_____Date of first referral

1.49 – 1.51) Number of prior *referrals*; 99999=Unknown
49. _____ Felony
50. _____ Misdemeanor
51. _____ Delinquent

1.52) _____ Has the offender ever been referred on a drug charge?
1=Yes
2=No

1.53 – 1.55) Number of prior *adjudications*; 99999=Unknown
53. _____ Felony
54. _____ Misdemeanor
55. _____ Delinquent

1.56) _____ Number of prior sentences to a secure facility; 99999=Unknown

1.57) _____ Number of prior sentences to community supervision; 99999=Unknown

1.58) _____ Number of unsuccessful terminations from community supervision; 99999=Unknown

1.59) _____ Is there evidence that the offender is a member of a gang?
1=Yes
2=No

1.60) _____ Does the youth have a prior history of running away from home?

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1=Yes
2=No

1.61) _____ Does the youth have a record of out-of-school suspensions?
1=Yes
2=No

1.62) _____ Does the youth have a record of truancy?
1=Yes
2=No

Drug Use History

1.63) _____ Record the offender's primary drug of choice

1=Alcohol	6=Stimulants
2=Marijuana	7=Hallucinogens
3=Crack/Cocaine	8=Methamphetamine
4=Narcotics	9=Prescriptions
5=Depressants	10=Other

1.64) _____"Other" primary drug of choice if applicable

1.65 - 1.73) Has the offender used any of the following drugs?
1=Yes
2=No

65. _____ Alcohol	70. _____ Stimulants
66. _____ Marijuana	71. _____ Hallucinogens
67. _____ Crack/Cocaine	72. _____ Methamphetamine
68. _____ Narcotics	73. _____ Prescription
69. _____ Depressants	

1.74) _____ Age of first alcohol use

1.75) _____ Frequency of alcohol use
1=Daily
2=Once a week or more
3=Less than once a week

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1.76) _____ Age of first drug use

1.77) _____ Type of drug first used

1.78) _____ Frequency of drug use
1=Daily
2=Once a week or more
3=Less than once a week

1.79) _____ Do any immediate family members have a chemical dependency problem?
1=Yes
2=No

1.80) _____ Are any immediate family members currently involved with the criminal justice system?
1=Yes
2=No

1.81) _____ Is the family currently involved with child welfare agencies?
1=Yes
2=No

1.82) _____ Has the offender received previous drug/alcohol treatment?
1=Yes
2=No

1.83) _____ Is the offender dual diagnosed with mental illness and substance abuse?
1=Yes
2=No

Treatment and Problem Areas

1.84) _____ Did the offender receive a drug assessment for/during intake?
1=Yes
2=No

1.85) What drug assessment instrument(s) was (were) used? _____

_____

_____

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1.86) What was the diagnosis/recommendation? _____

_____

_____

1.87) _____ Did the offender receive a risk assessment?
1=Yes
2=No

1.88) What risk assessment instrument(s) was (were) used? _____

_____

_____

1.89) What was the score or level of the assessment? _____

_____

_____

1.90) _____Did the offender receive a needs assessment?
1=Yes
2=No

1.91) What needs assessment instrument(s) was (were) used? _____

_____

_____

1.92) What was the score or level of the assessment? _____

_____

_____

1.93) _____Was the offender referred to drug/alcohol treatment?
1=Yes
2=No

1.94) Initial referred treatment provider _____

_____

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1.95) _____ Treatment setting
1=Long Term Residential (30+ days)
2=Short Term Residential (< 30 days)
3=Day Treatment
4=Intensive Outpatient (3+ contacts per week)
5=Outpatient (< 3 contacts per week)
6=Aftercare
7=Assessment Only
8=Unknown

1.96) _____/_____/_____ Date of initial treatment referral

1.97 – 1.106) Problem Areas
1=Frequent Disruption; serious disruption, frequent problem
2=Situational/Minor; occasional problem, some disruption of functioning
3=None; no disruption of functioning

97. _____ Alcohol Abuse
98. _____ Employment
99. _____ Family
100. _____ Mental Health
101. _____ ADHD
102. _____ Drug Abuse
103. _____ Housing
104. _____ Education
105. _____ Physical Health
106. _____ History of Abuse/Trauma

Behavioral Risk Indicators

1.107) _____ Has the offender ever been the victim of physical abuse?
1=Yes
2=No
3=Unknown

1.108) _____ Has the offender ever been the victim of sexual abuse?
1=Yes
2=No
3=Unknown

1.109) _____ Has the offender ever received mental health counseling/treatment?
1=Yes
2=No
3=Unknown

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1.110) _____ Is the offender currently receiving mental health counseling/treatment?
1=Yes
2=No

1.111) _____ Has the offender ever taken medications for a mental health condition?
1=Yes
2=No

1.112) _____ Has the offender ever taken medication for ADHD?
1=Yes
2=No

1.113) _____ Does the offender currently have a diagnosed mental health condition?
1=Yes
2=No

1.114) _____Current mental health condition

1.115) _____/_____/_____ Date of data entry

1.116) _____ Name of data enterer

II. STANDARDIZED PROCESS FORM

Identifying Data

2.1) ____ ____ - ____ ____ - ____ ____ ____ CLIENT ID

2.2) ____ ____ SITE ID

01=Ada County	05=Lucas County	08=Rhode Island County
02=Clackamas County	06=Medina County	09=San Diego County
03=Jefferson County	07=Polk County	10=Santa Clara County
04=Lane County		

2.3) _____/_____/_____Date form is initiated

2.4) _____Name of Data Collector

2.5) _____ Case Number

2.6) _____ Last Name

2.7) _____ First Name

2.8) _____Middle Initial

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2.9) _____/_____/_____ Date of Birth

2.10) _____ Is this offender in the drug court group or the comparison group?
1=drug court
2=comparison

Process Data

2.11) _____/_____/_____ Date of referral

2.12) _____/_____/_____ Date of arraignment

2.13) _____/_____/_____ Date of disposition

2.14) _____/_____/_____ Date offender was released from detention

2.15) _____ Number of pretrial suppression hearings

2.16) _____ Number of pretrial bench warrants

2.17) _____ Number of pretrial days spent in detention

2.18) _____/_____/_____ Date of data entry

2.19) _____ Name of data enterer

III. STANDARDIZED TREATMENT FORM

Identifying Data

2.20) ____ ____ - ____ ____ - ____ ____ ____ CLIENT ID

2.21) ____ ____ SITE ID

01=Ada County	05=Lucas County	08=Rhode Island County
02=Clackamas County	06=Medina County	09=San Diego County
03=Jefferson County	07=Polk County	10=Santa Clara County
04=Lane County		

2.22) _____/_____/_____Date form is initiated

2.23) _____Name of Data Collector

2.24) _____ Case Number

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2.25) _____ Last Name

2.26) _____ First Name

2.27) _____Middle Initial

2.28) _____/_____/_____ Date of Birth

2.29) _____ Is this offender in the drug court group or the comparison group?
1=drug court
2=comparison

Treatment Data

For all phases of treatment received, please indicate the following:

3.11) Start Date
3.12) Placement Location
3.13) 1=Long term residential
2=Short term residential
3=Intensive outpatient
4=Outpatient
5=Aftercare
6=Day treatment
7=Other
8=Unknown
3.14) 1=Completed phase
2=Did not complete phase
3=Unknown
3.15) 1=Referral to different level
2=Noncompliance
3=Absconded
4=Revoked
5=Other
6=Unknown
7=Not applicable
3.16) End Date
3.17) Type
3.18) Date Entered
3.19) Initials

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IV. STANDARDIZED DRUG TEST FORM

Identifying Data

2.30) ____ ____ - ____ ____ - ____ ____ ____ CLIENT ID

2.31) ____ ____ SITE ID

01=Ada County
02=Clackamas County
03=Jefferson County
04=Lane County
05=Lucas County
06=Medina County
07=Polk County
08=Rhode Island County
09=San Diego County
10=Santa Clara County

2.32) _____/_____/_____Date form is initiated

2.33) _____Name of Data Collector

2.34) _____ Case Number

2.35) _____ Last Name

2.36) _____ First Name

2.37) _____Middle Initial

2.38) _____/_____/_____ Date of Birth

2.39) _____ Is this offender in the drug court group or the comparison group?
1=drug court
2=comparison

Drug Testing Data

For **each** drug test administered, record the following information:

4.11) Date of Test
4.12) Result
1=Positive
2=Negative
3=Altered
4=No Show
5=Rescheduled
6=Unknown

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4.13) Positive Drug

1=Alcohol
2=Marijuana
3=Crack/Cocaine
4=Narcotics
5=Depressants
6=Stimulants
7=Hallucinogens
8=Other

4.14) Type of Test

1=Full Panel
2=Instant
3=Patch
4=Electronic Source
5=Breathalyzer
6=Unknown

4.15) Date Entered

4.16) Initials

V. STANDARDIZED VIOLATIONS FORM

Identifying Data

2.40) ____ ____ - ____ ____ - ____ ____ ____ CLIENT ID

2.41) ____ ____ SITE ID

01=Ada County	05=Lucas County	08=Rhode Island County
02=Clackamas County	06=Medina County	09=San Diego County
03=Jefferson County	07=Polk County	10=Santa Clara County
04=Lane County		

2.42) _____/_____/_____Date form is initiated

2.43) _____Name of Data Collector

2.44) _____ Case Number

2.45) _____ Last Name

2.46) _____ First Name

2.47) _____Middle Initial

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2.48) _____/_____/_____ Date of Birth

2.49) _____ Is this offender in the drug court group or the comparison group?
1=drug court 2=comparison

Court Reported Violations

For **each** drug test administered, record the following information:

5.11) Date
5.12) Type
1=New referral
2=FTA in court
3=Positive Urine
4=Absconded
5=Treatment noncompliance
6=School
7=Other
5.13) Sanctions
1=Bench Warrant
2=Work detail
3=Detention
4=Fines
5=Curfew
6=Community service
7=”Time Out”
8=House arrest
9=Increased PO contact/ISP
10=Increased court contact
11=EM/Voice track
12=Increased drug testing
13=License suspension
14=Change in tx intensity
15=Court Observation
16=Other
5.14) Date Enterer
5.15) Initials

VI. STANDARDIZED INCENTIVES FORM

Identifying Data

2.50) ____ ____ - ____ ____ - ____ ____ ____ CLIENT ID

2.51) ____ ____ SITE ID

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01=Ada County
02=Clackamas County
03=Jefferson County
04=Lane County
05=Lucas County
06=Medina County
07=Polk County
08=Rhode Island County
09=San Diego County
10=Santa Clara County

2.52) _____/_____/_____Date form is initiated

2.53) _____Name of Data Collector

2.54) _____ Case Number

2.55) _____ Last Name

2.56) _____ First Name

2.57) _____Middle Initial

2.58) _____/_____/_____ Date of Birth

2.59) _____ Is this offender in the drug court group or the comparison group?
1=drug court
2=comparison

Incentives

6.11) Date of Incident
6.12) Incentives
6.13) Justification

VII. STANDARDIZED CLOSURE FORM

Identifying Data

1.20) ____ ____ - ____ ____ - ____ ____ ____ CLIENT ID

1.21) ____ ____ SITE ID

01=Ada County
02=Clackamas County
03=Jefferson County
04=Lane County
05=Lucas County
06=Medina County
07=Polk County
08=Rhode Island County
09=San Diego County
10=Santa Clara County

1.22) _____/_____/_____Date form is initiated

1.23) _____Name of data collector

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1.24) _____ Case number

1.25) _____ Last name

1.26) _____ First name

1.27) _____ Middle initial

1.28) ____ ____ ____ - ____ ____ - ____ ____ ____ ____ SSN

1.29) _____
Mailing Address: Street, City, State; Telephone Number

1.30) _____
Mailing Address: Zip Code

1.31) _____/_____/_____ Date of Birth

1.32) _____ Is this offender in the drug court group or the comparison group?
1=Drug court
2=Comparison

Services Received

Please indicate whether the defendant was referred to the following services, whether they are still participating in these services (i.e., "active"), and whether they completed these services.

For each category: **1 = yes** and **2 = no**.

		Referred	Active	Completed
1.33)	Substance Abuse Treatment	_____	_____	_____
1.34)	Employment Services	_____	_____	_____
1.35)	Educational Services	_____	_____	_____
1.36)	Housing Assistance	_____	_____	_____
1.37)	Family Services	_____	_____	_____
1.38)	Medical Services	_____	_____	_____
1.39)	Mental Health Services	_____	_____	_____

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Fees and Community Service

Record the amount of payment ordered and paid. If no payment was ordered or made, record zero. If no information is available, enter "99999."

1.40) _____ Court costs ordered
1.41) _____ Court costs paid

1.42) _____ Fines ordered
1.43) _____ Fines paid

1.44) _____ Restitution ordered
1.45) _____ Restitution paid

1.46) _____ Supervision fees ordered
1.47) _____ Supervision fees paid

1.48) _____ Community service hours ordered
1.49) _____ Community service hours performed

Court Appearances

Record the number of hearings scheduled and held for the offender. If no information is available, record "99999."

1.50) _____ Number of case hearings (court appearances) scheduled

1.51) _____ Number of FTAs for case hearings (court appearances)

1.52) _____ Number of status review hearings (treatment hearings) scheduled

1.53) _____ Number of FTAs for status review hearings (treatment hearings)

School Performance

1.54) _____ How would you rate the youth's school performance while under supervision?
1=Excellent
2=Good
3=Fair
4=Poor

1.55) _____ Number of in-school suspensions while under supervision

1.56) _____ Number of out-of-school suspensions while under supervision

1.57) _____ Number of unexcused absences from school while under supervision

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Termination

1.58) _____/_____/_____ Date terminated from the drug court or probation

1.59) _____ Did the offender successfully complete all treatment requirements?
1=Yes
2=No

1.60) _____ While under supervision (drug court, probation, etc.) how many days **total** did the offender serve in a confined facility?

1.61) _____ Were the original charges dismissed?
1=Yes
2=No

1.62) _____ Was the offender's record expunged?
1=Yes
2=No

1.63) _____ Status at termination
1="Graduated" from drug court / Successfully discharged from probation
2=Terminated unsuccessful
3=Expiration of term
4=Absconded
5=Other

1.64) _____ Other termination type

New Referrals

For any **new** referrals and adjudications brought against the offender **while in** the drug court program or probation, indicate the following information:

1.65) _____ Did the defendant have any new referrals while in the drug court program or probation?
1=Yes
2=No

7.47) Date of Referral	7.48) Offense	7.49) Offense Level 1=Fel. 2=Misd. 3=Del.	7.50) Drugs 1=Yes 2=No 3=Unk	7.51)Adjudicated? 1=Yes 2=No
A.___/___/___	_____	_____	_____	_____
B.___/___/___	_____	_____	_____	_____

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C.___/___/___ _____ _____ _____ _____

D.___/___/___ _____ _____ _____ _____

E.___/___/___ _____ _____ _____ _____

7.52) _____ Was the defendant under court supervision following termination from drug court?
1=Yes
2=No
3=Not applicable

7.53) _____ If yes, what type of supervision?
1=Regular probation
2=ISP
3=Detention
4=Other secure facility
5=Other
6=Not applicable

7.54) _____/_____/_____ Date of data entry

7.55) _____ Name of data enterer

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Appendix B: Motivation Surveys

TCU Treatment Motivation Scales
(Taken from CESI: Client Evaluation of Self at Intake)

Respondents were asked to rate their agreement with the following statements on a five-point Likert-type scale, with 1 being "disagree strongly" and 5 being "agree strongly."

1) Your drug use is a problem for you.
2) You need help in dealing with your drug use.
3) You have too many outside responsibilities now to be in this treatment program.
4) Your drug use is more trouble than it's worth.
5) You could be sent to jail or prison if you are not in treatment.
6) You drug use is causing problems with the law.
7) This treatment program seems too demanding for you.
8) Your drug use is causing problems in thinking or doing your work.
9) It is urgent that you find help immediately for your drug use.
10) You feel a lot of pressure to be in treatment.
11) Your drug use is causing problems with your family and friends.
12) This treatment may be your last chance to solve your drug problems.
13) You are tired of the problems caused by drugs.
14) This kind of treatment program will not be very helpful to you.
15) Your drug use is causing problems in finding or keeping a job.
16) You have legal problems that require you to be in treatment.
17) You plan to stay in this treatment program for awhile.
18) You will give up your friends and hangouts to solve your drug problems.
19) You can quite using drugs without any help. (Reverse coded)
20) Your drug use is causing problems with your health.
21) You are in this treatment program because someone else made you come.
22) You are concerned about legal problems.
23) Your life has gone out of control.
24) Your drug use is making your life become worse and worse.
25) This treatment program can really help you.
26) You want to be in a drug treatment program.
27) Your drug use is going to cause your death if you do not quit soon.
28) You want to get your life straightened out.
29) You have family members who want you to be in treatment.

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Appendix C: Satisfaction Surveys

SURVEY FOR DRUG COURT CLIENTS
90-Day Survey

Directions: Please complete all of the following questions to the best of your ability. All responses are confidential.

Part I. Please **circle** the answer that best describes how you feel about the **judge** in your case.

1. The judge treated me with respect.	Strongly agree	Agree	Disagree	Strongly disagree
2. The judge was fair.	Strongly agree	Agree	Disagree	Strongly disagree
3. The judge was concerned about me.	Strongly agree	Agree	Disagree	Strongly disagree
4. Visits with the judge helped me to stay drug free.	Strongly agree	Agree	Disagree	Strongly disagree
5. The judge expected too much of me.	Strongly agree	Agree	Disagree	Strongly disagree

Part II. Please **circle** the answer that best describes how you feel about your **probation officer**.

1. My probation officer treated me with respect.	Strongly agree	Agree	Disagree	Strongly disagree
2. My probation officer was fair.	Strongly agree	Agree	Disagree	Strongly disagree
3. My probation officer was concerned about me.	Strongly agree	Agree	Disagree	Strongly disagree
4. Visits with my probation officer helped me to stay drug free.	Strongly agree	Agree	Disagree	Strongly disagree
5. My probation officer expected too much of me.	Strongly agree	Agree	Disagree	Strongly disagree

Part III. Please **circle** the answer that best describes how you feel about the **treatment staff.**

1. The treatment staff treated me with respect.	Strongly agree	Agree	Disagree	Strongly disagree
2. The treatment staff was fair.	Strongly agree	Agree	Disagree	Strongly disagree
3. The treatment staff was concerned about me.	Strongly agree	Agree	Disagree	Strongly disagree
4. Visits with the treatment staff helped me to stay drug free.	Strongly agree	Agree	Disagree	Strongly disagree
5. The treatment staff expected too much of me.	Strongly agree	Agree	Disagree	Strongly disagree

Part IV. Please **circle** the answer that best describes your **overall experience** with the Drug Court.

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1. It helped me to appear in court on a regular basis.	Strongly agree	Agree	Disagree	Strongly disagree
2. It helped me to report to my probation officer on a regular basis.	Strongly agree	Agree	Disagree	Strongly disagree
3. It helped me attend treatment on a regular basis.	Strongly agree	Agree	Disagree	Strongly disagree
4. Drug Court was easier than detention.	Strongly agree	Agree	Disagree	Strongly disagree
5. Drug Court was easier than regular probation.	Strongly agree	Agree	Disagree	Strongly disagree
6. I think that my participation in the Drug Court will help me avoid drug use in the future.	Strongly agree	Agree	Disagree	Strongly disagree
7. In general, I am better off for participating in Drug Court as opposed to other court sanctions.	Strongly agree	Agree	Disagree	Strongly disagree
8. I was personally helped through participation in Drug Court	Strongly agree	Agree	Disagree	Strongly disagree

Part V. Please rate each of the following programs by **circling** the answer that best describes your opinion. If you did not participate in the program as part of the Drug Court, circle "did not participate."

Residential treatment:	Poor	Good	Excellent	Did not participate
Outpatient treatment:	Poor	Good	Excellent	Did not participate
Intensive probation supervision:	Poor	Good	Excellent	Did not participate
Regular probation supervision:	Poor	Good	Excellent	Did not participate
Electronic monitoring:	Poor	Good	Excellent	Did not participate
Community service:	Poor	Good	Excellent	Did not participate
Drug testing:	Poor	Good	Excellent	Did not participate
AA/NA:	Poor	Good	Excellent	Did not participate

Part VI. Please answer the remaining questions.

1. Have you been in trouble with the law before?	Yes	No
2. Have you been in substance abuse treatment before?	Yes	No
3. What have you liked best about the drug court so far?		
4. What have you liked least about the drug court so far?		

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SURVEY FOR COMPARISON CLIENTS
90-Day Survey

Directions: Please complete all of the following questions to the best of your ability. All responses are confidential.

Part I. Please **circle** the answer that best describes how you feel about the **judge** in your case.

1. The judge treated me with respect.	Strongly agree	Agree	Disagree	Strongly disagree
2. The judge was fair.	Strongly agree	Agree	Disagree	Strongly disagree
3. The judge was concerned about me.	Strongly agree	Agree	Disagree	Strongly disagree
4. Visits with the judge helped me to stay drug free.	Strongly agree	Agree	Disagree	Strongly disagree
5. The judge expected too much of me.	Strongly agree	Agree	Disagree	Strongly disagree

Part II. Please **circle** the answer that best describes how you feel about your **probation officer**.

1. My probation officer treated me with respect.	Strongly agree	Agree	Disagree	Strongly disagree
2. My probation officer was fair.	Strongly agree	Agree	Disagree	Strongly disagree
3. My probation officer was concerned about me.	Strongly agree	Agree	Disagree	Strongly disagree
4. Visits with my probation officer helped me to stay drug free.	Strongly agree	Agree	Disagree	Strongly disagree
5. My probation officer expected too much of me.	Strongly agree	Agree	Disagree	Strongly disagree

Part III. Please **circle** the answer that best describes how you feel about the **treatment staff.**

1. The treatment staff treated me with respect.	Strongly agree	Agree	Disagree	Strongly disagree
2. The treatment staff was fair.	Strongly agree	Agree	Disagree	Strongly disagree
3. The treatment staff was concerned about me.	Strongly agree	Agree	Disagree	Strongly disagree
4. Visits with the treatment staff helped me to stay drug free.	Strongly agree	Agree	Disagree	Strongly disagree
5. The treatment staff expected too much of me.	Strongly agree	Agree	Disagree	Strongly disagree

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Part IV. Please rate each of the following programs by **circling** the answer that best describes your opinion. If you did not participate in the program as part of Probation, circle "did not participate."

Residential treatment:	Poor	Good	Excellent	Did not participate
Outpatient treatment:	Poor	Good	Excellent	Did not participate
Intensive probation supervision:	Poor	Good	Excellent	Did not participate
Regular probation supervision:	Poor	Good	Excellent	Did not participate
Electronic monitoring:	Poor	Good	Excellent	Did not participate
Community service:	Poor	Good	Excellent	Did not participate
Drug testing:	Poor	Good	Excellent	Did not participate
AA/NA:	Poor	Good	Excellent	Did not participate

Part V. Please answer the remaining questions.

1. Have you been in trouble with the law before?	Yes	No
2. Have you been in substance abuse treatment before?	Yes	No

3. What have you liked best about probation so far?

4. What have you liked least about probation so far?

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SURVEY FOR DRUG COURT CLIENTS
Termination Survey

Directions: Please complete all of the following questions to the best of your ability. All responses are confidential.

Part I. Please **circle** the answer that best describes how you feel about the **judge** in your case.

1. The judge treated me with respect.	Strongly agree	Agree	Disagree	Strongly disagree
2. The judge was fair.	Strongly agree	Agree	Disagree	Strongly disagree
3. The judge was concerned about me.	Strongly agree	Agree	Disagree	Strongly disagree
4. Visits with the judge helped me to stay drug free.	Strongly agree	Agree	Disagree	Strongly disagree
5. The judge expected too much of me.	Strongly agree	Agree	Disagree	Strongly disagree

Part II. Please **circle** the answer that best describes how you feel about your **probation officer**.

1. My probation officer treated me with respect.	Strongly agree	Agree	Disagree	Strongly disagree
2. My probation officer was fair.	Strongly agree	Agree	Disagree	Strongly disagree
3. My probation officer was concerned about me.	Strongly agree	Agree	Disagree	Strongly disagree
4. Visits with my probation officer helped me to stay drug free.	Strongly agree	Agree	Disagree	Strongly disagree
5. My probation officer expected too much of me.	Strongly agree	Agree	Disagree	Strongly disagree

Part III. Please **circle** the answer that best describes how you feel about the **treatment staff**.

1. The treatment staff treated me with respect.	Strongly agree	Agree	Disagree	Strongly disagree
2. The treatment staff was fair.	Strongly agree	Agree	Disagree	Strongly disagree
3. The treatment staff was concerned about me.	Strongly agree	Agree	Disagree	Strongly disagree
4. Visits with the treatment staff helped me to stay drug free.	Strongly agree	Agree	Disagree	Strongly disagree
5. The treatment staff expected too much of me.	Strongly agree	Agree	Disagree	Strongly disagree

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Part IV. Please **circle** the answer that best describes your **overall experience** with the Drug Court.

1. It helped me to appear in court on a regular basis.	Strongly agree	Agree	Disagree	Strongly disagree
2. It helped me to report to my probation officer on a regular basis.	Strongly agree	Agree	Disagree	Strongly disagree
3. It helped me attend treatment on a regular basis.	Strongly agree	Agree	Disagree	Strongly disagree
4. Drug Court was easier than detention.	Strongly agree	Agree	Disagree	Strongly disagree
5. Drug Court was easier than regular probation.	Strongly agree	Agree	Disagree	Strongly disagree
6. I think that my participation in the Drug Court will help me avoid drug use in the future.	Strongly agree	Agree	Disagree	Strongly disagree
7. In general, I am better off for participating in Drug Court as opposed to other court sanctions.	Strongly agree	Agree	Disagree	Strongly disagree
8. I was personally helped through participation in Drug Court	Strongly agree	Agree	Disagree	Strongly disagree

Part V. Please rate each of the following programs by **circling** the answer that best describes your opinion. If you did not participate in the program as part of the Drug Court, circle "did not participate."

Residential treatment:	Poor	Good	Excellent	Did not participate
Outpatient treatment:	Poor	Good	Excellent	Did not participate
Intensive probation supervision:	Poor	Good	Excellent	Did not participate
Regular probation supervision:	Poor	Good	Excellent	Did not participate
Electronic monitoring:	Poor	Good	Excellent	Did not participate
Community service:	Poor	Good	Excellent	Did not participate
Drug testing:	Poor	Good	Excellent	Did not participate
AA/NA:	Poor	Good	Excellent	Did not participate

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Part VI. Please answer the remaining questions.

1. Have you been in trouble with the law before?	Yes	No
2. Have you been in substance abuse treatment before?	Yes	No
3. What did you like best about the drug court?		
4. What did you like least about the drug court?		

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SURVEY FOR COMPARISON CLIENTS
Termination Survey

Directions: Please complete all of the following questions to the best of your ability. All responses are confidential.

Part I. Please **circle** the answer that best describes how you feel about the **judge** in your case.

1. The judge treated me with respect.	Strongly agree	Agree	Disagree	Strongly disagree
2. The judge was fair.	Strongly agree	Agree	Disagree	Strongly disagree
3. The judge was concerned about me.	Strongly agree	Agree	Disagree	Strongly disagree
4. Visits with the judge helped me to stay drug free.	Strongly agree	Agree	Disagree	Strongly disagree
5. The judge expected too much of me.	Strongly agree	Agree	Disagree	Strongly disagree

Part II. Please **circle** the answer that best describes how you feel about your **probation officer**.

1. My probation officer treated me with respect.	Strongly agree	Agree	Disagree	Strongly disagree
2. My probation officer was fair.	Strongly agree	Agree	Disagree	Strongly disagree
3. My probation officer was concerned about me.	Strongly agree	Agree	Disagree	Strongly disagree
4. Visits with my probation officer helped me to stay drug free.	Strongly agree	Agree	Disagree	Strongly disagree
5. My probation officer expected too much of me.	Strongly agree	Agree	Disagree	Strongly disagree

Part III. Please **circle** the answer that best describes how you feel about the **treatment staff**.

1. The treatment staff treated me with respect.	Strongly agree	Agree	Disagree	Strongly disagree
2. The treatment staff was fair.	Strongly agree	Agree	Disagree	Strongly disagree
3. The treatment staff was concerned about me.	Strongly agree	Agree	Disagree	Strongly disagree
4. Visits with the treatment staff helped me to stay drug free.	Strongly agree	Agree	Disagree	Strongly disagree
5. The treatment staff expected too much of me.	Strongly agree	Agree	Disagree	Strongly disagree

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Part IV. Please rate each of the following programs by **circling** the answer that best describes your opinion. If you did not participate in the program as part of Probation, circle "did not participate."

Residential treatment:	Poor	Good	Excellent	Did not participate
Outpatient treatment:	Poor	Good	Excellent	Did not participate
Intensive probation supervision:	Poor	Good	Excellent	Did not participate
Regular probation supervision:	Poor	Good	Excellent	Did not participate
Electronic monitoring:	Poor	Good	Excellent	Did not participate
Community service:	Poor	Good	Excellent	Did not participate
Drug testing:	Poor	Good	Excellent	Did not participate
AA/NA:	Poor	Good	Excellent	Did not participate

Part V. Please answer the remaining questions.

1. Have you been in trouble with the law before?	Yes	No
2. Have you been in substance abuse treatment before?	Yes	No

3. What did you like best about probation?

4. What did you like least about probation?

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Appendix D: Self-Report Follow-Up Surveys

OJJDP & University of Cincinnati Juvenile Drug Court Research Study
Youth Follow-up Survey (Six months)

Directions: Please answer each question honestly and to the best of your ability. Remember, your responses are completely c*onfidential*. Don't forget to circle the kind of gift card you would like for completing the survey.

Please check all that apply.
Question 1: In the past month, have you…

- ☐ Completed chores at home
- ☐ Played a musical instrument
- ☐ Chatted in an online chat room
- ☐ Participated in recreational sports
- ☐ Performed community service
- ☐ Played video games
- ☐ Gone to the library
- ☐ Attended a performance (concert, ballet, theater, etc.)
- ☐ Been involved in religious activities
- ☐ Received awards or certificates

Please check all that apply.
Question 2: In the past 6 months, have you…

- ☐ Been absent from school 10 or more days
- ☐ Been in detention or suspension from school
- ☐ Been employed
- ☐ Been fired from a job
- ☐ Been in a physical fight with another person
- ☐ Vandalized property (graffiti, tagging, etc.)
- ☐ Drank alcohol
- ☐ Purchased alcohol or drugs
- ☐ Been involved with a gang
- ☐ Been arrested
- ☐ Skipped school
- ☐ Cheated in school
- ☐ Been absent from work 5 or more days
- ☐ Been in an argument with a parent/guardian
- ☐ Bullied someone
- ☐ Stolen something
- ☐ Used drugs
- ☐ Taken drugs, alcohol, or weapons to school
- ☐ Ran away from home
- ☐ Been involved in any crime

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Directions: Please answer each question honestly and to the best of your ability. Remember, your responses are completely c*onfidential*.

Please circle the best option.
Question 3: Describe your average grade in school.

A	B	C	D or below

Please circle the best option.
Question 4: Describe your relationship with your family.

Great	Okay	Poor	I'm not sure

Please circle one answer for each alcohol/drug.
Question 5: In the past 6 months, how often have you used any of the following drugs?

Alcohol	Never	Once	A few times	Regularly
Marijuana	Never	Once	A few times	Regularly
Crystal Meth	Never	Once	A few times	Regularly
Crack/Cocaine	Never	Once	A few times	Regularly
Heroin	Never	Once	A few times	Regularly
Ecstasy	Never	Once	A few times	Regularly
Prescription	Never	Once	A few times	Regularly
Other	Never	Once	A few times	Regularly

Please circle one answer for each activity.
Question 6: In the near future, how likely is it that you will…

Get grounded at home	Not Likely	Somewhat Likely	Very Likely	I'm not sure
Skip school	Not Likely	Somewhat Likely	Very Likely	I'm not sure
Get suspended at school	Not Likely	Somewhat Likely	Very Likely	I'm not sure
Use drugs or alcohol	Not Likely	Somewhat Likely	Very Likely	I'm not sure
Get arrested	Not Likely	Somewhat Likely	Very Likely	I'm not sure

Question 7: As honestly as possible, please indicate how much of this survey you answered *truthfully*.

My answers on this survey are…	0% true	25% true	50% true	75% true	100% true

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OJJDP & University of Cincinnati Juvenile Drug Court Research Study
Youth Follow-up Survey (12 & 18 months)

Directions: Please answer each question honestly and to the best of your ability. Remember, your responses are completely c*onfidential*. Don't forget to circle the kind of gift card you would like for completing the survey.

Please check all that apply.
Question 1: In the past month, have you…

- ☐ Completed chores at home
- ☐ Participated in recreational sports
- ☐ Volunteered for an organization
- ☐ Been involved in religious activities
- ☐ Gone to the library
- ☐ Received awards or certificates

Please check all that apply.
Question 2: In the past 6 months, have you…

- ☐ Been absent from school 10 or more days
- ☐ Been in detention or suspension from school
- ☐ Been employed
- ☐ Been fired from a job
- ☐ Been in a physical fight with another person
- ☐ Vandalized property (graffiti, tagging, etc.)
- ☐ Drank alcohol
- ☐ Purchased alcohol or drugs
- ☐ Been involved with a gang
- ☐ Been arrested
- ☐ Skipped school
- ☐ Cheated in school
- ☐ Been absent from work 5 or more days
- ☐ Been in an argument with a parent/guardian
- ☐ Bullied someone
- ☐ Stolen something
- ☐ Used drugs
- ☐ Taken drugs, alcohol or weapons to school
- ☐ Ran away from home
- ☐ Done anything illegal

Directions: For each question below, please circle the best option. Please answer each question honestly and to the best of your ability. Remember, your responses are completely c*onfidential*.

Question 3: Describe you average grad in school.

A B C D or below

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Question 4: In the past month, how many days have you attended school?

16-20 days	11-15 days	10-6 days	0-5 days

Question 5: If you've worked in the past 6 months, how many hours per week did you work?

30+ hours	21-30 hours	11-20 hours	1-10 hours	0 hours

Directions: For each question below, please circle the best option. Please answer each question honestly and to the best of your ability. Remember, your responses are completely c*onfidential*.

Question 6: Describe your relationship with your family.

Great	Okay	Poor	I'm not sure

Question 7: Describe your communication with your family.

Great	Okay	Poor	I'm not sure

Question 8: In the past month, how often have you…

Argued with your parents?	Never	Once	A few times	Regularly
Hung out with your family?	Never	Once	A few times	Regularly

Question 9: In the past 6 months, has someone in your family…

Verbally attacked you? (called you names, made you feel worthless, etc.)	Never	Once	A few times	Regularly
Physically attacked you? (hit you, kicked you, shoved you, etc.)	Never	Once	A few times	Regularly

Please circle one answer for each alcohol/drug.
Question 10: In the past 6 months, how often have you used any of the following drugs?

Alcohol	Never	Less than once per week	Once a week or more	Daily
Marijuana	Never	Less than once per week	Once a week or more	Daily
Crystal Meth	Never	Less than once per week	Once a week or more	Daily

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Crack/Cocaine	Never	Less than once per week	Once a week or more	Daily
Heroin	Never	Less than once per week	Once a week or more	Daily
Ecstasy	Never	Less than once per week	Once a week or more	Daily
Prescriptions	Never	Less than once per week	Once a week or more	Daily
Other	Never	Less than once per week	Once a week or more	Daily

Please select your gift card!! (If you do not make a selection, you will receive one at random.)

☐ Subway ☐ Pizza Hut ☐ McDonald's

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Appendix E: CPC-DC Final Reports

EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST – DRUG COURT (CPC-DC) SYNOPSIS OF FINDINGS

Performed as part of the OJJDP study Outcome and Process Evaluation of Juvenile Drug Courts

Ada County Juvenile Drug Court

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Final Report Submitted: February 2012

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OUTCOME AND PROCESS EVALUATION OF JUVENILE DRUG COURTS STUDY

This project is funded by a grant received from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The purpose of this study is to evaluate a national sample of juvenile drug court programs. The goals of this research are: (1) To determine if there is a reduction in recidivism and substance abuse associated with participation in a juvenile drug court program; (2) to determine if there are improvements in social functioning (e.g. school performance, employment, and family functioning) related to participating in juvenile drug court programs; (3) to identify the characteristics of successful juvenile drug court participants; (4) to determine if juvenile drug courts are operating in a manner consistent with an evidence-based approach; (5) to identify the programmatic characteristics of effective juvenile drug courts; and (6) to provide information to policymakers about the effectiveness of drug courts for juvenile offenders.

This study includes both an outcome and a process evaluation. The outcome portion of the study examines outcomes of youth participating in drug courts as compared to similar youth who are on probation. The process evaluation explores the effectiveness of the drug court and drug court programming and is the focus of this report. Ten drug courts from across the country participated in this four-year study, nine of which participated in both the process and outcome evaluation pieces. The final report for the Outcome and Process Evaluation of Juvenile Drug Courts study will offer outcome and process evaluation findings across all nine drug court sites and is expected to be submitted to OJJDP in December 2012.

CONTEXT AND SCOPE OF THIS EVALUATION

The following report is part of a larger national project centered on the effectiveness of juvenile drug court programs and provides a synopsis of findings from the process evaluation, as well as recommendations to enhance the effectiveness of the services delivered by the Ada County Juvenile Drug Court. Programs that adhere to the principles of effective intervention are more likely to impact criminal reoffending (see Andrews & Bonta, 2003 for a review). Specifically, correctional research suggests that cognitive behavioral and social learning models of treatment are associated with considerable reductions in recidivism (Gendreau, 1996; Smith, Goggin & Gendreau, 2002). As such, the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) was used to evaluate the juvenile drug courts participating in the Outcome and Process Evaluation of Juvenile Drug Courts study. The objectives of this assessment are to conduct a detailed review of services and program materials of the juvenile drug courts and the agencies they refer youth to and to compare their current practices with the literature on "best practices" in corrections.

PROCEDURES

Description of the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC)

The Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) is a tool that the University of Cincinnati developed for assessing drug court programs. It is used to determine how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. The CPC-DC was modified from the Evidence-Based Correctional Program Checklist (CPC) [1] and includes important indicators from drug court meta-analyses (see Shaffer, 2006). The CPC

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has been validated by several recent studies conducted by the University of Cincinnati. These studies found strong correlations between outcome and both domain areas and individual items (Holsinger, 1999; Lowenkamp, 2003; Lowenkamp and Latessa, 2003, Lowenkamp & Latessa, 2005a; Lowenkamp and Latessa, 2005b; Shaffer, 2006). As part of the larger national study, the indicators on the CPC-DC will be validated using the outcome data collected on the drug court participants.

The CPC-DC consists of two instruments: one for the formal drug court (CPC-DC) and the other for the major referral agencies (CPC-DC: RA) involved in providing treatment and services to drug court clients. Each of these tools is divided into two basic areas: Content and Capacity. The capacity area is designed to measure whether the drug court and its referral agencies have the capability to deliver evidence-based interventions and services to offenders. There are two domains in the capacity area: 1) Development, Coordination, Staff and Support, and 2) Quality Assurance. The content area focuses on the substantive aspect of the drug court and its referral agencies, and also includes two areas: 1) Assessment Practices, and 2) Treatment. This area examines the extent to which the drug court and its referral agencies meet the principles of risk, need, responsivity, and treatment.

The Drug Court tool includes 41 indicators, worth 43 total points. The Referral Agency tool has 49 indicators worth a total of 51 points. Each area and all domains are scored and rated as “highly effective” (65% to 100%); “effective” (55% to 64%); “needs improvement” (46% to 54%); or “ineffective” (45% to 0%). The scores in all domains are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the domains are given equal weight. Further, some items may be considered "not applicable," in which case they are not included in the scoring. Data are collected through structured interviews with selected program staff and program participants, as well as through observation of groups and services. In some instances, surveys may be used to gather additional information. Other sources of information include policy and procedure manuals, schedules, treatment materials, curricula, case files, and other selected program materials. Once the information is gathered and reviewed, the program is scored. The following report highlights strengths, areas that need improvement, and recommendations for each of the areas for both the drug court and the referral agencies.

There are several limitations to the CPC-DC that should be noted. First, as with any research process, objectivity and reliability are an issue. Although steps are taken to ensure that the information gathered is accurate and reliable, decisions about the information gathered are invariably made by the assessors. Second, the process is time specific. That is, the assessment is based on the program at the time of the assessment. Though changes or modifications may be planned for the future, only those activities and processes that were present at the time of the review in July 2009 are considered for scoring. Third, the process does not take into account all system issues that can affect program integrity (i.e., political climate of the court). Finally, the process does not address the reasons that a problem exists within a program or why certain practices do or do not take place. Rather, the process is designed to determine the overall integrity of the program.

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[1] The CPC is modeled after the Correctional Program Assessment Inventory developed by Gendreau and Andrews. However, only those indicators that were found to be positively correlated with outcome were retained. In addition, the CPC includes a number of items not contained in the CPAI.

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Despite these limitations, there are a number of advantages to this process. First, the criteria are based on empirically derived principles of effective programs, and all of the indicators included in the CPC-DC are correlated with reductions in recidivism. Second, it allows researchers to get inside the "black box" of a drug court and its referral agencies, something that an outcome study alone does not provide. This means researchers are able to measure the degree to which programs are meeting evidence-based standards. Third, the CPC-DC enables researchers to "quantify" the quality of a program through a scoring process. This allows for comparisons across programs, the setting of benchmarks, and for reassessment to measure progress. Fourth, it identifies both the strengths and weaknesses of a program and provides specific recommendations for program improvement.

Assessment Process

The assessment process consisted of a series of structured interviews with staff members and program participants during an on-site visit to Ada County Juvenile Drug Court on July 7th, 8th, and 9th 2009. Additionally, ten representative files (five open and five closed) as well as other relevant program materials (e.g., treatment manuals, assessments, training protocol, ethical guidelines, and staff evaluations) were examined. Finally, three treatment groups were observed: "Family Group", Phase 1 and 2 group entitled "Foundations of Recovery", and Phase 3 and 4 group entitled "Recovery Enhancement". Two evaluators conducted the various interviews, observations and file reviews. Data from the various sources were then combined to generate a consensus CPC-DC score and the specific recommendations.

SUMMARY OF THE DRUG COURT

The Ada County Juvenile Drug Court has been in operation since 2003 and is a pre-adjudication drug court. The drug court is funded by the state of Idaho. Youth range in age from fourteen to eighteen and must evidence drug abuse issues. Only Ada County residents are eligible for the program. At the time of assessment, William Harrifeld was the drug court judge, Leslee Whiteman was the juvenile court program manager, Claryce Manweiler was the program coordinator for the drug court, John Goodwin was the drug court probation supervisor, and Jason Zelus was the treatment clinical supervisor.

The drug court requires clients to progress through four phases of treatment lasting a minimum of nine months. Phase 1 youth spend an average of seven to eight hours in drug court programming per week. Phase 2 youth spend an average of five to six hours in drug court programming per week. Phase 3 youth spend an average of four to five hours in drug court programming per week. Phase 4 youth spend an average of two to three hours in drug court programming per week. The drug court relies on the following techniques to supervise youth in the program: curfew, drug and alcohol testing, participation in school or work, and attendance at court. The drug court does not utilize any referral agencies; it provides all required treatment to drug court participants. This treatment includes the following: drug education, three substance abuse groups (Foundations of Recovery, Everyday Living, and Recovery Enhancement), a family education group, individual counseling, and family counseling. The drug court has five treatment staff that provide all group and individual treatment.

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FINDINGS – DRUG COURT

CPC-DC SECTIONS	SCORE	RATING
Development, Coordination, Staff and Support	66.7%	Highly Effective
Offender Assessment	88.9%	Highly Effective
Treatment	44.4%	Ineffective
Quality Assurance	28.6%	Ineffective
Overall Capacity	50.0%	**Needs Improvement**
Overall Content	59.3%	**Effective**
Overall Score	55.8%	**Effective**

Development, Coordination, Staff and Support

Strengths:

- There is a program coordinator who has overall responsibility for oversight and management of the program.
- Regular staff meetings are held to discuss participants in the drug court.
- Drug court staff provide direct case management and supervision services to the youth in the drug court.
- Funding for the drug court is rated by staff as adequate and there have been no changes in the level of funding in the past two years.
- The drug court has leverage over the youth; the drug court will dismiss the youth's legal charges once the youth completes drug court.

Recommendations for Improvement:

- The program coordinator should have a more direct role in selecting, approving, and supervising the counselors hired to provide treatment.
- Drug court staff should be trained on drug court programming and receive at least 40 hours of on-going training a year. Staff training should relate to the theory and practice of interventions used by the program including effective correctional practices and the cognitive-behavioral model.
- Ethical guidelines should dictate staff boundaries and interactions with drug court youth.

Offender Assessment

Strengths:

- There are established criteria for the exclusion of certain types of offenders. The policy is written and followed, and clients are deemed appropriate for drug court by the majority of staff.
- Violent offenders are excluded from participating in the drug court.
- Risk, as well as a range of criminogenic needs, are assessed using the Youthful Level of Service/Case Management Inventory (YLS/CMI).
- Domain specific needs are assessed with Global Appraisal of Individual Needs (GAIN) instruments.
- Responsivity is assessed using the Texas Christian University Client Evaluation of Self and Treatment (CESI/CEST), and the Idaho Standard Mental Health Assessment.

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- The drug court targets relevant higher need youth. The file review indicated that 60% were high need for substance abuse and 40% were moderate need for substance abuse.
- Assessments are shared with everyone on the drug court team.

Recommendations for Improvement:

- Drug courts should target moderate and high risk youth, and low risk youth should be screened out. The file review found that 20% of youth in the drug court were low risk as classified by the YLS/CMI. This percentage should be under 5%.

Treatment Characteristics

Strengths:

- The average length in drug court is 10-12 months with a range of 9-16 months. It is recommended that the majority of youth graduate in less than 12 months.
- Drug court participants spend an adequate amount of time in structured activities.
- The drug court has completion criteria which measures how well a youth has progressed in acquiring prosocial behaviors. Phase advancement is used as well as reassessment on the GAIN, YLS/CMI, and CEST.
- The drug court completion rate is approximately 70% which falls within the acceptable range.
- The drug court has an appropriate reward structure including verbal praise, candy bars in court, choosing an item from a basket during court, group outings, gift cards with increasing dollar amounts based on sobriety length, and sobriety chips.
- The drug court responds to noncompliance appropriately including community service, WILD (full days of work service), writing papers, electronic monitoring, and detention. Sanctions for noncompliance progress in their intensity until the noncompliance is resolved.
- The Ada County Juvenile Drug Court does not require youth to participate in AA. Youth in drug court should not be required to attend self-help meetings as there is no evidence that these meetings are beneficial to youth and may in fact be harmful.
- The drug court randomly drug tests youth on a regular basis. Three random tests are administered three times per week in the Phase 1, two times per week in the Phase 2, and one time per week in Phase 3 and 4.

Recommendations for Improvement:

- The Ada County Juvenile Drug Court should target a wider range of criminogenic needs. While some of the primary targets identified by staff are criminogenic in nature, such as substance abuse and education, others, such as life goals, self-belief, independent living, and motivation are not criminogenic in nature. At least 75% of drug court interventions should focus on criminogenic needs. Examples of appropriate criminogenic targets include: Attitudes, orientations & values favorable to law violations & anti-criminal role models, antisocial personality; antisocial peer associations; problems associated with alcohol/drug abuse; anger/hostility level; replacing the skills of lying, stealing and aggression with prosocial alternatives; increased self-control, self-management and problem solving skills; improved skills in interpersonal conflict resolution; promotion of more positive attitudes /increase performance in school or work; promote family affection/communication; promote family monitoring and supervision; improved family problem solving; focus on harm done

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to victim; relapse prevention; and ensuring the offender is able to recognize high risk situations that lead to law-breaking and has a concrete plan to deal with these situations.

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Observation of groups and interviews with youth in the drug court revealed that little to no cognitive restructuring or role play/practicing of skills took place during group treatment. Instead, groups appeared to be unstructured, using more of a "talk therapy" approach and allowed youth (and parents) to frequently get off topic.
- Participants should be assigned to groups and services that match their style of learning and other responsivity factors. Since the drug court is using responsivity instruments, those results should be tied to these decisions.
- Intensity of the drug court programming should vary by risk level. High risk youth should receive higher intensity and/or duration of service than moderate risk youth. Moderate risk youth should receive higher intensity and/or duration of service than low risk youth.
- The ratio of rewards to punishers should be at least 4:1. Staff consistently reported a ratio of 3:1, at the highest.
- As part of drug court, the family/caregivers should be trained to provide support, including the ability to identify high risk situations for their youth and strategies for managing their environment using prosocial skills. Support groups are not sufficient to achieve these goals. Family groups should therefore target prosocial behavior and participation should be mandatory. Examples of evidence-based family/caregiver curriculum include: The Parent Project, Common Sense Parenting, Strengthening Families Program, and Parenting Wisely.
- After treatment is completed, the drug court should include an aftercare component of high quality. The aftercare should be a formal component in which supervision/meetings are required and an evidence-based model is used.

Other Recommendations for Improvement: Since treatment occurs in-house at the Ada County Juvenile Drug Court, no referral agencies were scored. By not scoring in-house treatment separately, several important treatment characteristics were not included in the score for the drug court. We have provided additional suggestions for improvement in the Treatment Characteristics area from the Referral Agency Score sheet below to further enhance the treatment provided to the drug court youth.

- Treatment groups should start on time and end on time, breaks should be limited to 5-10 minutes, and the check in process should not take up the majority of the treatment session or be the focus of the treatment session.
- Males and females are more productive in treatment sessions when they attend treatment separately. Treatment groups should be gender specific.
- The group facilitators should be knowledgeable and comfortable with the material. Material should be presented clearly and the facilitator should be able to answer questions.
- Homework should be regularly assigned to participants and the homework should be reviewed by the facilitator and constructive feedback should be provided to the participants.

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- Group rules and norms should be established, regularly reviewed, and followed. The facilitator should address inappropriate behavior and non-compliance consistently. Appropriate behavior should be rewarded with a variety of rewards, rewards should outweigh punishers at least 4:1, rewards should be delivered immediately, the facilitator should explain why a reward was given, and the reward should be tied to specific behavior. Similarly, punishers should be used to extinguish inappropriate behavior, the facilitator should recognize inappropriate behavior consistently, the punisher should be explained to the group, the level of punishment should correspond to the intensity of the behavior, the facilitator should move on immediately after the punishment is administered, and the facilitator should recognize and deal appropriately with any negative effects that result from the punishment. Once a punisher has been administered, a prosocial alternative behavior should be taught.
- When there are two facilitators, both should have a significant role in the treatment session.
- While the drug court stated they use the Matrix Model, the Cannabis Youth Treatment Series (CYT), and Group Based Outpatient Treatment for Adolescent Substance Abuse (GBT) manuals, there was little evidence of their use in the groups or individual treatment. Structured curricula or manuals should be used consistently for all treatment sessions and staff should undergo training on appropriate use of curricula. Examples of substance abuse curriculum for youth include Pathways to Self Discovery and Change; and CYT. Examples of groups that address criminal thinking include Thinking for a Change; Aggression Replacement Therapy; Prepare; and Choices, Changes, and Challenges. Examples of evidence-based curricula for parents include The Parent Project; Common Sense Parenting; Strengthening Families Program; and Parenting Wisely. Examples of gender specific therapy for criminal thinking include Girls…Moving On.
- Participants should be shown how to identify underlying thoughts, values, and beliefs. Participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost benefit analysis should be used to assist the participant in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- Risk or relapse prevention plans should be developed and clients should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths:

- The drug court has a management audit system in place to evaluate internal service providers. Treatment group facilitators are observed in group once a month by a supervisor and formal feedback is provided after the session. File review also takes place.
- Offender reassessment is completed for youth on the GAIN and YLS/CMI every 6 months, and detailed treatment plans are created and regularly updated for youth.

Recommendations for Improvement:

- Participant satisfaction with the drug court and treatment programming should be measured with an exit survey.

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- Youth re-arrest, re-conviction, or re-incarceration data should be examined regularly to evaluate outcomes at least six months post graduation. The drug court should review this information.
- The drug court should go through a formal evaluation every five years comparing treatment outcome with a risk-control comparison group. Effectiveness is supported if there is some reduction in recidivism in the drug court group versus the comparison group.
- A program evaluator should be available (on staff or contract) to assist with research and evaluation of the drug court. Regular reports should be provided to the drug court.

OVERALL PROGRAM RATING

Ada County Juvenile Drug Court received an overall score of **55.8** percent on the CPC-DC. This just falls into the **Effective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **50.0** percent, which falls into the **Needs Improvement** category. The overall Content score, which focuses on the *substantive* domains of assessment and treatment, is **59.3** percent, which falls into the **Effective** category.

CONCLUSION

Researchers at the University of Cincinnati have assessed 512 programs nationwide and have developed a large database on correctional intervention programs.[2] Approximately 7 percent of the programs assessed have been classified as HIGHLY EFFECTIVE, 17 percent have been classified as EFFECTIVE, 31 percent have been classified as NEEDS IMPROVEMENT, and 45 percent have been classified as INEFFECTIVE.

A graph representing the results of this assessment are provided below. The graph compares the drug court in the capacity domain, content domain, and overall score with the average scores from all 512 programs evaluated by the University of Cincinnati.

Recommendations have been made in each of the four CPC domains for the Ada County Juvenile Drug Court. These recommendations should assist the program in making necessary changes to increase program effectiveness. The drug court should not to attempt to address all "areas needing improvement" at once. Agencies that find the assessment process most useful are those that prioritize need areas and develop action plans to systematically address such needs. Previous localities have also been successful at improving the provision of services by formulating committees charged with developing strategies for delivering evidence-based programming.

[2] Several versions of the CPAI were used prior to the development of the CPC. Scores and averages have been adjusted as needed.

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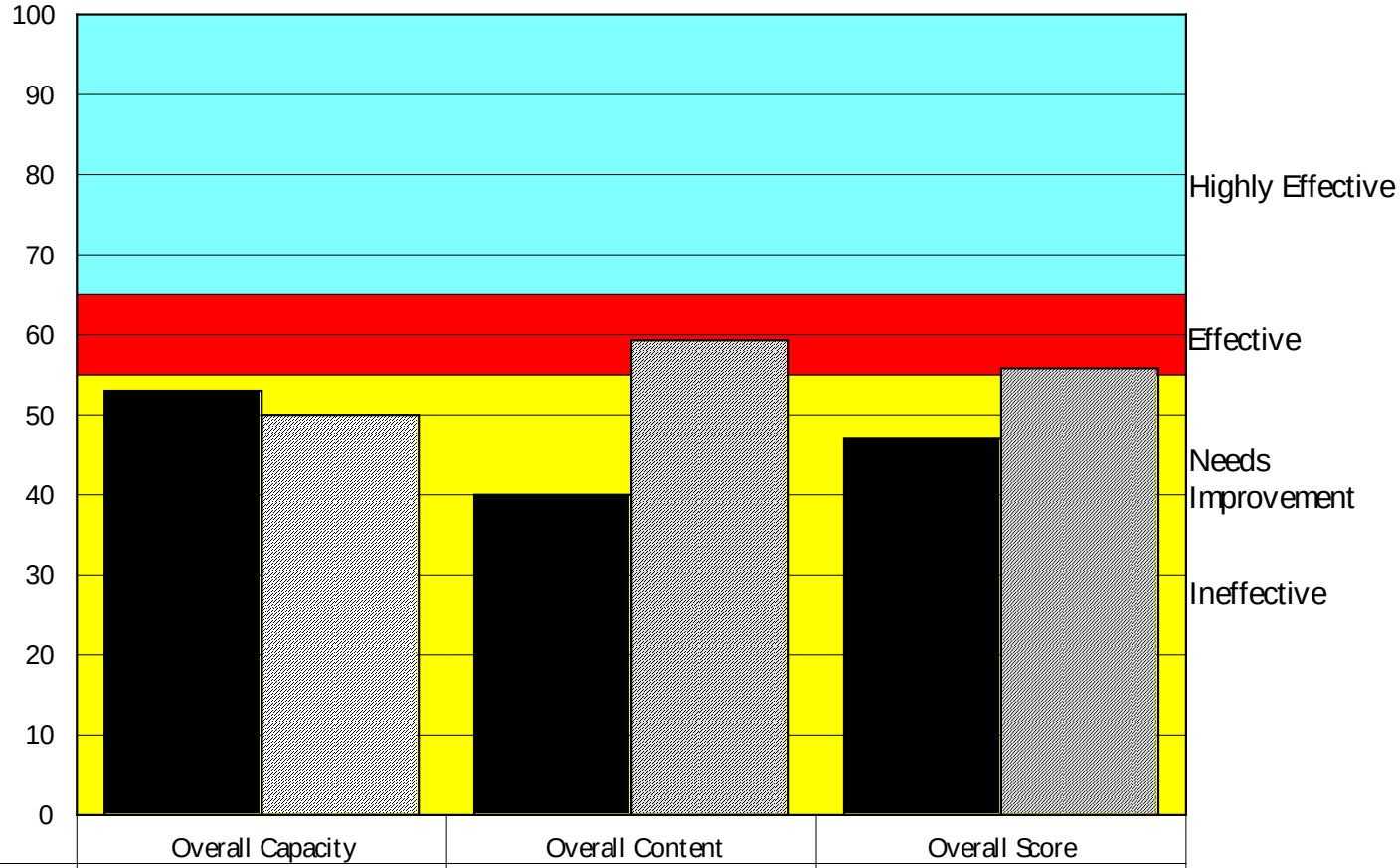
FIGURE 1:

Ada County Juvenile Drug Court CPC-DC Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Ada County	50	59.3	55.8

* The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST – DRUG COURT (CPC-DC) SYNOPSIS OF FINDINGS

Performed as part of the OJJDP study Outcome and Process Evaluation of Juvenile Drug Courts

Clackamas County Juvenile Drug Court

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OUTCOME AND PROCESS EVALUATION OF JUVENILE DRUG COURTS STUDY

This project is funded by a grant received from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The purpose of this study is to evaluate a national sample of juvenile drug court programs. The goals of this research are: (1) To determine if there is a reduction in recidivism and substance abuse associated with participation in a juvenile drug court program; (2) to determine if there are improvements in social functioning (e.g. school performance, employment, and family functioning) related to participating in juvenile drug court programs; (3) to identify the characteristics of successful juvenile drug court participants; (4) to determine if juvenile drug courts are operating in a manner consistent with an evidence-based approach; (5) to identify the programmatic characteristics of effective juvenile drug courts; and (6) to provide information to policymakers about the effectiveness of drug courts for juvenile offenders.

This study includes both an outcome and a process evaluation. The outcome portion of the study examines outcomes of youth participating in drug courts as compared to similar youth who are on probation. The process evaluation explores the effectiveness of the drug court and drug court programming and is the focus of this report. Ten drug courts from across the country participated in this four-year study, nine of which participated in both the process and outcome evaluation pieces. The final report for the Outcome and Process Evaluation of Juvenile Drug Courts study will offer outcome and process evaluation findings across all nine drug court sites and is expected to be submitted to OJJDP in December 2012.

CONTEXT AND SCOPE OF THIS EVALUATION

The following report is part of a larger national project centered on the effectiveness of juvenile drug court programs and provides a synopsis of findings from the process evaluation, as well as recommendations to enhance the effectiveness of the services delivered by the Clackamas County Juvenile Drug Court. Programs that adhere to the principles of effective intervention are more likely to impact criminal reoffending (see Andrews & Bonta, 2003 for a review). Specifically, correctional research suggests that cognitive behavioral and social learning models of treatment are associated with considerable reductions in recidivism (Gendreau, 1996; Smith, Goggin & Gendreau, 2002). As such, the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) was used to evaluate the juvenile drug courts participating in the Outcome and Process Evaluation of Juvenile Drug Courts study. The objectives of this assessment are to conduct a detailed review of services and program materials of the juvenile drug courts and the agencies they refer youth to and to compare their current practices with the literature on "best practices" in corrections.

PROCEDURES

Description of the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC)

The Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) is a tool that the University of Cincinnati developed for assessing drug court programs. It is used to determine how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. The CPC-DC was modified from the Evidence-Based Correctional Program Checklist (CPC) [1] and includes important indicators from drug court meta-analyses (see Shaffer, 2006). The CPC

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has been validated by several recent studies conducted by the University of Cincinnati. These studies found strong correlations between outcome and both domain areas and individual items (Holsinger, 1999; Lowenkamp, 2003; Lowenkamp and Latessa, 2003, Lowenkamp & Latessa, 2005a; Lowenkamp and Latessa, 2005b; Shaffer, 2006). As part of the larger national study, the indicators on the CPC-DC will be validated using the outcome data collected on the drug court participants.

The CPC-DC consists of two instruments: one for the formal drug court (CPC-DC) and the other for the major referral agencies (CPC-DC: RA) involved in providing treatment and services to drug court clients. Each of these tools is divided into two basic areas: Content and Capacity. The capacity area is designed to measure whether the drug court and its referral agencies have the capability to deliver evidence-based interventions and services to offenders. There are two domains in the capacity area: 1) Development, Coordination, Staff and Support, and 2) Quality Assurance. The content area focuses on the substantive aspect of the drug court and its referral agencies, and also includes two areas: 1) Assessment Practices, and 2) Treatment. This area examines the extent to which the drug court and its referral agencies meet the principles of risk, need, responsivity, and treatment.

The Drug Court tool includes 41 indicators, worth 43 total points. The Referral Agency tool has 49 indicators worth a total of 51 points. Each area and all domains are scored and rated as “highly effective” (65% to 100%); “effective” (55% to 64%); “needs improvement” (46% to 54%); or “ineffective” (45% to 0%). The scores in all domains are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the domains are given equal weight. Further, some items may be considered "not applicable," in which case they are not included in the scoring. Data are collected through structured interviews with selected program staff and program participants, as well as through observation of groups and services. In some instances, surveys may be used to gather additional information. Other sources of information include policy and procedure manuals, schedules, treatment materials, curricula, case files, and other selected program materials. Once the information is gathered and reviewed, the program is scored. The following report highlights strengths, areas that need improvement, and recommendations for each of the areas for both the drug court and the referral agencies.

There are several limitations to the CPC-DC that should be noted. First, as with any research process, objectivity and reliability are an issue. Although steps are taken to ensure that the information gathered is accurate and reliable, decisions about the information gathered are invariably made by the assessors. Second, the process is time specific. That is, the assessment is based on the program at the time of the assessment. Though changes or modifications may be planned for the future, only those activities and processes that were present at the time of the review in July 2009 are considered for scoring. Third, the process does not take into account all system issues that can affect program integrity (i.e., political climate of the court). Finally, the process does not address the reasons that a problem exists within a program or why certain practices do or do not take place. Rather, the process is designed to determine the overall integrity of the program.

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[1] The CPC is modeled after the Correctional Program Assessment Inventory developed by Gendreau and Andrews. However, only those indicators that were found to be positively correlated with outcome were retained. In addition, the CPC includes a number of items not contained in the CPAI.

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Despite these limitations, there are a number of advantages to this process. First, the criteria are based on empirically derived principles of effective programs, and all of the indicators included in the CPC-DC are correlated with reductions in recidivism. Second, it allows researchers to get inside the "black box" of a drug court and its referral agencies, something that an outcome study alone does not provide. This means researchers are able to measure the degree to which programs are meeting evidence-based standards. Third, the CPC-DC enables researchers to "quantify" the quality of a program through a scoring process. This allows for comparisons across programs, the setting of benchmarks, and for reassessment to measure progress. Fourth, it identifies both the strengths and weaknesses of a program and provides specific recommendations for program improvement.

Assessment Process

The assessment process consisted of a series of structured interviews with staff members and program participants during an on-site visit to Clackamas County Juvenile Drug Court on July 14th, 15th, and 16th 2009. Additionally, data were gathered via the examination of ten representative files (five open and five closed) as well as other relevant program materials (e.g., treatment manuals, assessments, training protocol, ethical guidelines, and staff evaluations). Finally, four treatment groups were observed: Parents Support Group, Girls Skills Group, and two Phase 1 and 2 groups for substance abuse. Two evaluators conducted the various interviews, observations and file reviews. Data from the various sources were then combined to generate a consensus CPC-DC score and the specific recommendations in what follows.

SUMMARY OF THE DRUG COURT

The Clackamas County Juvenile Drug Court has been in operation since 2001. The drug court is funded by Clackamas County. Youth range in age from fourteen to eighteen and must evidence drug abuse issues. Only Clackamas County residents are eligible for the program. At the time of assessment Deanne Darling was the drug court judge, Michelle Barrera was the juvenile department services supervisor, Jay Arzadon was the juvenile drug court coordinator (Darin Mancuso has since taken over the position), Kellee Shoemaker was the case manager, Rachel Pearl was the community service liaison, and Don Tomfohr was the out of home placement facilitator.

The drug court requires clients to progress through four phases of treatment designed to last seven to eight months. Phase 1 youth spend an average of seven to eight hours in drug court programming per week. Phase 2 youth spend an average of five to six hours in drug court programming per week. Phase 3 youth spend an average of four to five hours in drug court programming per week. Phase 4 youth spend an average of two to three hours in drug court programming per week. The drug court relies on the following supervision techniques to monitor youth in the program: curfew, drug and alcohol testing, participation in school or work, participation in substance abuse treatment, and attendance at court. Treatment for youth in the drug court is provided by both county employees and outside referral agencies. One county employee administers the Girls Skills Group and is calculated in the score for the drug court. The two referral agencies included in this report are Tim O'Brien LPC (parenting group and family treatment sessions) and Wright Counseling and Consultation Services, LLC (youth substance abuse treatment, group and individuals).

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FINDINGS – DRUG COURT

CPC-DC SECTIONS	SCORE	RATING
Development, Coordination, Staff and Support	66.6%	Effective
Offender Assessment	55.6%	Effective
Treatment	33.3%	Ineffective
Quality Assurance	42.9%	Ineffective
Overall Capacity	**56.3%**	**Effective**
Overall Content	**40.7%**	**Ineffective**
Overall Score	**46.5%**	**Needs Improvement**

Development, Coordination, Staff and Support

Strengths:

- There is a program coordinator who has overall responsibility for oversight and management of the program.
- The program coordinator has a direct role in selecting and approving the individuals hired to provide treatment.
- Regular staff meetings are held to discuss clients in the drug court.
- Drug court staff provide direct case management and supervision services to the youth in the drug court.
- Funding for the drug court was consistently rated by staff as adequate and there have been no changes in the level of funding in the past two years.

Recommendations for Improvement:

- Drug court staff should be trained on drug court programming and receive at least 40 hours of on-going training a year. Staff training should relate to the theory and practice of interventions used by the program including effective correctional practices and the cognitive-behavioral model.
- Ethical guidelines should dictate staff boundaries and interactions with drug court youth.
- The drug court is post-conviction/adjudication. Drug courts have more impact on outcomes when they accept only youth who are pre-conviction/adjudication and the youth's charges are held in abeyance (or sealed), dropped, or reduced if the youth successfully completes drug court.

Offender Assessment

Strengths:

- There are established criteria for the exclusion of certain types of offenders. The policy is written and followed, and clients were deemed appropriate for drug court by the majority of staff.
- Violent offenders are excluded from participating in the drug court.
- Risk, as well as a range of criminogenic needs, are assessed using the Juvenile Crime Prevention (JCP) assessment in the Juvenile Justice Information System (JJIS).
- Assessments are shared with everyone on the drug court team including the external treatment providers.

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Recommendations for Improvement:

- Domain specific needs, especially substance abuse, should be assessed using a validated, standardized, and objective instrument. While the drug court uses the American Society of Addiction Medicine (ASAM) assessment, we recommend a substance abuse assessment that is standardized, objective and validated. Examples of proper instrumentation for substance abuse include the Adolescent Substance Abuse Subtle Screening Inventory (SASSI) and the Juvenile Automated Substance Abuse Evaluation (JASAE).
- The drug court should assess factors that directly affect engagement in the drug court or treatment programming. Additionally, there should be evidence that clinical or staffing decisions are made based upon these responsivity factors. At least two major factors should be assessed, such as personality, motivational level/readiness for change, or mental illness. Examples of appropriate responsivity instrumentation include the TCU Client Self-Rating scale, Jesness Inventory, Beck's Depression, Massachusetts Youth Screening Instrument (MAYSI), and IQ tests.
- Drug courts should target moderate and high risk youth, and low risk youth should be screened out. The file review found that 10% of youth in the drug court were low risk as classified by the JJIS. This percentage should be under 5%.
- The drug court should target relevant higher need youth (high or moderate need for substance abuse treatment). Since no domain specific instrument was used by the drug court, no determination could be made about the need level for the youth participating in the drug court.

Treatment Characteristics

Strengths:

- The Clackamas County Juvenile Drug Court targets a wide range of criminogenic needs and meets criteria that at least 75% of drug court interventions should focus on criminogenic needs. The drug court team consistently stated the following criminogenic needs were targeted: antisocial peer associations; promotion of more positive attitudes/increase performance regarding school or work; promote family affection/communication; promote family monitoring and supervision; and relapse prevention.
- Drug court participants spend an adequate amount of time in structured activities.
- The drug court has an appropriate reward structure including verbal praise, gift frog (representing a leap forward and not being able to move backward), growth grab prize, participant gift certificates, parent gift certificates, phase advancement certificate, and graduation parties.
- The drug court responds to noncompliance appropriately including community service projects, road crew, electronic monitoring, house arrest, and detention. Sanctions for noncompliance progress in their intensity until the noncompliance is resolved.
- The drug court randomly drug tests youth on a regular basis. Youth have to call in to the UA hotline each morning, and tests are conducted on average twice a week in the earlier phases and one to two times a week in the later phases.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive

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restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Observation of groups and interviews with youth in the drug court revealed that little cognitive restructuring and no role play or practicing of skills took place during group treatment. Instead, groups appeared to be unstructured, using more of a "talk therapy" approach and allowed youth to frequently get off topic. For the girl's skills group, which is an internal program administered by a county employee, Girls Circle curriculum is used. While the use of Girls Circle shows the drug court's commitment to gender specific treatment options, it does not focus on criminogenic needs using an evidence-based treatment modality. We would encourage a switch from Girls Circle to a different gender specific therapy that addresses criminogenic needs using cognitive-behavioral interventions, such as Girls…Moving On.

- Staff stated that while the drug court is designed to last an average seven to eight months, the actual time in drug court averages 12-14 months. It is recommended that the majority of youth graduate in less than 12 months.
- Clients should be assigned to groups and services that match their style of learning and other responsivity factors. The drug court should use responsivity instruments and tie those results to placement in appropriate groups and services.
- Intensity of the drug court programming should vary by risk level. High risk youth should receive higher intensity and/or duration of service than moderate risk youth. Moderate risk youth should receive higher intensity and/or duration of service than low risk youth.
- The drug court should have measurable completion criteria which determine how well a youth has progressed in acquiring prosocial behaviors. While phase advancement is used, other methods should be incorporated such as reassessment on risk/need or other formalized processes which track progress over time.
- The drug court completion rate is 59.6% which falls outside of the recommended range of 65% to 85%.
- The ratio of rewards to punishers should be at least 4:1. Staff consistently reported a ratio of 1:1, at the highest.
- As part of drug court, the family/caregivers should be trained to provide support, including the ability to identify high risk situations for their youth and strategies for managing their environment using prosocial skills. While there is a required support group for family members, there is no evidence that support groups impact family functioning. There is a voluntary Parent Empowerment Program; however, parent/caregiver sessions should target family communication, family monitoring and supervision, family problem solving and family members should be taught new skills to assist their child to monitor and anticipate risky situations in the community. Participation in these types of parent/caregiver treatment programs should be mandatory. Examples of evidence-based family/caregiver curriculum include: The Parent Project, Common Sense Parenting, Strengthening Families Program, and Parenting Wisely.
- After treatment is completed, the drug court should include an aftercare component of high quality. The aftercare should be a formal component in which supervision/meetings are required and an evidence-based model is used.
- The Clackamas County Juvenile Drug Court requires youth to participate in AA/NA. Youth in drug court should not be required to attend self-help meetings. There is no evidence that these meetings are beneficial to youth and may in fact be harmful.

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Quality Assurance

Strengths:

- Youth re-arrest, re-conviction, or re-incarceration data is examined regularly by drug court staff.
- The drug court went through a formal evaluation in 2003 with an update completed in 2006. Outcomes for youth in the drug court were compared with a risk-control comparison group. Recidivism was significantly reduced for youth in the drug court group at fifteen months and twenty-four months post program entry. Other outcomes highlighted in the report were the cost effectiveness of the drug court compared to other programming, and increased family functioning specifically related to communication and problem solving.

Recommendations for Improvement:

- The drug court should have a management audit system in place to evaluate internal and external service providers. This includes site visits, monitoring of groups, regular progress reports, and file review.
- Participant satisfaction with the drug court and treatment programming should be measured with an exit survey.
- Offender reassessment should be completed to determine progress on meeting target behaviors. This can be achieved through a pre-post test or through reassessment on validated risk and need instruments such as the JCP. Examples of a proper pre-post tests are the Pride in Delinquency Scale (PID), TCU Criminal Thinking Scale (TCU-CTS), How I Think Questionnaire (HIT), and the Criminal Sentiments Scale – Modified (CSS-M).
- A program evaluator should be available (on staff or contract) to assist with research and evaluation of the drug court. Regular reports should be provided to the drug court.

OVERALL PROGRAM RATING

Clackamas County Juvenile Drug Court received an overall score of **46.5** percent on the CPC-DC. This falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **56.3** percent, which falls into the **Effective** category. The overall Content score, which focuses on the *substantive* domains of assessment and treatment, is **40.7** percent, which falls into the **Ineffective** category.

FINDINGS – TIM O'BRIEN LPC

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	75.0%	Highly Effective
Offender Assessment	0.0%	Ineffective
Treatment	25.9%	Ineffective
Quality Assurance	0.0%	Ineffective
Overall Capacity	**56.3%**	**Effective**
Overall Content	**23.3%**	**Ineffective**
Overall Score	**34.8%**	**Ineffective**

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Leadership, Staff, and Support

Strengths:

- Mr. O'Brien is professionally trained and has requisite experience to run his agency. He also has sufficient education and adequate experience in treatment programs with youth involved in the criminal justice system.
- Mr. O'Brien provides direct services to parents via group sessions and also provides family treatment sessions.
- Mr. O'Brien has regular meetings with the drug court.
- Mr. O'Brien reports being supported by the juvenile drug court and other stakeholders.
- Program funding is adequate and stable.

Recommendations for Improvement:

- Mr. O'Brien should be regularly evaluated with regard to service delivery skills. Even though Mr. O'Brien runs his own agency, an experienced clinical supervisor should observe group and individual sessions and provide constructive feedback at least once per group cycle.
- Mr. O'Brien should receive formal training on the interventions he uses and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills needed to deliver effective programming in group and individual sessions.
- Ethical guidelines should dictate his boundaries and interactions with youth.

Client Assessment

Strengths: None.

Recommendations for Improvement:

- The individual family sessions should be reserved for youth who are high and moderate risk and who score as high or moderate need in the family domain on the JCP. Results from the family section of the JCP should be used to inform referrals to Mr. O'Brien. Mr. O'Brien should incorporate other instruments to determine appropriate placement into the individual family sessions. Examples of proper instrumentation include the Family Adaptability and Cohesion Evaluation Scale (FACES), Family Assessment Device (FAD), and the Family Assessment Measure III (FAM III).
- Responsivity is not measured by Mr. O'Brien. Factors that affect youth and parental engagement in treatment should be measured by validated tools. Examples include Jesness Inventory, Beck's Depression, the Massachusetts Youth Screening Instrument (MAYSI), IQ tests or measures of motivation such as the Desire for Help, Treatment Readiness, or External Pressures scales. Once assessed, this information should be incorporated into treatment plans. Texas Christian University's Institute of Behavioral Research has developed a number of assessment tools in this regard, including several that address readiness to change and other responsivity factors (i.e. the CEST). These are available from their web site: www.ibr.tcu.edu.

Treatment

Strengths:

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- Family functioning is a valid criminogenic need to address in treatment sessions.
- Mr. O'Brien is knowledgeable about the materials discussed in group and encourages participation.
- Length of treatment is sufficient. For the Parent Empowerment Program, parents attend two hour sessions once per week for ten weeks. For the parent support group, parents are required to attend the group after each court session their youth is required to attend during Phase I and Phase II of the drug court program. For the family treatment sessions, families must attend a total of seven sessions over the course of the drug court program.
- Treatment groups are always conducted and monitored by Mr. O'Brien.
- Mr. O'Brien has good rapport with group participants.
- Underlying thoughts and values are identified during family treatment sessions. Antisocial thinking is addressed, and prosocial thoughts are explored.

Recommendations for Improvement:

- The primary treatment model used in the various parent/caregiver and family sessions is talk therapy. Significantly more evidence-based treatment modalities (i.e., cognitive behavioral elements) should be incorporated into all treatment sessions. While there is a required support group for family members, there is no evidence that support groups impact family functioning. While there is a voluntary Parent Empowerment Program, parent/caregiver sessions should target family communication, family monitoring and supervision, family problem solving and family members should be taught new skills to assist their child to monitor and anticipate risky situations in the community. Participation in a parent/caregiver treatment program should be mandatory. Examples of evidence-based family/caregiver curriculum include: The Parent Project, Common Sense Parenting, Strengthening Families Program, and Parenting Wisely. Finally, individual family sessions should only be required for those families that need the service. These sessions should be used to determine how family functioning has changed and if parents are progressing in monitoring and supervising their youth. The individual family sessions should be tied back to a specific curriculum to reinforce the techniques and skills acquired in the parent/caregiver group, as well as address other areas of concern in the family (i.e., communication).
- Treatment groups should start on time and end on time, breaks should be limited to 5-10 minutes, and the check-in process should not take up the majority of the treatment session or be the focus of the treatment session.
- Group sizes are too large for one facilitator; on average, 12-15 parents participate per session. The program should use a co-facilitator when the group size exceeds ten. If a co-facilitator is used, both should be meaningfully active in group.
- Homework should be a regular part of the treatment process, and the counselor should consistently review homework with the parent/caregiver and family.
- Group norms/rules should be established, documented, and reviewed with the groups regularly.
- Groups should have a set manual (or curriculum) that is consistently followed.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- Mr. O'Brien does not incorporate any rewards above verbal praise, and he does not incorporate any punishers. He relies on the drug court to administer all rewards and punishers.

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- Rewards should be used to increase desired behavior. The range of rewards used to reinforce offender or parent behavior needs to be improved, and rewards should outweigh punishers by a ratio of at least 4:1. The procedure by which offenders and their families are reinforced should be improved so that rewards are immediate, seen as valuable for shaping behavior, consistently applied, and individualized.
- Similarly, Mr. O'Brien should have some punishers to extinguish antisocial expressions and promote behavioral change by showing that behavior has consequences. The process for punishing should also include the following components: punishers should be individualized; considered undesirable by the client; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator.
- While Mr. O'Brien avoids arguments with participants, there were numerous opportunities observed where redirection and extinction techniques should have been used to refocus the group and keep the group moving forward in a productive way.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback, and finally, they should include graduated practice of new skills in increasingly difficult situations.
- While Mr. O'Brien identified underlying thoughts and values, participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be incorporated into the treatment sessions. Parents/caregivers and youth should have to regularly practice the coping skills listed on the plan and the counselor should provide feedback.

Quality Assurance

Strengths: None.

Recommendations for Improvement:

- The program should incorporate a management audit system that consists of monitoring of groups by a clinical supervisor with feedback for improvement; file review; problem oriented records to monitor treatment progress; and formal offender and parent/caregiver feedback on services.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in family functioning and can be completed on FACES, FAD, FAM III or other need instruments.
- A formal discharge summary should be created for all clients, and the summary should be provided to the drug court.

Overall Program Rating

Tim O'Brien LPC received an overall score of **34.8** percent on the CPC-DC. This falls into the **Ineffective** category.

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The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **56.3** percent, which falls into the **Effective** category. The overall Content score, which focuses on the *substantive* domains of assessment and treatment, is **23.3** percent, which falls into the **Ineffective** category.

FINDINGS – WRIGHT COUNSELING AND CONSULTATION SERVICES, LLC

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	75.0%	Highly Effective
Offender Assessment	0.0%	Ineffective
Treatment	39.3%	Ineffective
Quality Assurance	0.0%	Ineffective
Overall Capacity	**56.3%**	**Effective**
Overall Content	**35.5%**	**Ineffective**
Overall Score	**42.3%**	**Ineffective**

Leadership, Staff, and Support

Strengths:

- Mr. Wright is professionally trained and has requisite experience to run his agency. He also has sufficient education and adequate experience in treatment programs with youth involved in the criminal justice system.
- Mr. Wright provides direct services to youth via group substance abuse sessions and also provides individual treatment sessions as needed.
- Mr. Wright has regular meetings with the drug court.
- Mr. Wright reports being supported by the juvenile drug court and other stakeholders.
- Program funding is adequate and stable.

Recommendations for Improvement:

- Mr. Wright should be regularly evaluated with regard to service delivery skills. Even though Mr. Wright runs his own agency, an experienced clinical supervisor should observe group and provide constructive feedback at least once per group cycle.
- Mr. Wright should receive formal training on the interventions he uses and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills needed to deliver effective programming in group and individual sessions.
- Ethical guidelines should dictate his boundaries and interactions with youth.

Client Assessment

Strengths: None.

Recommendations for Improvement:

- Responsivity is not measured by Mr. Wright. Factors that affect engagement in group should be measured by validated tools. Examples include TCU Client Self-Rating Scale,

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Jesness Inventory, Beck's Depression, or the Massachusetts Youth Screening Instrument (MAYSI).

- The program should serve high and moderate risk youth; the file review found that 10% of youth in the drug court were low risk as classified by the JCP. These youth should not be mixed in the treatment sessions with the high and moderate risk youth.
- The program should serve high and moderate need youth. Since the drug court does not assess need level of the youth, the program should do this and low need youth should not be accepted into the program. Examples of proper instrumentation for substance abuse include the Adolescent Substance Abuse Subtle Screening Inventory (SASSI) and the Juvenile Automated Substance Abuse Evaluation (JASAE). If the drug court does incorporate one of these instruments into the assessment protocol, the program does not need to reassess each drug court participant, but the program should receive the scores from the drug court to assist in planning treatment services.

Treatment

Strengths:

- Cessation of substance use and relapse prevention are valid criminogenic needs to address in treatment sessions.
- Mr. Wright is knowledgeable about the materials discussed in group and encouraged participation.
- Length of treatment is sufficient. Youth in Phases I and II attend two ninety minute substance abuse groups per week. Youth in Phase III and IV attend a ninety minute skills group once per week (Mr. Wright conducts the boy's skills group, but does not conduct the girl's skills group).
- Treatment groups are always conducted and/or monitored by Mr. Wright.
- Group size is appropriate. The substance abuse treatment group typically has 8-10 youth and the boy's skills group usually has 6-10 participants. On the rare occasion that the groups have more than 10 youth, Mr. Wright should utilize a co-facilitator (possibly someone from the drug court).
- Mr. Wright utilizes an appropriate reward structure including verbal praise, candy, group grab, and video games after treatment sessions.
- Mr. Wright uses appropriate punishers including verbal prompts and writing assignments.
- Mr. Wright has good rapport with group participants.
- Mr. Wright avoids arguments with participants and rolls with resistance appropriately.
- Underlying thoughts and values are identified during group and individual treatment sessions. Antisocial thinking is addressed, and prosocial thoughts are explored.

Recommendations for Improvement:

- While Mr. Wright has the Pathways to Self Discovery and Change curriculum for substance abuse, it is not regularly incorporated into the treatment sessions. Additionally, Mr. Wright does not have a curriculum for the skills group. The primary treatment model used in the groups and individual treatment sessions is talk therapy. Significantly more evidence-based treatment modalities (i.e., cognitive-behavioral elements) should be incorporated into all treatment sessions. Structured curricula or manualized interventions should be used for all treatment sessions, and facilitators should undergo formal training on the appropriate use of curricula. Examples of substance abuse curriculum for youth include Pathways to Self

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Discovery and Change, and Cannabis Youth Treatment Series (CYT). The skills group should focus on criminogenic needs. Examples of a curriculum that address criminal thinking include Thinking for a Change, Aggression Replacement Therapy, Prepare, and Choices, Changes, and Challenges.

- Males and females are more productive in treatment sessions when they attend treatment separately. Treatment groups should be gender specific. While the drug court has shifted to separate skills groups for girls and boys, the substance abuse treatment should also be gender specific.
- All treatment groups should consistently start and end on time. Both of the groups observed started late and one ended early. Participants also confirmed that groups frequently either started late or ended early.
- Homework should be regularly assigned to participants. The homework should be reviewed by the facilitator, and constructive feedback should be provided to the participants.
- Group norms/rules should be established, documented, and reviewed with the groups regularly.
- Groups should have a set manual that is consistently followed.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- The range of rewards used to reinforce offender behavior needs to be increased as well as the frequency of rewards. Rewards should outweigh punishers by a ratio of at least 4:1. The procedure by which offenders are reinforced should be improved so that rewards are immediate, seen as valuable for shaping behavior, consistently applied, and individualized.
- The program should have additional punishers to extinguish antisocial expressions and promote behavioral change by showing that behavior has consequences. The program should not rely so much on the drug court to administer punishers. The process for punishing should also include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- While Mr. Wright identified underlying thoughts and values, participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participant in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be incorporated into the treatment sessions. Youth should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths: None.

Recommendations for Improvement:

- The program should incorporate a management audit system including monitoring of groups by a clinical supervisor with feedback for improvement; file review; problem oriented

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records to monitor treatment progress; and formal offender and parent/caregiver feedback on services.

- A pre-post test should be used to measure client progress on target behaviors. Offender reassessment should be completed to determine progress on meeting target behaviors. This can be achieved through a pre-post test that measures criminal thinking or through reassessment on validated risk and need instruments. Examples of a proper pre-post tests for criminal thinking are the Pride in Delinquency Scale (PID), TCU Criminal Thinking Scale (TCU-CTS), How I Think Questionnaire (HIT), and the Criminal Sentiments Scale – Modified (CSS-M).
- A formal discharge summary should be created for all clients and the summary should be provided to the court.

Overall Program Rating

Wright Counseling and Consultation Services, LLC received an overall score of **42.3** percent on the CPC-DC. This falls into the **Ineffective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **56.3** percent, which falls into the **Effective** category. The overall Content score, which focuses on the *substantive* domains of assessment and treatment, is **35.5** percent, which falls into the **Ineffective** category.

CONCLUSION

Researchers at the University of Cincinnati have assessed 512 programs nationwide and have developed a large database on correctional intervention programs.[2] Approximately 7 percent of the programs assessed have been classified as HIGHLY EFFECTIVE, 17 percent have been classified as EFFECTIVE, 31 percent have been classified as NEEDS IMPROVEMENT, and 45 percent have been classified as INEFFECTIVE.

Graphs representing the results of this assessment are provided below. The first graph or set of graphs compares the drug court or referral agency score in the capacity domain, content domain, and overall score with the average scores from all 512 programs evaluated by the University of Cincinnati. The final graph shows the drug court score and an average of the scores from all referral agencies used by the drug court compared to the average of all programs evaluated by the University of Cincinnati.

Recommendations have been made in each of the four CPC domains for the Clackamas County Juvenile Drug Court. These recommendations should assist the program in making necessary changes to increase program effectiveness. Certainly, care should be taken not to attempt to address all "areas needing improvement" at once. Programs that find the assessment process most useful are those that prioritize need areas and develop action plans to systematically address such needs. Previous programs have also been successful at improving the provision of services by formulating committees charged with developing strategies for delivering evidence-based programming.

[2] Several versions of the CPAI were used prior to the development of the CPC. Scores and averages have been adjusted as needed.

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This report also provides the drug court with a snapshot of the referral agency where its youth are receiving treatment in the community. This evaluation should assist the drug court in determining what type of treatment is effective when working with juvenile drug court clients. It should also assist the referral agencies with ways they can improve the services they provide to drug court youth.

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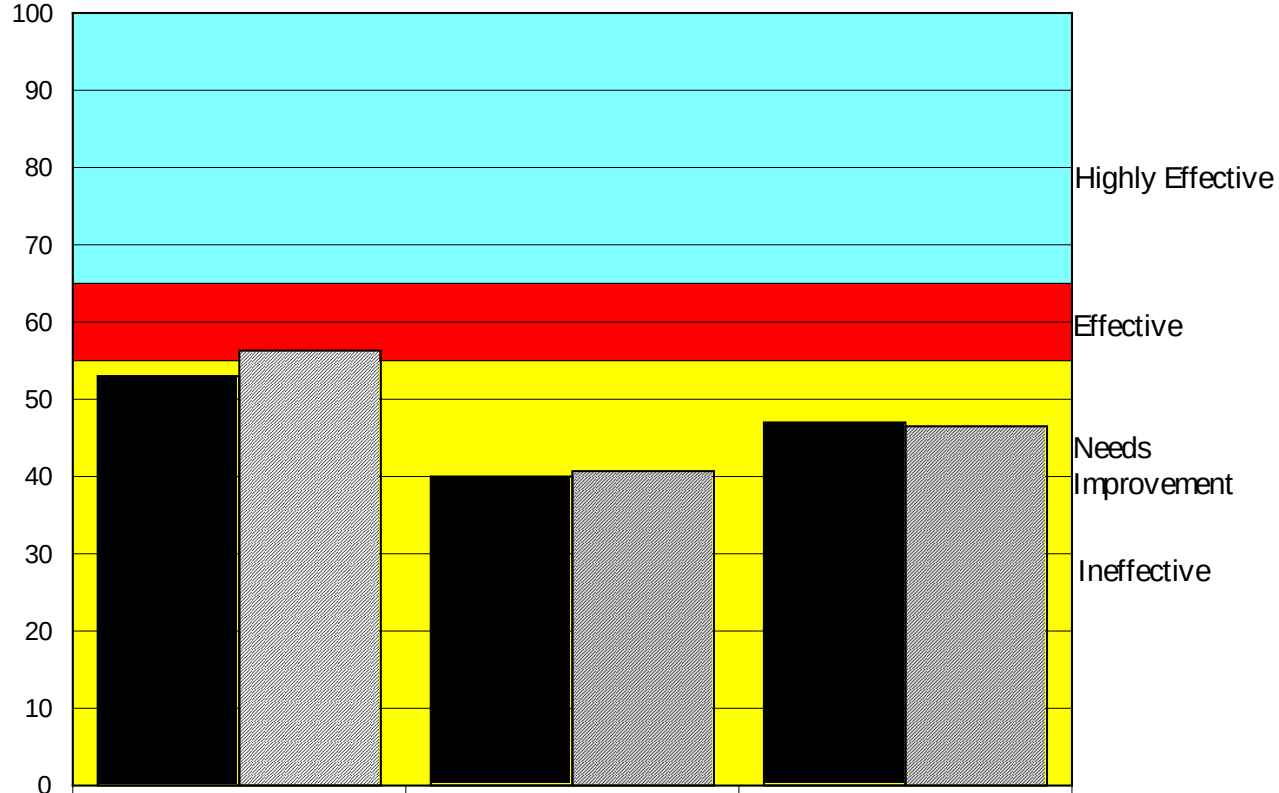
FIGURE 1:

Clackamas County Juvenile Drug Court CPC-DC Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Clackamas County	56.3	40.7	46.5

* The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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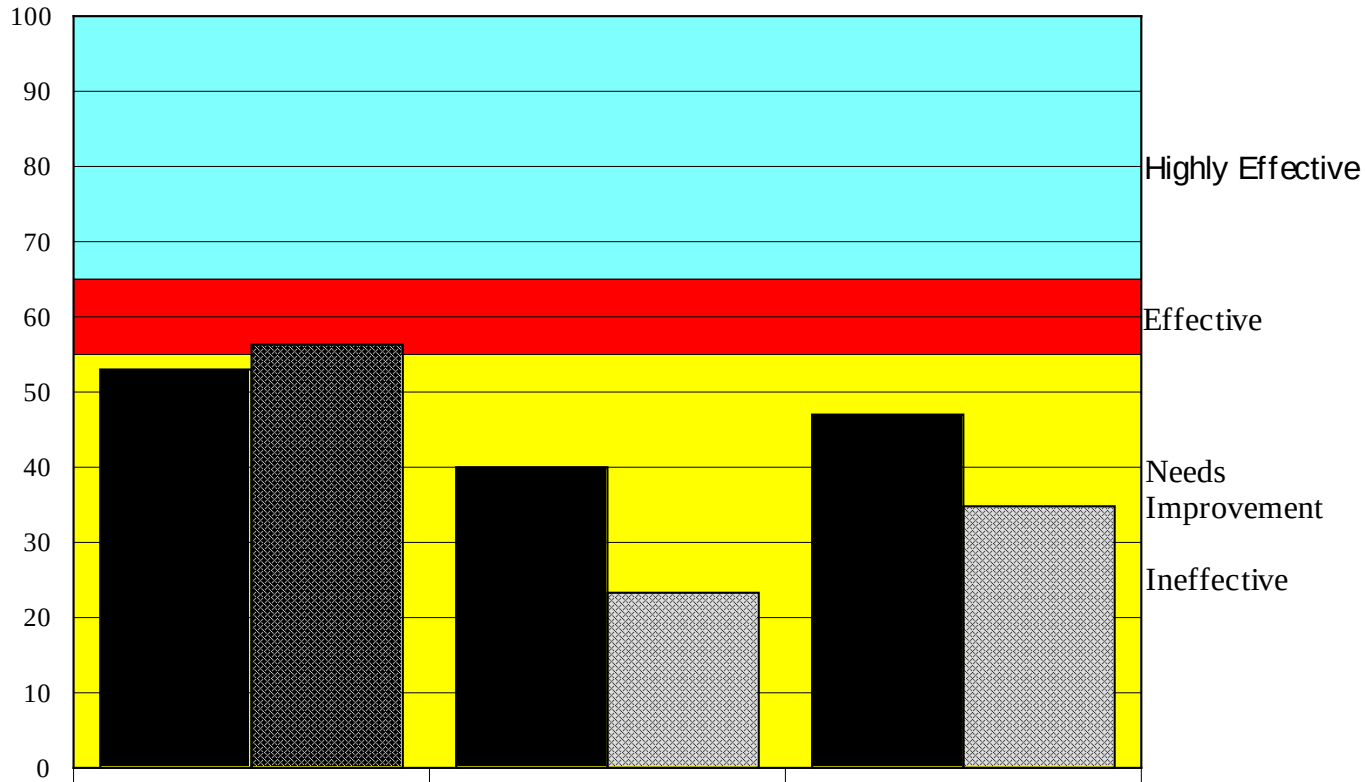
FIGURE 2:
Tim O'Brien LPC CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Tim O'Brien	56.3	23.3	34.8

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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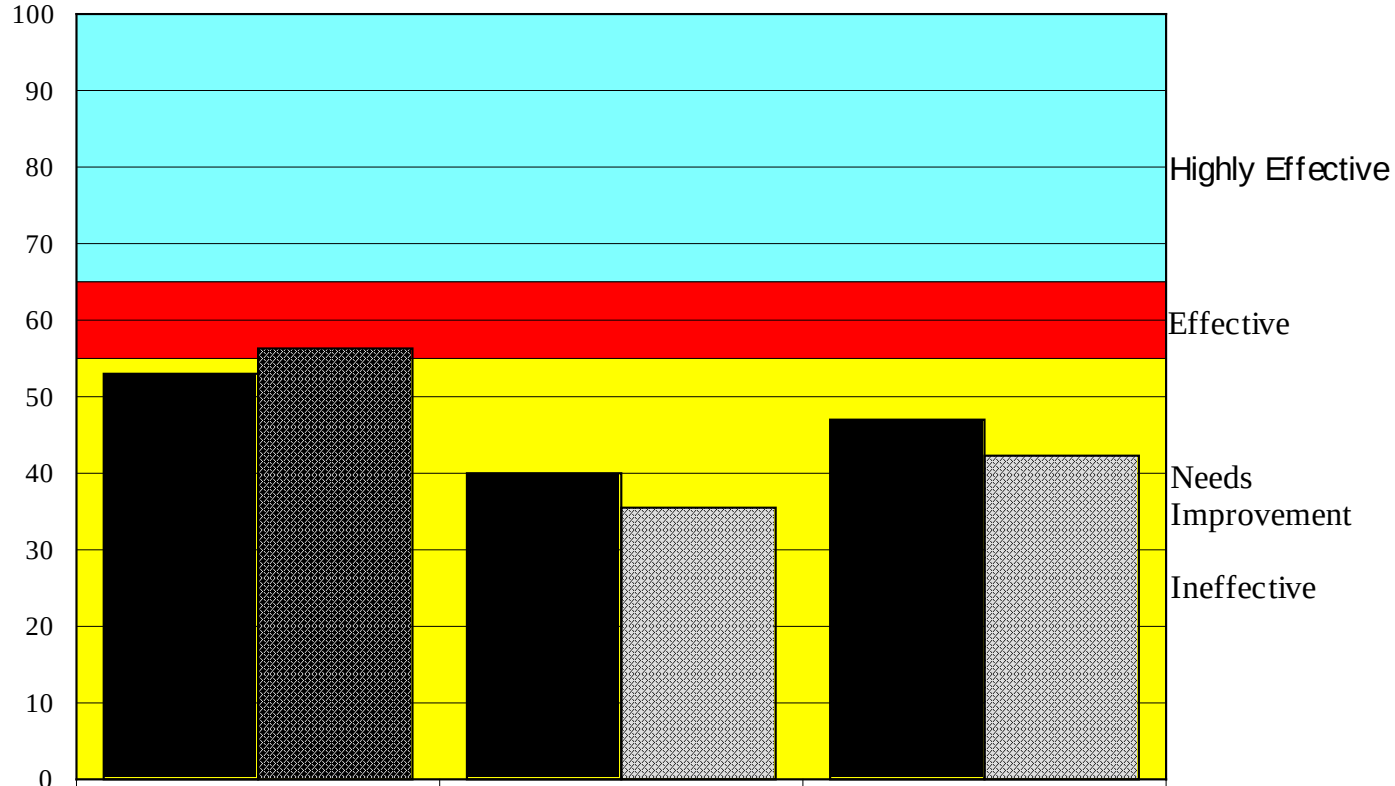
FIGURE 3:
Wright Counseling and Consultation Services, LLC
CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Wright Counseling	56.3	35.5	42.3

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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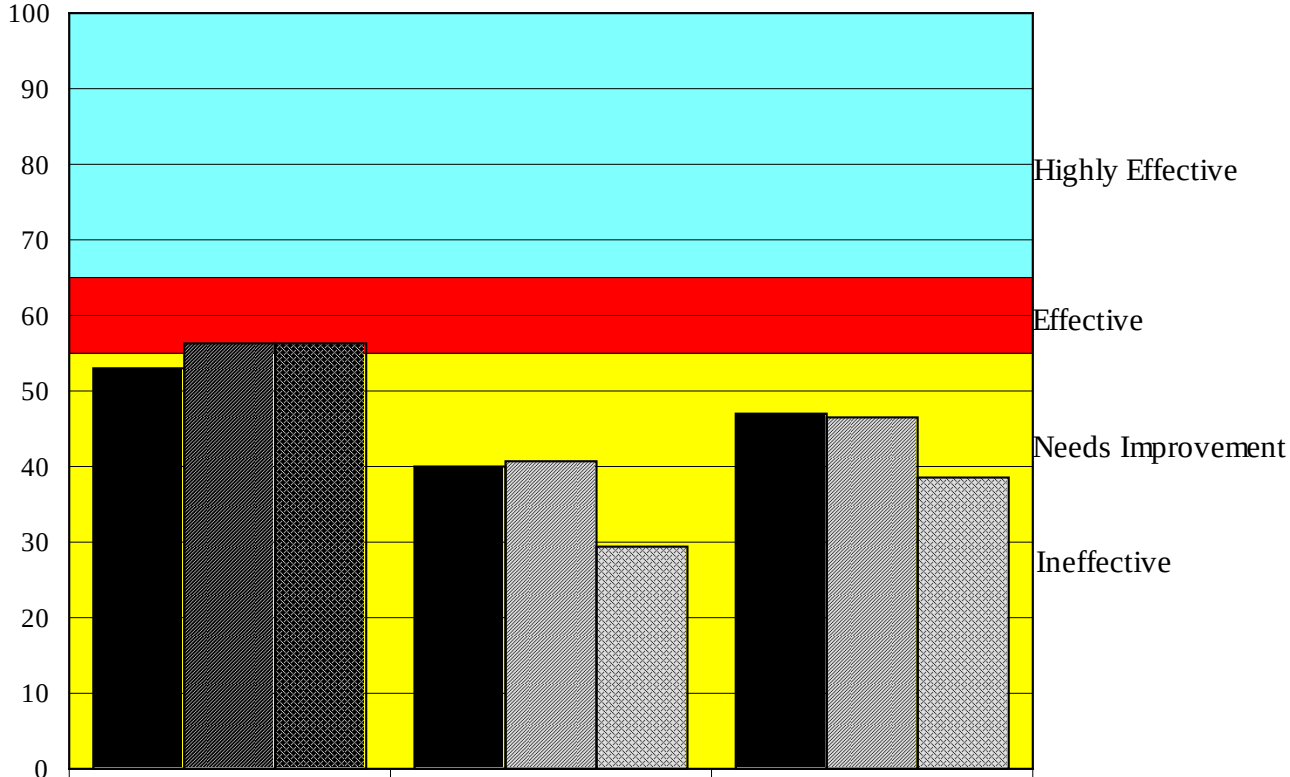
FIGURE 4:
Clackamas County Juvenile Drug Court Overall



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Clackamas County	56.3	40.7	46.5
Referral Agency Average	56.3	29.4	38.55

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST – DRUG COURT (CPC-DC) SYNOPSIS OF FINDINGS

Performed as part of the OJJDP study Outcome and Process Evaluation of Juvenile Drug Courts

Jefferson County Juvenile Drug Court

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OUTCOME AND PROCESS EVALUATION OF JUVENILE DRUG COURTS STUDY

This project is funded by a grant received from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The purpose of this study is to evaluate a national sample of juvenile drug court programs. The goals of this research are: (1) To determine if there is a reduction in recidivism and substance abuse associated with participation in a juvenile drug court program; (2) to determine if there are improvements in social functioning (e.g. school performance, employment, and family functioning) related to participating in juvenile drug court programs; (3) to identify the characteristics of successful juvenile drug court participants; (4) to determine if juvenile drug courts are operating in a manner consistent with an evidence-based approach; (5) to identify the programmatic characteristics of effective juvenile drug courts; and (6) to provide information to policymakers about the effectiveness of drug courts for juvenile offenders.

This study includes both an outcome and a process evaluation. The outcome portion of the study examines outcomes of youth participating in drug courts as compared to similar youth who are on probation. The process evaluation explores the effectiveness of the drug court and drug court programming and is the focus of this report. Ten drug courts from across the country participated in this four-year study, nine of which participated in both the process and outcome evaluation pieces. The final report for the Outcome and Process Evaluation of Juvenile Drug Courts study will offer outcome and process evaluation findings across all nine drug court sites and is expected to be submitted to OJJDP in December 2012.

CONTEXT AND SCOPE OF THIS EVALUATION

The following report is part of a larger national project centered on the effectiveness of juvenile drug court programs and provides a synopsis of findings from the process evaluation, as well as recommendations to enhance the effectiveness of the services delivered by the Jefferson County Juvenile Drug Court. Programs that adhere to the principles of effective intervention are more likely to impact criminal reoffending (see Andrews & Bonta, 2003 for a review). Specifically, correctional research suggests that cognitive behavioral and social learning models of treatment are associated with considerable reductions in recidivism (Gendreau, 1996; Smith, Goggin & Gendreau, 2002). As such, the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) was used to evaluate the juvenile drug courts participating in the Outcome and Process Evaluation of Juvenile Drug Courts study. The objectives of this assessment are to conduct a detailed review of services and program materials of the juvenile drug courts and the agencies they refer youth to and to compare their current practices with the literature on "best practices" in corrections.

PROCEDURES

Description of the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC)

The Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) is a tool that the University of Cincinnati developed for assessing drug court programs. It is used to determine how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. The CPC-DC was modified from the Evidence-Based Correctional Program Checklist (CPC) [1] and includes important indicators from drug court meta-analyses (see Shaffer, 2006). The CPC

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has been validated by several recent studies conducted by the University of Cincinnati. These studies found strong correlations between outcome and both domain areas and individual items (Holsinger, 1999; Lowenkamp, 2003; Lowenkamp and Latessa, 2003, Lowenkamp & Latessa, 2005a; Lowenkamp and Latessa, 2005b; Shaffer, 2006). As part of the larger national study, the indicators on the CPC-DC will be validated using the outcome data collected on the drug court participants.

The CPC-DC consists of two instruments: one for the formal drug court (CPC-DC) and the other for the major referral agencies (CPC-DC: RA) involved in providing treatment and services to drug court clients. Each of these tools is divided into two basic areas: Content and Capacity. The capacity area is designed to measure whether the drug court and its referral agencies have the capability to deliver evidence-based interventions and services to offenders. There are two domains in the capacity area: 1) Development, Coordination, Staff and Support, and 2) Quality Assurance. The content area focuses on the substantive aspect of the drug court and its referral agencies, and also includes two areas: 1) Assessment Practices, and 2) Treatment. This area examines the extent to which the drug court and its referral agencies meet the principles of risk, need, responsivity, and treatment.

The Drug Court tool includes 41 indicators, worth 43 total points. The Referral Agency tool has 49 indicators worth a total of 51 points. Each area and all domains are scored and rated as “highly effective” (65% to 100%); “effective” (55% to 64%); “needs improvement” (46% to 54%); or “ineffective” (45% to 0%). The scores in all domains are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the domains are given equal weight. Further, some items may be considered "not applicable," in which case they are not included in the scoring. Data are collected through structured interviews with selected program staff and program participants, as well as through observation of groups and services. In some instances, surveys may be used to gather additional information. Other sources of information include policy and procedure manuals, schedules, treatment materials, curricula, case files, and other selected program materials. Once the information is gathered and reviewed, the program is scored. The following report highlights strengths, areas that need improvement, and recommendations for each of the areas for both the drug court and the referral agencies.

There are several limitations to the CPC-DC that should be noted. First, as with any research process, objectivity and reliability are an issue. Although steps are taken to ensure that the information gathered is accurate and reliable, decisions about the information gathered are invariably made by the assessors. Second, the process is time specific. That is, the assessment is based on the program at the time of the assessment. Though changes or modifications may be planned for the future, only those activities and processes that were present at the time of the review in August 2009 are considered for scoring. Third, the process does not take into account all system issues that can affect program integrity (i.e., political climate of the court). Finally, the process does not address the reasons that a problem exists within a program or why certain practices do or do not take place. Rather, the process is designed to determine the overall integrity of the program.

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[1] The CPC is modeled after the Correctional Program Assessment Inventory developed by Gendreau and Andrews. However, only those indicators that were found to be positively correlated with outcome were retained. In addition, the CPC includes a number of items not contained in the CPAI.

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Despite these limitations, there are a number of advantages to this process. First, the criteria are based on empirically derived principles of effective programs, and all of the indicators included in the CPC-DC are correlated with reductions in recidivism. Second, it allows researchers to get inside the "black box" of a drug court and its referral agencies, something that an outcome study alone does not provide. This means researchers are able to measure the degree to which programs are meeting evidence-based standards. Third, the CPC-DC enables researchers to "quantify" the quality of a program through a scoring process. This allows for comparisons across programs, the setting of benchmarks, and for reassessment to measure progress. Fourth, it identifies both the strengths and weaknesses of a program and provides specific recommendations for program improvement.

Assessment Process

The assessment process consisted of a series of structured interviews with staff members and program participants during an on-site visit to Jefferson County Juvenile Drug Court on August 4th, 5th, and 6th 2009. Additionally, ten files (five open and five closed) as well as other relevant program materials (e.g., treatment manuals, assessments, training protocol, ethical guidelines, and staff evaluations) were examined. Finally, four treatment groups were observed; one at Trinity Behavioral Medicine and three at Ezra Academy and Center for Treatment Services. Two evaluators conducted the various interviews, observations and file reviews. Data from the various sources were then combined to generate a consensus CPC-DC score and the specific recommendations in what follows.

SUMMARY OF THE DRUG COURT

The Jefferson County Juvenile Drug Court has been in operation since 2003. The drug court is funded through the Ohio Department of Youth Services Juvenile Accountability Incentive Block Grant (JAIBG) program. Youth range in age from fourteen to eighteen and must evidence drug abuse issues. Only Jefferson County residents are eligible for the program. At the time of assessment, Samuel Kerr was the drug court judge, Doug Knight was the juvenile drug court program coordinator, Frank Noble was the drug court magistrate, Fred Abdalla was the chief probation officer, Joseph Colabella was the drug court administrator, Sam Pate was the prosecutor, Costra Mastros was the defense attorney, Beverly Mayhew was the drug court clerk, Brian Kosikowski was the school liaison, Kim Mark was the nurse, and Dan Keenan was the drug court evaluator.

The drug court has two different tracks for youth based upon the youth's substance dependency level. Track I: Basic Education requires eight, hour long drug education/intervention classes, one AA/NA meeting, random urine drug screens, 90 consecutive clean days, acceptable academic performance, and gainful employment or other structured activity. Track I is designed to last three to six months, and youth spend an average of two hours per week in drug court programming. Track II: Intensive Outpatient requires clients to progress through three phases of treatment designed to last six to nine months. Phase 1 youth spend an average of nine hours in drug court programming per week. Phase 2 youth spend an average of four hours in drug court programming per week. Phase 3 youth spend an average of three hours in drug court programming per week. The drug court relies on the following techniques to supervise youth in the program: weekly drug and alcohol testing, participation in school or work, participation in substance abuse treatment, school and home visits, and monthly attendance at court. Treatment for youth in the drug court is provided

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by four outside referral agencies. The referral agencies included in this report are Trinity Behavioral Medicine (group substance abuse treatment sessions), Family Services Association (individual counseling for boys, youth life skills and family counseling), Jefferson Behavioral Health Services (individual counseling for girls, youth life skills and family counseling), and Ezra Academy and Center for Treatment Services (residential substance abuse services).

FINDINGS – DRUG COURT

CPC-DC SECTIONS	SCORE	RATING
Development, Coordination, Staff and Support	77.8%	Highly Effective
Offender Assessment	44.4%	Ineffective
Treatment	33.3%	Ineffective
Quality Assurance	42.9%	Ineffective
Overall Capacity	**62.5%**	**Effective**
Overall Content	**37.0%**	**Ineffective**
Overall Score	**46.5%**	**Needs Improvement**

Development, Coordination, Staff and Support

Strengths:

- There is a program coordinator who has overall responsibility for oversight and management of the program.
- The program coordinator has a direct role in selecting and approving the individuals hired to provide treatment.
- Regular staff meetings are held to discuss participants in the drug court.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- Drug court staff provide direct case management and supervision services to the youth in the drug court.
- Funding for the drug court is adequate and there have been no changes in the level of funding in the past two years.

Recommendations for Improvement:

- Drug court staff should be trained on drug court programming and receive at least 40 hours of on-going training a year. Staff training should relate to the theory and practice of interventions used by the program including effective correctional practices and the cognitive-behavioral model.
- The drug court is both pre- and post-conviction/adjudication. Drug courts have more impact on outcomes when they accept only youth who are pre-conviction/adjudication and the youth's charges are held in abeyance (or sealed), dropped, or reduced if the youth successfully completes drug court.

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Offender Assessment

Strengths:

- There are established criteria for the exclusion of certain types of offenders. The policy is written and followed, and clients are deemed appropriate for drug court by the majority of staff.
- Violent offenders are excluded from participating in the drug court.
- Domain specific needs are assessed with the Adolescent Substance Abuse Subtle Screening Inventory (SASSI).
- Assessment results are shared with everyone on the drug court team including the external treatment providers.

Recommendations for Improvement:

- Risk, as well as a range of criminogenic need factors should be assessed using a validated, standardized, and objective instrument. Currently, all youth are given the Structured Assessment of Violence Risk in Youth (SAVRY). This instrument is intended to measure the risk of violence and does not provide an overall level of general risk (low, moderate, high) to recidivate based on an actual score. However, the drug court has since adopted the Ohio Youth Assessment System (OYAS), which has been validated in Ohio.
- The drug court should assess factors that directly affect participant engagement in the drug court or treatment programming. Additionally, there should be evidence that clinical or staffing decisions are made based upon these responsivity factors. At least two major factors such as personality, motivational level/readiness for change, or mental illness should be assessed. Examples of appropriate responsivity instrumentation include the TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, Massachusetts Youth Screening Instrument (MAYSI), and IQ tests.
- Drug courts should target moderate and high risk youth, and low risk youth should be screened out. Since the SAVRY does not measure general risk to recidivate, no determination could be made about the risk level for youth participating in the drug court. Low risk offenders should not make-up more than 5% of the drug court participant population.
- The drug court should be commended for having separate tracks for youth based upon their substance abuse needs. Drug courts are most effective when they target only high and moderate need youth for substance abuse treatment. File review of the SASSI indicated that 15% were low need for substance abuse. This percentage should be under 5%.

Treatment Characteristics

Strengths:

- The Jefferson County Juvenile Drug Court targets a wide range of criminogenic needs and meets criteria that at least 75% of drug court interventions focus on criminogenic needs. The following criminogenic needs are targeted for change in the drug court: antisocial attitudes and values; antisocial peer associations; reduction of alcohol/drug use; increasing self-control/problem solving skills; and family problem solving skills.
- The average length in drug court is 10-12 months with a range of 7-14 months. It is recommended that the majority of youth graduate in less than 12 months.
- Drug court participants spend an adequate amount of time in structured activities.

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- The drug court has completion criteria which measures how well a youth has progressed in acquiring prosocial behaviors. Phase advancement is used as well as completion of substance abuse treatment, completion of life skills or family stability counseling, completion of a community involvement project, being drug free for 60-90 days consecutive days (the number of days depends on which track the youth is in), and positive school progress for at least 30 days prior to graduation.
- The drug court completion rate is approximately 73% which falls within the acceptable range.
- The drug court responds to noncompliance appropriately including warnings, community service hours, suspended weekend stay in detention, and longer sobriety periods for aftercare phase. Sanctions for noncompliance progress in their intensity until the noncompliance is resolved.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play which needs to be implemented in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Observation of groups and interviews with youth in the drug court revealed that no cognitive restructuring or role play/practicing of skills took place during group treatment. Instead, groups appeared to be unstructured, using more of a "talk therapy" approach.
- Drug court youth are required to receive individual treatment sessions related to life skills. Boys attend one program at Family Services Association, and girls attend one program at Jefferson Behavioral Health Services. Overall, the life skills training is very vague. It is also evident that each of the programs targets different life skills and incorporates the use of evidence-based practices to varying degrees. It is highly recommended that any skills group the drug court requires should focus on criminogenic needs and use evidence-based treatment modalities. Examples of curricula that address criminal thinking include Thinking for a Change (T4C), Aggression Replacement Therapy (ART), Prepare, and Choices, Changes, and Challenges. If the drug court is interested in a gender specific therapy that addresses criminogenic needs using cognitive-behavioral modalities, Girls Moving On is recommended.
- Clients should be assigned to groups and services that match their style of learning and other responsivity factors. The drug court should use responsivity instruments and tie those results to placement in appropriate groups and services.
- Intensity of the drug court programming should vary by risk level. High risk youth should receive higher intensity and/or duration of service than moderate risk youth. Moderate risk youth should receive higher intensity and/or duration of service than low risk youth. Almost all low risk youth should be screened out of the drug court. While the drug court has separate tracks for youth based upon their substance abuse needs, a recommendation to better make use of the tracks would be to separate the tracks by risk level and have one track for moderate risk youth and one track for high risk youth and then vary the substance abuse treatment hours based on their need for substance abuse services.

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- The drug court should have an identified pool of appropriate rewards to use to encourage program participation and reward progress in drug court. Appropriate rewards include earning privileges, certificates of completion, praise/acknowledgement, points/tokens, gift certificates, or reduction in time. Court staff reported only using two of these rewards. Rewards should be expanded and incorporated into the drug court process.
- The ratio of rewards to punishers should be at least 4:1. Staff consistently reported a ratio of 2:1, at the highest.
- Currently at the Jefferson County Juvenile Drug Court, some families are encouraged to participate in family stability counseling. It is highly recommended that as part of drug court, family/caregivers should be trained to provide support, including the ability to identify high risk situations for their youth and strategies for managing their environment using prosocial skills. Participation in a parent/caregiver treatment program should be mandatory for those youth who show a need in the family area. There are several evidence-based family/caregiver curricula: The Parent Project, Common Sense Parenting, Strengthening Families Program, and Parenting Wisely.
- After formalized treatment is completed, the drug court should include a high quality aftercare component. The aftercare should be a formal component in which supervision/meetings are required and an evidence-based model is used.
- The Jefferson County Juvenile Drug Court requires youth to participate in AA/NA. Youth in drug court should not be required to attend self-help meetings. There is no evidence that these meetings are beneficial to youth and may in fact be harmful.
- The drug court randomly drug tests youth either weekly or monthly. Drug tests should be conducted randomly and need to be completed at least two times per week in the earlier phases and at least once per week in the later phases.

Quality Assurance

Strengths:

- Participant satisfaction with the drug court and treatment programming is measured with an exit survey.
- Youth re-arrest, re-conviction, or re-incarceration data is examined regularly by the drug court staff.
- A program evaluator is on staff and assists with research and evaluation of the drug court. Regular reports are provided to the drug court.

Recommendations for Improvement:

- The drug court should have a management audit system in place to evaluate internal and external service providers. This includes site visits, monitoring of groups, regular process reports, and file review.
- Offender reassessment should be completed to determine progress on meeting target behaviors. This can be achieved through a pre-post test that measures criminal thinking or through reassessment on validated risk and need instruments (OYAS and SASSI). Examples of a proper pre-post tests for criminal thinking are the Pride in Delinquency Scale (PID), TCU Criminal Thinking Scale (TCU-CTS), How I Think Questionnaire (HIT), and the Criminal Sentiments Scale – Modified (CSS-M).
- The drug court should go through a formal evaluation every five years comparing treatment outcome with a risk-control comparison group. Effectiveness would be supported should there be some reduction in recidivism in the drug court group versus the comparison group.

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OVERALL PROGRAM RATING

Jefferson County Juvenile Drug Court received an overall score of **46.5** percent on the CPC-DC. This falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **62.5** percent, which falls into the **Effective** category. The overall Content score, which focuses on the *substantive* domains of assessment and treatment, is **37.0** percent, which falls into the **Ineffective** category.

FINDINGS – TRINITY BEHAVIORAL MEDICINE

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	92.9%	Highly Effective
Offender Assessment	0.0%	Ineffective
Treatment	35.7%	Ineffective
Quality Assurance	25.0%	Ineffective
Overall Capacity	**77.8%**	**Highly Effective**
Overall Content	**31.3%**	**Ineffective**
Overall Score	**48.0%**	**Needs Improvement**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to lead the program.
- The program director has a significant role in selecting, training, and supervising staff.
- The program director provides direct services via assessments, group treatment, and individual treatment to youth in the program.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Staff are regularly evaluated with regard to service delivery skills, including the observation of groups with feedback at least once per group cycle.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency consistently reports being supported by the juvenile drug court and other stakeholders.
- Program funding is adequate and stable.

Recommendations for Improvement:

- Staff should receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.

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Client Assessment

Strengths: None.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral that the juvenile drug court makes to the program. Some of the clients were deemed inappropriate by program staff, because the clients needed a higher level of care than the program offered or had mental health issues that made them inappropriate for group services.
- Responsivity is not measured by the program. Factors that affect engagement in group should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, or the Massachusetts Youth Screening Instrument (MAYSI). If the drug court is measuring a range of responsivity issues, then results of those assessments should be utilized in treatment planning.
- The program should serve high and moderate risk youth, and low risk youth should be serviced separately. Since the drug court is not using a risk assessment, it is incumbent upon the referral agency to determine risk level. Low risk youth should not be placed into treatment with moderate or high risk youth.
- The program should serve high and moderate need youth. While the program states that they use the SASSI to determine level of care, the researchers were not given access to the files to review them. The drug court keeps the completed SASSI on file in the drug court paperwork. Using that information, it is estimated that 15% of youth completing substance abuse treatment services at Trinity are low need. Low need youth should not be required to participate in intensive services.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The groups start and end on time.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Group norms/rules are established, documented, and reviewed with the groups regularly.
- The program's average length is ten weeks with youth in the IOP program attending two groups a week (each group lasts three hours; total of six hours). Youth in the OP program attend one group a week (three hours).
- Treatment groups are always conducted and monitored by staff.
- Group size is appropriate and averages no more than eight youth.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace

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antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Observation of groups and interviews with youth in the drug court revealed that little to no cognitive restructuring or role play/practicing of skills took place during group treatment. Instead, groups rely heavily on the 12-step process and use more of a "talk therapy" approach. Examples of evidence-based substance abuse curricula for youth include Pathways to Self Discovery and Change, and Cannabis Youth Treatment Series (CYT).

- Males and females are more productive in treatment sessions when they attend treatment separately. As such, treatment groups should be gender specific.
- Homework should be a regular part of the treatment process and should be a formalized component of the services. Homework should be assigned at the end of a session and reviewed at the beginning of the next session. The counselor should consistently review homework with the youth.
- Groups should have a set manual (or curriculum) that is consistently followed.
- The facilitators should address and respond to the learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- Currently, no rewards are used by the program. Rewards should be used to reinforce positive behavior. In order for rewards to be effective, there should be a range of rewards and rewards should outweigh punishers by a ratio of at least 4:1. Rewards should be immediate, seen as valuable for shaping behavior, consistently applied, and individualized.
- Similarly, the program should use punishers to discourage negative behavior. Punishers should be used to extinguish antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.
- Facilitators should consistently (almost every group or individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- Facilitators should be consistent in their attempts to identify and replace antisocial attitudes and thoughts with prosocial attitudes and thoughts.
- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms, such as file reviews and client surveys.

Recommendations for Improvement:

- Internal quality assurance could be improved by providing observation of direct service with feedback to staff. Observation should occur once every group cycle, and formal feedback should be provided to the facilitator.

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- A pre- post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in behaviors and/or attitudes concerning substance use/abuse. The SASSI would be an appropriate measure to incorporate.
- The program should complete a discharge summary for all clients and provide the summary to the drug court (or referral agency).

Overall Program Rating

Trinity Behavioral Medicine received an overall score of **48.0** percent on the CPC-DC: RA. This falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **77.8** percent, which falls into the **Highly Effective** category. The overall Content score, which focuses on the *substantive* domains of assessment and treatment, is **31.3** percent, which falls into the **Ineffective** category.

FINDINGS – EZRA ACADEMY AND CENTER FOR TREATMENT SERVICES

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	64.3%	Effective
Offender Assessment	25.0%	Ineffective
Treatment	39.3%	Ineffective
Quality Assurance	50.0%	Needs Improvement
Overall Capacity	**61.1%**	**Effective**
Overall Content	**37.5%**	**Ineffective**
Overall Score	**46.0%**	**Needs Improvement**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to lead the program.
- The program director is involved in providing direct services via assessments, group treatment, or individual treatment to youth in the program.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Staff are regularly evaluated with regard to service delivery skills including the observation of groups with feedback provided to group facilitators at least once per group cycle.
- The agency reports being supported by the juvenile drug court and other stakeholders.
- Program funding is rated by staff as adequate and stable.

Recommendations for Improvement:

- The program director should have a significant role in selecting, training, and supervising staff.

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- Direct care staff should be selected for skills and values conducive to offender treatment (the belief that offenders can change, empathy, etc.).
- Regular meetings (at least once every two weeks) should take place between the program director and program staff.
- Staff should receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.
- Ethical guidelines should dictate staff boundaries and interactions with youth.

Client Assessment

Strengths:

- The program has identified exclusionary criteria, and the percentage of clients deemed inappropriate by program staff is under 20%.

Recommendations for Improvement:

- Responsivity is not measured by the program. Factors that affect engagement in group should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, or the Massachusetts Youth Screening Instrument (MAYSI).
- Only clients who are high risk and moderate risk should receive intensive treatment services. Low risk offenders may be appropriate for residential treatment when they have a clear need for inpatient substance abuse treatment. However, low risk youth should not be mixed with high risk clients in treatment groups. The agency should utilize the risk assessment used by the court, or conduct its own risk assessment, to determine the risk level of their referrals from drug court and use those levels to inform treatment service delivery.
- The program should serve high and moderate need youth. While the program states that they use the SASSI results from the drug court to determine level of care, the researchers were not given access to the files to ensure this practice is taking place. The program should ensure that only youth who have a need for intensive residential treatment services are accepted into the program.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- Treatment groups are gender specific.
- The groups start and end on time.
- The group facilitators are knowledgeable about the materials discussed in group.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- The program's average length is appropriate with residential treatment ranging from four to six months.
- Treatment groups are always conducted and monitored by staff.
- Group size is appropriate and averages no more than ten youth with one facilitator.
- The types of rewards and punishers used by the program appear appropriate.
- The facilitators have good rapport with group participants.

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Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Observation of groups and interviews with youth in the drug court revealed that little to no role play or practicing of skills took place during group treatment. Instead, groups appeared to be unstructured, using more of a "talk therapy" approach. Examples of substance abuse curriculum for youth include Pathways to Self Discovery and Change, and Cannabis Youth Treatment Series (CYT). Examples of evidence-based curriculum for youth concerning antisocial thinking include Thinking for a Change; Aggression Replacement Therapy; Prepare; Choices, Changes, and Challenges; and Girls Moving On.
- All group participants should be actively involved in the group. The group facilitators do not encourage active participation in the group.
- Homework should be a regular part of the treatment process and should be a formalized component of the services. Homework should be assigned at the end of a session and reviewed at the beginning of the next session. The counselor should consistently review homework with the youth.
- All treatment groups should have a set manual (or curriculum) that is consistently followed.
- Facilitators should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- The range of rewards used to reinforce offender behavior needs to be increased as well as the frequency of rewards. Rewards should outweigh punishers by a ratio of at least 4:1. The procedure by which offenders are reinforced should be improved so that rewards are immediate, seen as valuable for shaping behavior, consistently applied, and individualized.
- The program relies heavily on the drug court to implement punishers. The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should also include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator.
- Facilitators should work to avoid arguments/power struggles with participants and should address resistance appropriately (i.e., by utilizing redirection or extinction).
- Facilitators should consistently (almost every group or individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- Facilitators should be consistent in their attempts to identify and replace antisocial attitudes and thoughts with prosocial attitudes and thoughts.
- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

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Strengths:

- The program incorporates sufficient internal quality review mechanisms such as file reviews and client surveys.
- The program completes a discharge summary for all clients and provides the summary to the drug court (or referral agency).

Recommendations for Improvement:

- Internal quality assurance could be improved by providing observation of direct service with feedback to staff. Observation should occur once every group cycle, and formal feedback should be provided to the facilitator.
- A pre- post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in behaviors and/or attitudes concerning substance use/abuse. The SASSI would be an appropriate measure to incorporate.

Overall Program Rating

Ezra Academy and Center for Treatment Services received an overall score of **46.0** percent on the CPC-DC: RA. This falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **61.1** percent, which falls into the **Effective** category. The overall Content score, which focuses on the *substantive* domains of assessment and treatment, is **37.5** percent, which falls into the **Ineffective** category.

FINDINGS – JEFFERSON BEHAVIORAL HEALTH SERVICES

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	85.7%	Highly Effective
Offender Assessment	25.0%	Ineffective
Treatment	57.7%	Effective
Quality Assurance	50.0%	Needs Improvement
Overall Capacity	**77.8%**	**Highly Effective**
Overall Content	**53.3%**	**Needs Improvement**
Overall Score	**62.5%**	**Effective**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to lead the program.
- The program director has a significant role in selecting, training, and supervising staff.
- The program director is involved in providing direct services via assessments and individual treatment to youth in the program.

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- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the criminal justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by the juvenile drug court and other stakeholders.
- Program funding is rated by staff as adequate and stable.

Recommendations for Improvement:

- Staff should be regularly evaluated with regard to service delivery skills. The program director or clinical supervisor should observe sessions and provide constructive feedback at least once per quarter.
- Staff should receive formal training on the treatment approaches/curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.

Client Assessment

Strengths:

- Responsivity is assessed using a Client Self-Rating Scale and the Burns Anxiety Inventory.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral the juvenile drug court makes to the program. The programs should enlist their own exclusionary criteria to ensure that youth are appropriate for the available services.
- The program should serve high and moderate risk youth, and low risk youth should be serviced separately. Since the drug court is not using a risk assessment, it is incumbent upon the referral agency to determine risk level. Low risk youth should not be placed into treatment with moderate or high risk youth.
- The program should serve high and moderate need youth in the areas of life skills and family counseling. The program does not assess the need level for life skills or family therapy. It is strongly encouraged that life skills taught in the program relate to criminogenic needs. Examples of proper instrumentation for the assessment of life skills need are the Youth Level of Service/Case Management Inventory (YLS/CMI) and the Ohio Youth Assessment System (OYAS). Examples of proper instrumentation for the assessment of family therapy need include the Family Adaptability and Cohesion Evaluation Scale (FACES), Family Assessment Device (FAD), and the Family Assessment Measure III (FAM III). Entry into the treatment should depend on need, and no low need youth or families should participate in treatment.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The sessions start and end on time.
- The counselors are knowledgeable about the materials discussed in treatment sessions and encourage participation during sessions.

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- Homework is a regular part of the treatment process.
- Sessions norms/rules are established, documented, and reviewed with the clients regularly.
- Sessions have a set manual/curriculum that is consistently followed.
- Counselors address and respond to the different learning styles and barriers of the participants.
- Counselors consistently model prosocial skills and explain to the clients the importance of learning the new skill.
- The counselors have good rapport with clients and appropriately address resistance.
- Counselors are consistent in their attempts to identify and replace antisocial attitudes and thoughts with prosocial attitudes and thoughts.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Lastly, while the program uses a life skills curriculum (Hazelton Youth Life Skills), it is strongly encouraged that life skills training focus on criminogenic needs. Examples of curriculum that address life skills for an offending population are Thinking for a Change (T4C); Aggression Replacement Therapy (ART); Prepare; Choices, Changes, and Challenges; and Girls Moving On. Since the program is also providing family counseling, evidence-based approaches should also be incorporated into those sessions. Examples of evidence-based family/caregiver curriculum include: The Parent Project; Common Sense Parenting; Strengthening Families Program; and Parenting Wisely.
- The length of treatment is restricted to eight-one hour sessions. Length of treatment should be based on need, with high need youth receiving more treatment than moderate need youth.
- Rewards should be used to reinforce positive behavior. Currently, very few rewards are used by the program (i.e, verbal praise and stickers on the workbook). In order for rewards to be effective, there should be a range of rewards and rewards should outweigh punishers by a ratio of at least 4:1. Rewards should be immediate, seen as valuable for shaping behavior, consistently applied, and individualized.
- Similarly, the program should use punishers to discourage negative behavior. Currently, the program relies heavily on the drug court to implement punishers. The program should have some punishers to extinguish antisocial expressions and promote behavioral change by showing that behavior has consequences. The process for punishing should also include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator.
- While counselors consistently model prosocial skills and explain the importance of learning the new skill, these steps alone are not effective for changing behavior. Three other steps need to occur in this process: (1) clients need to continuously practice and rehearse the new skills with the counselor; (2) counselors need to provide feedback to the clients; and (3) finally, counselors should require graduated practice of new skills in increasingly difficult situations.

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- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms such as file reviews and client surveys.
- The program completes a discharge summary for all clients and provides the summary to the drug court (or referral agency).

Recommendations for Improvement:

- Internal quality assurance could be improved by providing observation of direct service with feedback to staff. Observation should occur once every group cycle, and formal feedback should be provided to the facilitator.
- A pre- post test should be used to measure client progress on target behaviors. The pre- post test should measure acquisition of the skills being taught to youth and families and changes in thinking that may be targeted during the sessions.

Overall Program Rating

Jefferson Behavioral Health Services received an overall score of **62.5** percent on the CPC-DC: RA. This falls into the **Effective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **77.8** percent, which falls into the **Highly Effective** category. The overall Content score, which focuses on the *substantive* domains of assessment and treatment, is **53.3** percent, which falls into the **Needs Improvement** category.

FINDINGS – FAMILY SERVICES ASSOCIATION

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	57.1%	Effective
Offender Assessment	0.0%	Ineffective
Treatment	26.9%	Ineffective
Quality Assurance	25.0%	Ineffective
Overall Capacity	**50.0%**	**Needs Improvement**
Overall Content	**23.3%**	**Ineffective**
Overall Score	**33.3%**	**Ineffective**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to lead the program.

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- The program director has a significant role in selecting, training, and supervising staff.
- The program director is involved in providing direct services via assessments and individual treatment to youth in the program.
- All staff are sufficiently educated in helping professions.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by the juvenile drug court and other stakeholders.

Recommendations for Improvement:

- Direct care staff should have adequate experience in working with youth involved in the juvenile justice system. At least 75% of staff should have two or more years of experience working with criminally involved youth.
- Direct care staff should be selected for skills and values conducive to offender treatment (the belief that offenders can change, empathy, etc.).
- Staff should be regularly evaluated with regard to service delivery skills. The program director or clinical supervisor should observe sessions and provide constructive feedback at least once per quarter.
- Staff should receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.
- Funding is not considered adequate to run the program as designed. Additionally, funding has been adversely impacted within the past two years (of the assessment).

Client Assessment

Strengths: None.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral that the juvenile drug court makes to the program. Some of the clients are deemed inappropriate by program staff, because the clients' overall risk level are deemed to be too low.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, or the Massachusetts Youth Screening Instrument (MAYSI).
- The program should serve high and moderate risk youth, and low risk youth should be serviced separately. Since the drug court is not using a risk assessment, it is incumbent upon the referral agency to determine risk level. Low risk youth should not be placed into treatment with moderate or high risk youth.
- The program should serve high and moderate need youth in the areas of life skills and family counseling. The program does not assess the need level for life skills or family therapy. It is strongly encouraged that life skills taught in the program relate to criminogenic needs. Examples of proper instrumentation for the assessment of life skills need are the Youth Level of Service/Case Management Inventory (YLS/CMI) and the Ohio Youth Assessment System (OYAS). Examples of proper instrumentation for the assessment of family therapy need include the Family Adaptability and Cohesion Evaluation Scale

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(FACES), Family Assessment Device (FAD), and the Family Assessment Measure III (FAM III). Entry into the treatment should depend on need, and no low need youth or families should participate in treatment.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The sessions start and end on time.
- The counselors encourage participation in the treatment sessions.
- The counselors have good rapport with clients.
- Counselors are consistent in their attempts to identify and replace antisocial attitudes and thoughts with prosocial attitudes and thoughts.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Lastly, while the program uses a home grown life skills manual, it is strongly encouraged that life skills training focus on criminogenic needs. Examples of curricula that address life skills for an offending population are Thinking for a Change (T4C); Aggression Replacement Therapy (ART); Prepare; and Choices, Changes, and Challenges. Since the program is also providing family counseling, evidence-based approaches should also be incorporated into those sessions. Examples of evidence-based family/caregiver curricula include: The Parent Project; Common Sense Parenting; Strengthening Families Program; and Parenting Wisely.
- The counselors did not appear to be as knowledgeable about the content discussed in treatment sessions as they should be. This was confirmed in interviewing the counselors and talking with the participants.
- Homework should be a regular part of the treatment process, and the counselor should consistently review homework with the youth. Homework should be assigned at the end of the session and reviewed at the beginning of the next session.
- Sessions norms/rules need to be established, documented, and reviewed with the clients regularly.
- The length of treatment is restricted to eight-one hour sessions. Length of treatment should be based on need, with high need youth receiving more treatment than moderate need youth.
- The program should have a set curriculum or manual that is consistently followed.
- The program should address and respond to the different learning styles and barriers of the clients. Responsivity assessments will aid in this process
- Rewards should be used to reinforce positive behavior. Currently, very few rewards are used by the program (i.e, verbal praise and candy). In order for rewards to be effective, there should be a range of rewards and rewards should outweigh punishers by a ratio of 4:1. Rewards should be immediate, seen as valuable for shaping behavior, consistently applied, and individualized.
- Similarly, the program should use punishers to discourage negative behavior. Currently, the program relies heavily on the drug court to implement punishers. The program should have

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some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should also include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator.

- Facilitators should consistently (almost every session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, counselors should include graduated practice of new skills in increasingly difficult situations.
- Facilitators should work to avoid arguments/power struggles with participants and should address resistance appropriately (i.e., by utilizing redirection or extinction).
- Risk or relapse prevention plans should be developed and clients should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths:

- The program completes a discharge summary for all clients and provides the summary to the drug court (or referral agency).

Recommendations for Improvement:

- The program should incorporate a management audit system that consists of file review, problem-oriented records to monitor treatment progress, and formal offender and parent/caregiver feedback on services.
- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once per quarter, and formal feedback should be provided to the counselor.
- A pre- post test should be used to measure client progress on target behaviors. The pre- post test should measure acquisition of the skills being taught to youth and families and changes in thinking that may be targeted during the sessions.

Overall Program Rating

Family Services Association received an overall score of **33.3** percent on the CPC-DC: RA. This falls into the **Ineffective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **50.0** percent, which falls into the **Needs Improvement** category. The overall Content score, which focuses on the *substantive* domains of assessment and treatment, is **23.3** percent, which falls into the **Ineffective** category.

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CONCLUSION

Researchers at the University of Cincinnati have assessed 512 programs nationwide and have developed a large database on correctional intervention programs.[2] Approximately 7 percent of the programs assessed have been classified as HIGHLY EFFECTIVE, 17 percent have been classified as EFFECTIVE, 31 percent have been classified as NEEDS IMPROVEMENT, and 45 percent have been classified as INEFFECTIVE.

Graphs representing the results of this assessment are provided below. The first graph or set of graphs compares the drug court or referral agency score in the capacity domain, content domain, and overall score with the average scores from all 512 programs evaluated by the University of Cincinnati. The final graph shows the drug court score and an average of the scores from all referral agencies used by the drug court compared to the average of all programs evaluated by the University of Cincinnati.

Recommendations have been made in each of the four CPC domains for the Jefferson County Juvenile Drug Court. These recommendations should assist the program in making necessary changes to increase program effectiveness. Certainly, care should be taken not to attempt to address all "areas needing improvement" at once. Programs that find the assessment process most useful are those that prioritize need areas and develop action plans to systematically address such needs. Previous programs have also been successful at improving the provision of services by formulating committees charged with developing strategies for delivering evidence-based programming.

This report also provides the drug court with a snapshot of the referral agency where its youth are receiving treatment in the community. This evaluation should assist the drug court in determining what type of treatment is effective when working with juvenile drug court clients. It should also assist the referral agencies with ways they can improve the services they provide to drug court youth.

[2] Several versions of the CPAI were used prior to the development of the CPC. Scores and averages have been adjusted as needed.

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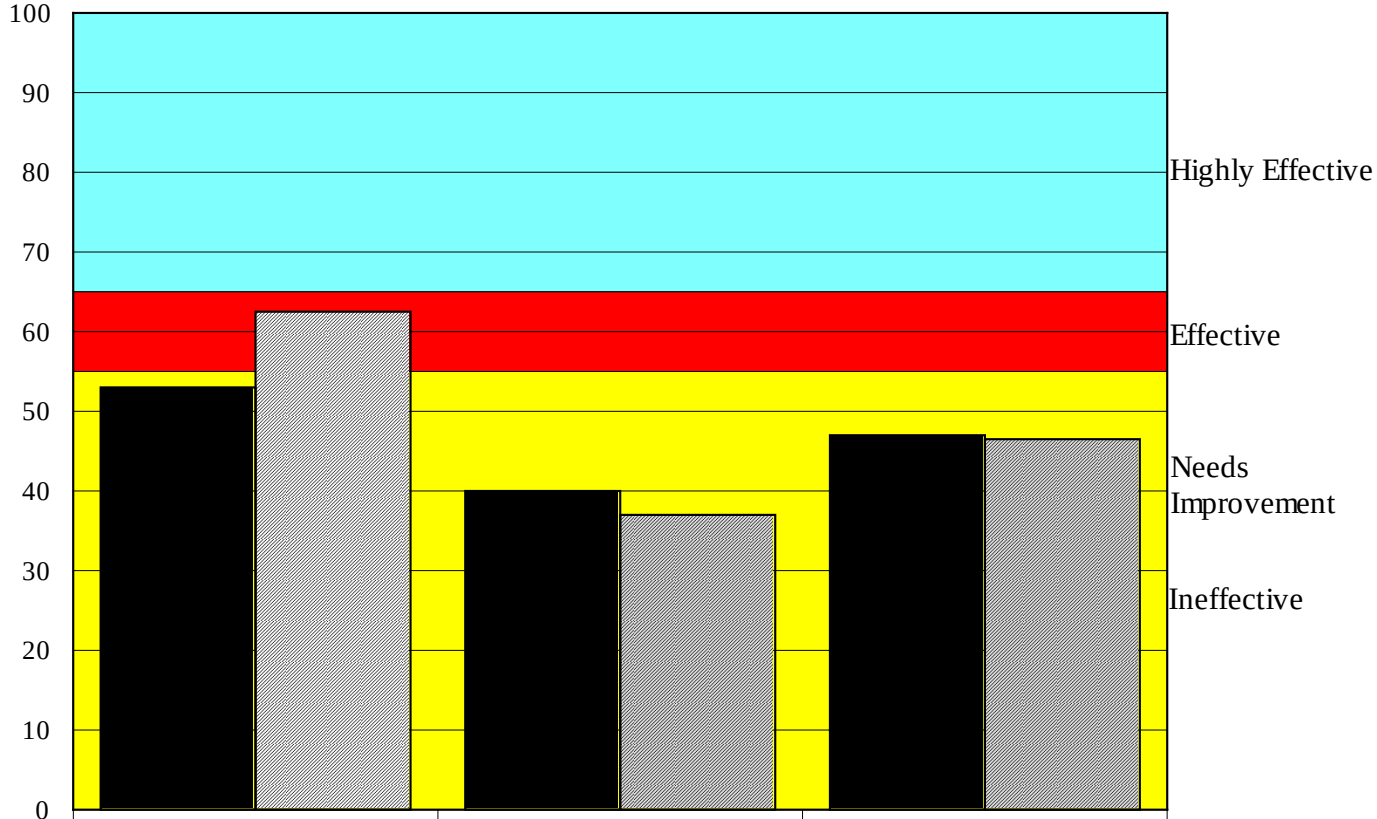
FIGURE 1:
Jefferson County Juvenile Drug Court CPC-DC Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Jefferson County	62.5	37	46.5

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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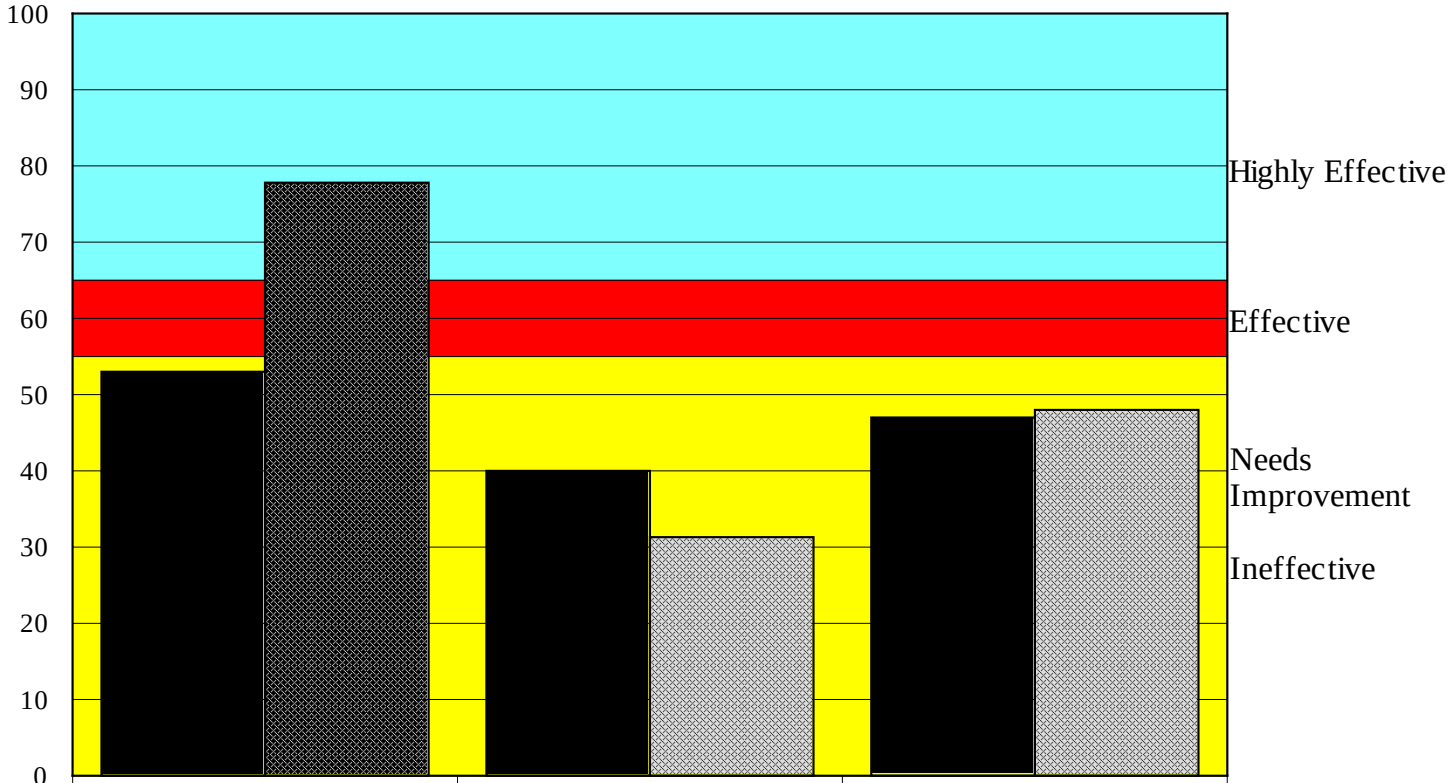
FIGURE 2:
Trinity Behavioral Medicine CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Trinity	77.8	31.3	48

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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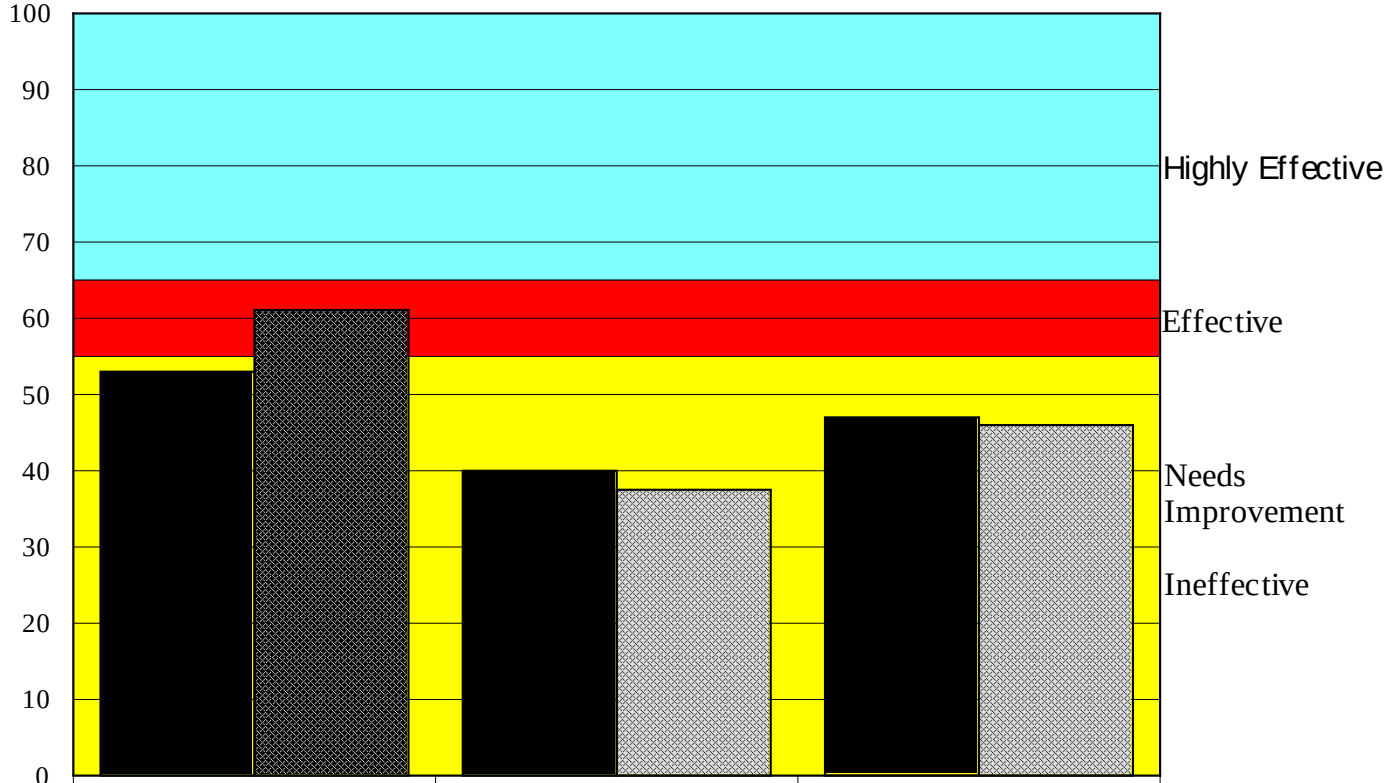
FIGURE 3:
Ezra Academy and Center for Treatment Services CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Ezra Academy	61.1	37.5	46

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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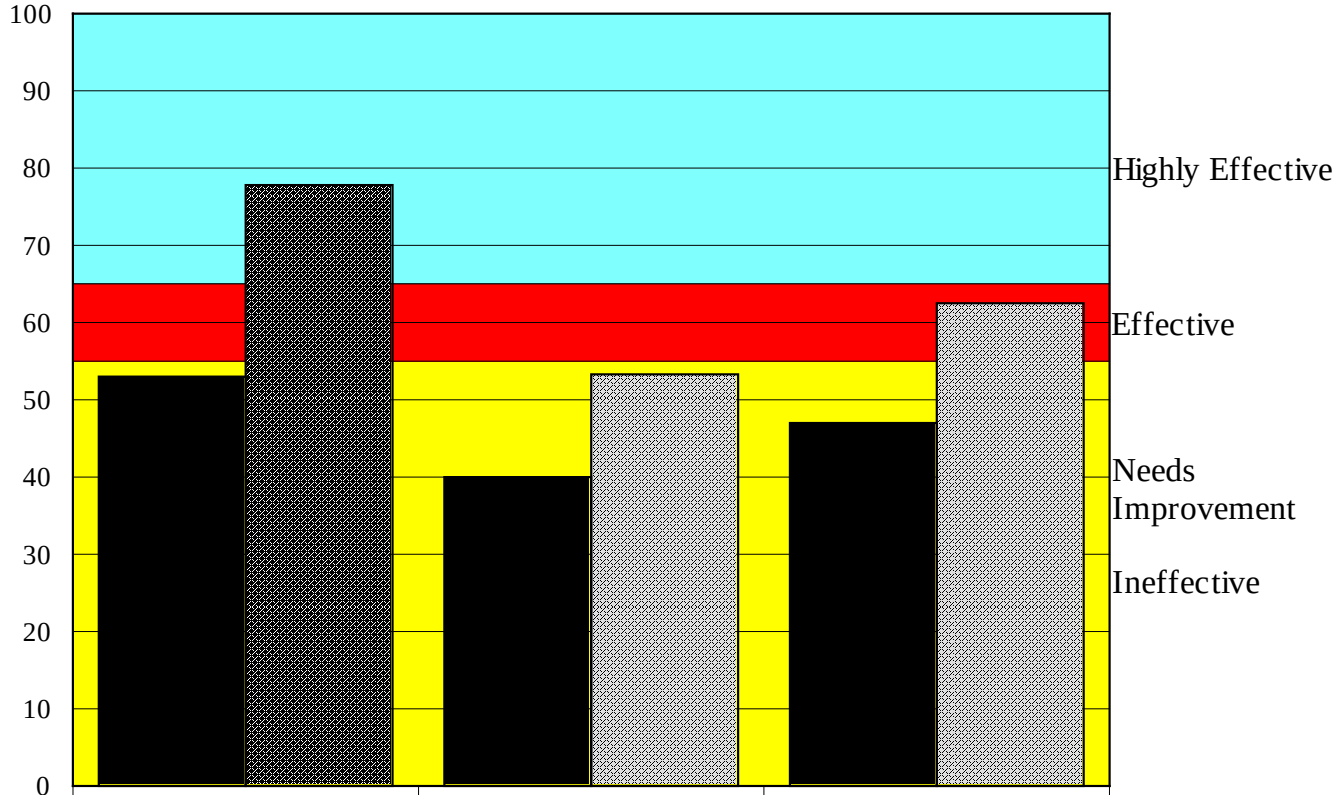
FIGURE 4:
Jefferson Behavioral Health Services CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Jefferson Behavioral	77.8	53.3	62.5

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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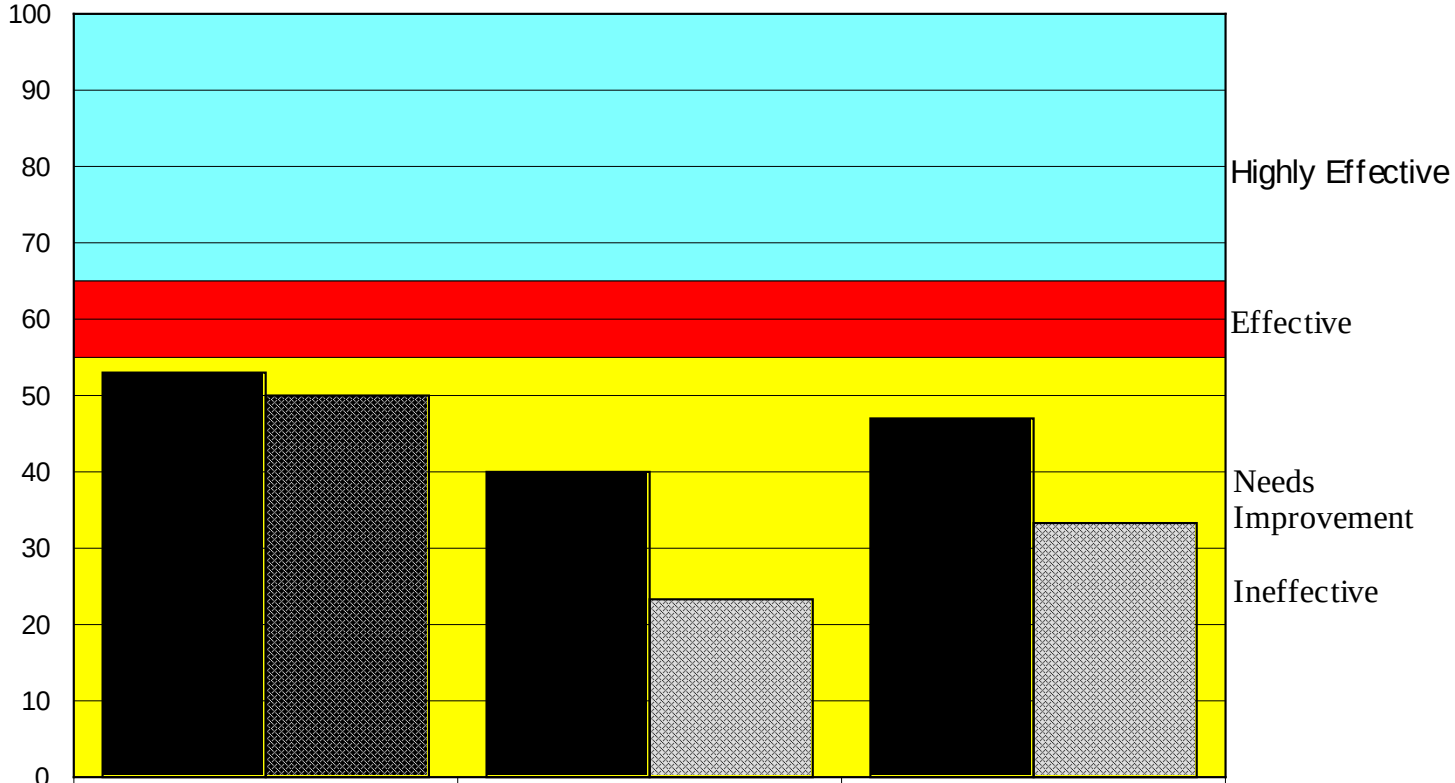
FIGURE 5:

Family Services Association CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
FSA	50	23.3	33.3

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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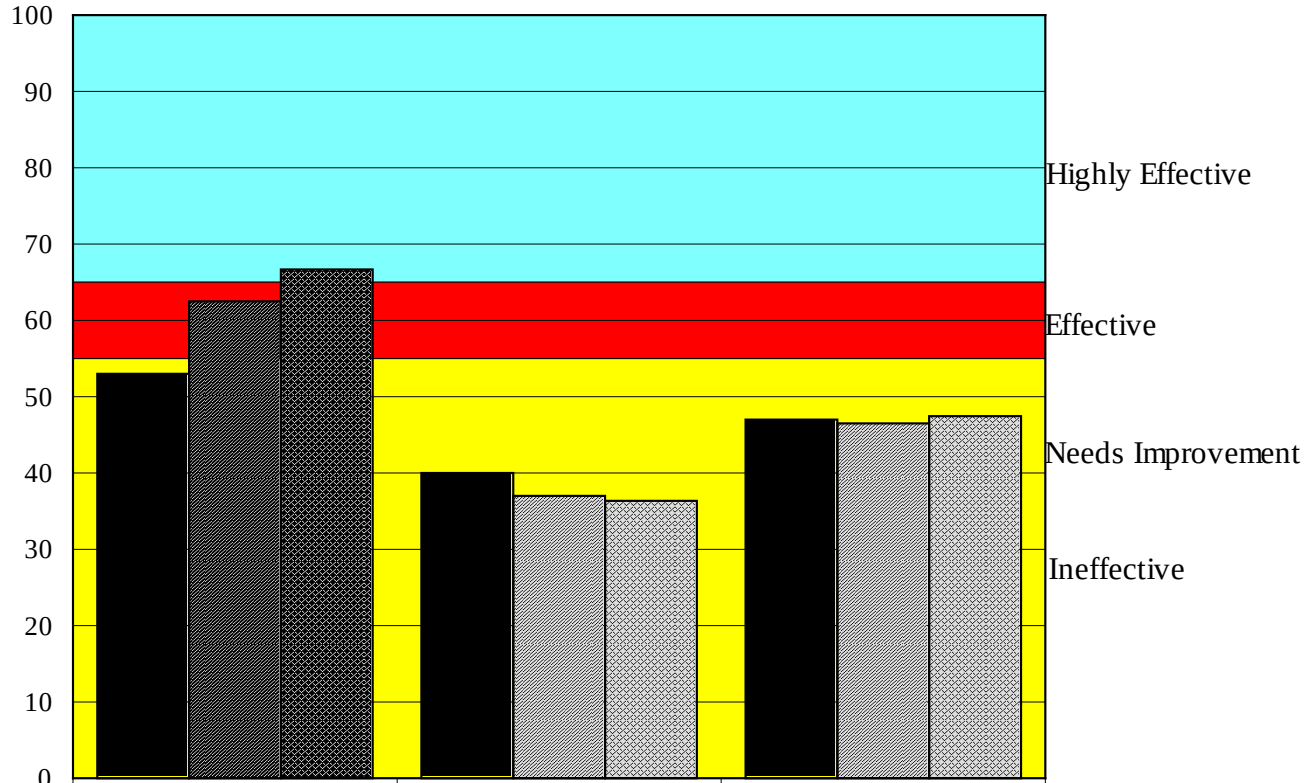
FIGURE 6:
Jefferson County Juvenile Drug Court Overall



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Jefferson County	62.5	37	46.5
Referral Agency Average	66.68	36.35	47.45

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST – DRUG COURT (CPC-DC) SYNOPSIS OF FINDINGS

Performed as part of the OJJDP study Outcome and Process Evaluation of Juvenile Drug Courts

Lane County Juvenile Drug Court

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OUTCOME AND PROCESS EVALUATION OF JUVENILE DRUG COURTS STUDY

This project is funded by a grant received from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The purpose of this study is to evaluate a national sample of juvenile drug court programs. The goals of this research are: (1) To determine if there is a reduction in recidivism and substance abuse associated with participation in a juvenile drug court program; (2) to determine if there are improvements in social functioning (e.g. school performance, employment, and family functioning) related to participating in juvenile drug court programs; (3) to identify the characteristics of successful juvenile drug court participants; (4) to determine if juvenile drug courts are operating in a manner consistent with an evidence-based approach; (5) to identify the programmatic characteristics of effective juvenile drug courts; and (6) to provide information to policymakers about the effectiveness of drug courts for juvenile offenders.

This study includes both an outcome and a process evaluation. The outcome portion of the study examines outcomes of youth participating in drug courts as compared to similar youth who are on probation. The process evaluation explores the effectiveness of the drug court and drug court programming and is the focus of this report. Ten drug courts from across the country participated in this four-year study, nine of which participated in both the process and outcome evaluation pieces. The final report for the Outcome and Process Evaluation of Juvenile Drug Courts study will offer outcome and process evaluation findings across all nine drug court sites and is expected to be submitted to OJJDP in December 2012.

CONTEXT AND SCOPE OF THIS EVALUATION

The following report is part of a larger national project centered on the effectiveness of juvenile drug court programs and provides a synopsis of findings from the process evaluation, as well as recommendations to enhance the effectiveness of the services delivered by the Lane County Juvenile Drug Court. Programs that adhere to the principles of effective intervention are more likely to impact criminal reoffending (see Andrews & Bonta, 2003 for a review). Specifically, correctional research suggests that cognitive behavioral and social learning models of treatment are associated with considerable reductions in recidivism (Gendreau, 1996; Smith, Goggin & Gendreau, 2002). As such, the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) was used to evaluate the juvenile drug courts participating in the Outcome and Process Evaluation of Juvenile Drug Courts study. The objectives of this assessment are to conduct a detailed review of services and program materials of the juvenile drug courts and the agencies they refer youth to and to compare their current practices with the literature on "best practices" in corrections.

PROCEDURES

Description of the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC)

The Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) is a tool that the University of Cincinnati developed for assessing drug court programs. It is used to determine how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. The CPC-DC was modified from the Evidence-Based Correctional Program Checklist (CPC) [1] and includes important indicators from drug court meta-analyses (see Shaffer, 2006). The CPC

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has been validated by several recent studies conducted by the University of Cincinnati. These studies found strong correlations between outcome and both domain areas and individual items (Holsinger, 1999; Lowenkamp, 2003; Lowenkamp and Latessa, 2003, Lowenkamp & Latessa, 2005a; Lowenkamp and Latessa, 2005b; Shaffer, 2006). As part of the larger national study, the indicators on the CPC-DC will be validated using the outcome data collected on the drug court participants.

The CPC-DC consists of two instruments: one for the formal drug court (CPC-DC) and the other for the major referral agencies (CPC-DC: RA) involved in providing treatment and services to drug court clients. Each of these tools is divided into two basic areas: Content and Capacity. The capacity area is designed to measure whether the drug court and its referral agencies have the capability to deliver evidence-based interventions and services to offenders. There are two domains in the capacity area: 1) Development, Coordination, Staff and Support, and 2) Quality Assurance. The content area focuses on the substantive aspect of the drug court and its referral agencies, and also includes two areas: 1) Assessment Practices, and 2) Treatment. This area examines the extent to which the drug court and its referral agencies meet the principles of risk, need, responsivity, and treatment.

The Drug Court tool includes 41 indicators, worth 43 total points. The Referral Agency tool has 49 indicators worth a total of 51 points. Each area and all domains are scored and rated as “highly effective” (65% to 100%); “effective” (55% to 64%); “needs improvement” (46% to 54%); or “ineffective” (45% to 0%). The scores in all domains are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the domains are given equal weight. Further, some items may be considered "not applicable," in which case they are not included in the scoring. Data are collected through structured interviews with selected program staff and program participants, as well as through observation of groups and services. In some instances, surveys may be used to gather additional information. Other sources of information include policy and procedure manuals, schedules, treatment materials, curricula, case files, and other selected program materials. Once the information is gathered and reviewed, the program is scored. The following report highlights strengths, areas that need improvement, and recommendations for each of the areas for both the drug court and the referral agencies.

There are several limitations to the CPC-DC that should be noted. First, as with any research process, objectivity and reliability are an issue. Although steps are taken to ensure that the information gathered is accurate and reliable, decisions about the information gathered are invariably made by the assessors. Second, the process is time specific. That is, the assessment is based on the program at the time of the assessment. Though changes or modifications may be planned for the future, only those activities and processes that were present at the time of the review in October 2009 are considered for scoring. Third, the process does not take into account all system issues that can affect program integrity (i.e., political climate of the court). Finally, the process does not address the reasons that a problem exists within a program or why certain practices do or do not take place. Rather, the process is designed to determine the overall integrity of the program.

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[1] The CPC is modeled after the Correctional Program Assessment Inventory developed by Gendreau and Andrews. However, only those indicators that were found to be positively correlated with outcome were retained. In addition, the CPC includes a number of items not contained in the CPAI.

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Despite these limitations, there are a number of advantages to this process. First, the criteria are based on empirically derived principles of effective programs, and all of the indicators included in the CPC-DC are correlated with reductions in recidivism. Second, it allows researchers to get inside the "black box" of a drug court and its referral agencies, something that an outcome study alone does not provide. This means researchers are able to measure the degree to which programs are meeting evidence-based standards. Third, the CPC-DC enables researchers to "quantify" the quality of a program through a scoring process. This allows for comparisons across programs, the setting of benchmarks, and for reassessment to measure progress. Fourth, it identifies both the strengths and weaknesses of a program and provides specific recommendations for program improvement.

Assessment Process

The assessment process consisted of a series of structured interviews with staff members and program participants during an on-site visit to Lane County Juvenile Drug Court on October 5th through October 7th, 2009. Additionally, data were gathered via the examination of ten representative files (five open and five closed) as well as other relevant program materials (e.g., treatment manuals, assessments, training protocol, ethical guidelines, and staff evaluations). Finally, three treatment groups were observed: "Center for Family Development – Day Treatment," "Looking Glass Pathways – Residential," and "Lane County Phoenix – Residential." Two evaluators conducted the various interviews, observations and file reviews. Data from the various sources were then combined to generate a consensus CPC-DC score and the specific recommendations in what follows.

SUMMARY OF THE DRUG COURT

The Lane County Juvenile Drug Court has been in operation since 2000. The drug court is funded through general funds from the county and donations from a foundation. Youth range in age from thirteen to seventeen and must evidence drug abuse issues. Violent and sex offenders are excluded from participation. At the time of assessment, Kip Leonard was the drug court judge, Pam Paschke was the drug court coordinator, and Rob Cook was the juvenile probation counselor.

The drug court requires clients to progress through four phases of treatment lasting a minimum of seven months, with an average of nine to twelve months. The focus in Phase 1 is behavior compliance; youth must attend weekly court hearings, complete an alcohol and drug assessment, and submit random drug screens. The focus in Phase 2 is treatment; youth must attend court hearings every other week, participate in treatment and continue random drug screens. The focus in Phase 3 is on completing treatment requirements; youth must attend court hearings every two to three weeks, continue treatment, and begin working on an aftercare plan. The focus in the final phase is transition; youth must attend court every three weeks, complete and follow an aftercare plan, and complete a written assignment outlining their commitment to staying crime and substance free. The drug court relies on the following techniques to supervise youth in the program: curfew, drug and alcohol testing, and attendance at court. The drug court utilizes the following five treatment programs run by three separate referral agencies: Phoenix Program run by Lane County; Pathways Residential Program run by Looking Glass; an Outpatient Program run by Looking Glass Counseling Center; and an outpatient program and day treatment program run by Center for Family Development. These agencies are evaluated as part of this assessment as well.

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FINDINGS – DRUG COURT

CPC-DC SECTIONS	SCORE	RATING
Development, Coordination, Staff and Support	77.8%	Highly Effective
Quality Assurance	0.0%	Ineffective
Offender Assessment	33.3%	Ineffective
Treatment	50.0%	Needs Improvement
Overall Capacity	**43.8%**	**Ineffective**
Overall Content	**44.4%**	**Ineffective**
Overall Score	**44.2%**	**Ineffective**

Development, Coordination, Staff and Support

Strengths:

- There is a program coordinator in place who has some responsibility for oversight and management of the program.
- Regular staff meetings are held to discuss clients in the drug court.
- Drug court staff provide direct case management and supervision services to the youth in the drug court.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- Funding for the drug court is as adequate and there have been no changes in the level of funding in the past two years.
- The drug court has leverage over the youth; the drug court dismisses the youth's legal charges once the youth completes drug court.

Recommendations for Improvement:

- The program coordinator should have a more direct role in selecting, approving, and supervising the counselors/staff hired to provide treatment.
- Drug court staff should be trained on drug court programming and receive at least 40 hours of on-going training a year. Staff training should relate to the theory and practice of interventions used by the program including effective correctional practices and the cognitive-behavioral model.

Offender Assessment

Strengths:

- Risk, as well as a range of criminogenic needs, are assessed using the Juvenile Crime Prevention (JCP) assessment in the Juvenile Justice Information System (JJIS).
- The assessment indicates that the drug court tries to target relevant higher need youth. Most drug court youth have failed on regular probation before they are referred to drug court. Additionally, the JCP and the Massachusetts Youth Screening Instrument (MAYSI) indicated some need for substance abuse treatment services.

Recommendations for Improvement:

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- While the offenders served by the drug court are appropriate, there should be exclusionary criteria in place to prevent inappropriate youth from being placed in drug court. The criteria should be written and followed.
- Violent offenders should be excluded from participation in drug court.
- Domain specific needs, especially substance abuse, should be assessed using a validated, standardized, and objective instrument. While the drug court uses the JCP and Massachusetts Youth Screening Instrument (MAYSI) to look at substance abuse issues, these are not sufficient. A substance abuse assessment that is standardized, objective and validated and provides an actual need score should be used to screen youth prior to drug court admittance. Examples of proper instrumentation for substance abuse include the Adolescent Substance Abuse Subtle Screening Inventory (SASSI) and the Juvenile Automated Substance Abuse Evaluation (JASAE).
- The drug court should assess factors that directly affect engagement in the drug court or treatment programming. Additionally, there should be evidence that clinical or staffing decisions are made based upon these responsivity factors. At least two major factors such as personality, motivational level or readiness for change, or mental illness should be assessed. Since the drug court is already using the MAYSI to measure mental health, at least one other responsivity factor should be incorporated into the assessment process. Examples of appropriate responsivity instrumentation include the TCU Client Self-Rating scale, Jesness Inventory, and IQ tests.
- Drug courts should target moderate and high risk youth, and low risk youth should be screened out. There should be a formal process to ensure that low risk youth are screened out, and that low risk youth make up no more than 5% of the drug court participant population.
- All assessments/assessment results should be freely shared with everyone on the drug court team, including referral agencies.

Treatment Characteristics

Strengths:

- The Lane County Juvenile Drug Court targets a wide range of criminogenic needs and meets criteria that at least 75% of drug court interventions should focus on criminogenic needs. The drug court targets the following criminogenic needs: antisocial attitudes; school or work; alcohol/drug abuse; family affection/communication; and family problem solving.
- The average length in drug court is eight to nine months. However, lower risk youth average six months, and higher risk youth average 10-12 months. It is recommended that the majority of youth graduate in less than 12 months.
- Drug court participants spend an adequate amount of time in structured activities. Youth spend an average of five to eight hours per week in drug court activities in addition to either school, work, or the day treatment center.
- The drug court has completion criteria which measures how well a youth has progressed in acquiring prosocial behaviors. Phase advancement is used as well as being drug free for the four months of the Transition Phase, meeting their own goals, being in school and/or working, and generally showing responsible behavior. Successful completion is determined by a team decision during regular staff meetings.

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- The drug court has an appropriate reward structure including verbal praise, gift cards based on individual preferences, court recognition, and a graduation ceremony with pizza and cake.
- Staff reported a ratio of rewards to punishers at 4:1. This ratio is consistent with evidence-based practices.
- The Lane County Juvenile Drug Court does not require youth to participate in AA. Youth in drug court should not be required to attend self-help meetings. There is no evidence that these meetings are beneficial to youth and may in fact be harmful.
- The drug court randomly drug tests youth on a regular basis. Daily drug tests are administered during Phase 1, and drug tests in Phases 2 through 4 are done randomly.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play which needs to be implemented in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Observation of groups and interviews with youth in the drug court revealed that many different approaches were utilized across the drug court and the various referral agencies. The drug court should work to ensure that internal and external staff working with drug court youth are consistently using cognitive restructuring and role play and practicing of skills during group and individual treatment sessions.
- Clients should be assigned to groups and services that match their style of learning and other responsivity factors. The drug court should use responsivity instruments and tie those results to appropriate groups and services.
- Intensity of the drug court programming should vary by risk level. High risk youth should receive higher intensity and/or duration of service than moderate risk youth. Moderate risk youth should receive higher intensity and/or duration of service than low risk youth. Almost all low risk youth should be screened out of the drug court.
- The drug court completion rate over the past several years is 50%.The completion rate should be between 65% and 85%.
- The drug court does not appropriately respond to noncompliance. For example, infractions such as being late or missing groups or a drug court session, and using substances needs to be addressed consistently across participants. Appropriate punishers include disapproval, response cost – loss of privileges, points, levels, or extra homework. Offenders should be aware of the possible consequences concerning noncompliance.
- As part of drug court, the family/caregivers should be trained to provide support, including the ability to identify high risk situations for their youth and strategies for managing their environment using prosocial skills. Currently, family involvement is not required in most situations. Participation in a parent/caregiver treatment program should be mandatory.
- After treatment is completed, the drug court should include an aftercare component of high quality. The aftercare should be a formal component in which supervision/meetings are required and an evidence-based model is used. Currently, aftercare is only provided to youth in residential treatment.

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Quality Assurance

Strengths: None.

Recommendations for Improvement:

- The drug court should have a management audit system in place to evaluate internal and external service providers. This should include site visits, monitoring of groups, regular process reports, and file review.
- Participant satisfaction with the drug court and treatment programming should be measured with an exit survey.
- This can be achieved through a pre-post test that measures criminal thinking or through reassessment on validated risk and need instruments (JCP). Examples of a proper pre-post tests for criminal thinking are the Pride in Delinquency Scale (PID), TCU Criminal Thinking Scale (TCU-CTS), How I Think Questionnaire (HIT), and the Criminal Sentiments Scale – Modified (CSS-M).
- Youth re-arrest, re-conviction, or re-incarceration data should be examined regularly to evaluate outcomes at least 6 months post graduation. The drug court should review this information regularly.
- The drug court should go a through formal evaluation every five years comparing treatment outcome with a risk-control comparison group. Effectiveness would be supported should there be some reduction in recidivism in the drug court group versus the comparison group.
- A program evaluator should be available (on staff or contract) to assist with research and evaluation of the drug court. Regular reports should be provided to the drug court.

OVERALL PROGRAM RATING

Lane County Juvenile Drug Court received an overall score of **44.2** percent on the CPC-DC. This just falls into the **Ineffective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **43.8** percent, which falls into the **Ineffective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **44.4** percent, which falls into the **Ineffective** category.

FINDINGS – PHOENIX PROGRAM

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	78.6%	Highly Effective
Quality Assurance	25.0%	Ineffective
Offender Assessment	75.0%	Highly Effective
Treatment	75.0%	Highly Effective
Overall Capacity	**66.7%**	**Highly Effective**
Overall Content	**75.0%**	**Highly Effective**
Overall Score	**72.0%**	**Highly Effective**

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Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- The program director is involved in providing direct services via facilitating group treatment with youth twice per week.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Staff are appropriately trained when they are initially hired and are required to complete more than 40 hours per year in training related to service delivery, as outlined in a formal training structure.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- Program funding was consistently is adequate to execute the program as designed.

Recommendations for Improvement:

- Staff should be regularly evaluated with regard to service delivery skills. The program director or clinical supervisor should observe group and provide constructive feedback at least once per group cycle. Currently, there is no formal evaluation process in place, aside from an annual staff evaluation for administrative purposes.
- Staff at the program reported little support from stakeholders, particularly Lane County Juvenile Court. Although relations have recently gotten better, there have been problems sharing information and a common vision.
- Although the agency's funding in advance of the site visit was rated by staff as adequate for the task at hand, at the time of the site visit, program staff provided evidence that budget cuts were leading to reduced amounts of direct care services.

Client Assessment

Strengths:

- The program has identified exclusionary criteria and the percentage of clients deemed inappropriate by program staff is under 20%.
- The program targets higher risk and higher need youth for admittance via drug court referrals.

Recommendations for Improvement:

- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools (at least two factors should be examined). Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, or the Massachusetts Youth Screening Instrument (MAYSI). Since the drug court uses the MASYI, the program can access those results and then assess for another responsivity factor to meet this CPC criterion.

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Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The program uses cognitive-behavioral approaches, such as Thinking for a Change and Options to Anger, as well as family-based models. These approaches meet the criteria for evidence-based practices.
- The groups start and end on-time.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Homework is a regular part of the treatment process and is regularly reviewed with the youth.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change.
- Groups/sessions have a set manual or curriculum that is consistently followed.
- Treatment groups are always conducted and monitored by staff.
- Group size is appropriate and averages no more than eight youth with one facilitator.
- The agency uses a wide range of appropriate rewards, such as home passes, extra privileges, and "bonus bucks". Rewards are appropriately applied to achieve reinforcement of positive behavior.
- A variety of punishers are utilized and appropriately applied to discourage negative behavior.
- Program participants are regularly taught to observe and anticipate problem situations through modeling by the facilitator and through practice with corrective feedback.
- The facilitators have good rapport with group participants.
- Facilitators avoided arguments with participants and rolled with resistance.
- Staff are consistent in their attempts to identify and replace antisocial attitudes and thoughts with prosocial attitudes and thoughts.

Recommendations for Improvement:

- Males and females are more productive in treatment sessions when they attend treatment separately. Treatment groups should be gender specific.
- The program and group facilitators should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- After a punisher is applied, prosocial alternatives should be modeled by the group facilitator or staff member issuing the punisher.
- Skill building exercises should include graduated practice in increasingly difficult situations.
- Risk or relapse prevention plans should be developed and clients should have to regularly practice the coping skills listed on the plan with their counselor or group facilitator.

Quality Assurance

Strengths:

- Pre/post tests are given to youth to assess changes in the targeted behavior.

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Recommendations for Improvement:

- Internal quality assurance should be enhanced to include monitoring of groups, file review, records that monitor treatment progress, observation of groups with feedback to facilitators, and formal offender feedback via satisfaction surveys.
- Observation of direct service with feedback to staff should occur once every group cycle or once per quarter (for staff working individually with youth) and formal feedback should be provided to the facilitator/staff member.
- A discharge summary should be completed for each youth and shared with the drug court. Examples of information to include in a discharge summary are progress in meeting target behaviors and goals, notes of areas that need continued work, and any testing results.

Overall Program Rating

Phoenix received an overall score of **72.0** percent on the CPC-DC. This falls into the **Highly Effective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **66.7** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **75.0** percent, which falls into the **Highly Effective** category.

FINDINGS –LOOKING GLASS PATHWAYS

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	57.1%	Effective
Quality Assurance	50.0%	Needs Improvement
Offender Assessment	75.0%	Highly Effective
Treatment	60.7%	Effective
Overall Capacity	**55.6%**	**Effective**
Overall Content	**62.5%**	**Effective**
Overall Score	**60.0%**	**Effective**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the criminal justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by the juvenile drug court and other stakeholders.

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Recommendations for Improvement:

- The program director should have a significant role in selecting, training, and supervising staff.
- To help understand the needs of the clients and the challenges that staff face, the program director should be providing direct service to clients. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- Staff should be regularly evaluated with regard to service delivery skills. The program director or clinical supervisor should observe group and provide constructive feedback at least once per group cycle.
- Staff should receive formal training on the curriculum being used and at least 40 hours of ongoing training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.
- Program funding should be sufficient and stable to run the program as designed. Recently, the program had cut several direct care staff positions.

Client Assessment

Strengths:

- The agency uses a committee to make admittance decisions. Only those individuals deemed to be in need of substance abuse services are admitted. Clients admitted to the program are appropriate for the treatment provided to them.

Recommendations for Improvement:

- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools (at least two factors should be examined). Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, or the Massachusetts Youth Screening Instrument (MAYSI). Since the drug court uses the MASYI, the program can access those results and then assess for another responsivity factor to meet this CPC criterion.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The groups start and end on-time.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change.
- Group sessions have a set manual/curriculum that is consistently followed.
- Treatment groups are always conducted and monitored by staff.
- Group size is appropriate and averages no more than eight youth with one facilitator.
- The types of rewards used by the program appear appropriate. The program uses a point system and reinforces positive behavior with verbal praise, incentive time, and privileges.

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Rewards also outweigh punishers by a ratio of 4:1. This is a sufficient ratio to illicit behavioral change.

- The Pathways program uses a variety of punishments and applies them appropriately. Types of punishments include docking points, writing assignments, and losing free time. When able, punishments are applied immediately following the undesirable behavior.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.
- Staff are consistent in their attempts to identify and replace antisocial attitudes and thoughts with prosocial attitudes and thoughts.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play which needs to be implemented in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. While staff reported using cognitive-behavioral interventions, they also utilize a twelve-step model. Twelve-step models have not been empirically proven to enact behavioral change in offenders.
- Homework should be regularly assigned to participants as part of treatment groups and the homework should be reviewed by the facilitator and constructive feedback should be provided to the participants.
- When a co-facilitator is present, they should be actively participating in the teaching process. Co-facilitators should not simply be there to monitor behavior or for technical assistance.
- The program and group facilitators should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- While punishers are applied appropriately, a prosocial alternative to the behavior should always be offered following punishment.
- Group facilitators should consistently (almost every group or individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback, and finally, facilitators should include graduated practice of new skills in increasingly difficult situations.
- Risk or relapse prevention plans should be developed and clients should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms. Quality assurance processes include monthly peer and file review and client satisfaction surveys.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

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- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once every group cycle and formal feedback should be provided to the facilitator.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning substance use and abuse.

Overall Program Rating

Pathways received an overall score of **60.0** percent on the CPC-DC. This falls into the **Effective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **55.6** percent, which falls into the **Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **62.5** percent, which falls into the **Effective** category.

FINDINGS - LOOKING GLASS OUTPATIENT PROGRAM

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	85.7%	Highly Effective
Quality Assurance	25.0%	Ineffective
Offender Assessment	50.0%	Needs Improvement
Treatment	70.4%	Highly Effective
Overall Capacity	**72.2%**	**Highly Effective**
Overall Content	**67.7%**	**Highly Effective**
Overall Score	**66.7%**	**Highly Effective**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director had a significant role in selecting, training, and supervising staff.
- The program director is involved in providing direct services via conducting assessments and carrying a caseload.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by the juvenile drug court and other stakeholders.
- Program funding is rated by staff as adequate and stable.

Recommendations for Improvement:

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- Staff should be regularly evaluated with regard to service delivery skills. The program director or clinical supervisor should observe sessions and provide constructive feedback at least once per cycle or once per quarter (for those staff delivering individual sessions).
- Staff should receive formal training on the curriculum being used and at least 40 hours of ongoing training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming. Currently, staff are required to complete 20 hours of training per year.

Client Assessment

Strengths:

- The program targets higher risk and higher need youth for admittance via drug court referrals.

Recommendations for Improvement:

- The agency should have exclusionary criteria that are written and followed to ensure only youth who are appropriate for the program are admitted. Currently, the program accepts every youth who is referred to them.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools (at least two factors should be examined). Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, or the Massachusetts Youth Screening Instrument (MAYSI). Since the drug court uses the MASYI, the program can access those results and then assess for another responsivity factor to meet this CPC criterion.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The sessions start and end on-time.
- Treatment staff are knowledgeable about the materials discussed.
- The treatment staff encourage participation in both the individual and group sessions.
- Homework is a regular part of the treatment process and is regularly reviewed with the youth.
- Treatment norms/rules are established, documented, and reviewed with the youth regularly.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change.
- Treatment sessions are always conducted and monitored by staff.
- Group size is appropriate and averages no more than 8-12 youth per facilitator.
- The types of rewards used by the program appear appropriate. Rewards also outweigh punishers by a ratio of 4:1. This is a sufficient ratio to illicit behavioral change.
- Program participants are regularly taught to observe and anticipate problem situations through modeling by the facilitator and through practice with corrective feedback.
- Program staff have good rapport with clients.
- Treatment staff avoid arguments with clients and roll with resistance.

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- Staff are consistent in their attempts to identify and replace antisocial attitudes and thoughts with prosocial attitudes and thoughts.
- Risk or relapse prevention plans are developed and clients regularly practice the coping skills listed on the plan with their counselor.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play which needs to be implemented in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. While the program staff stated that cognitive-behavioral interventions were used frequently, interviews with program participants (both youth and family members) indicated little to no cognitive restructuring and structured social learning.
- A manual should be developed and followed for all of the individual and group sessions to guide time in treatment and to ensure consistency across staff.
- The program and group facilitators should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- The program should use punishers to discourage negative behavior. Currently, the program relies on the court to implement punishers. The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should also include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator.
- While structured skill building is regularly used during treatment sessions, skill building exercises should include graduated practice in increasingly difficult situations.

Quality Assurance

Strengths:

- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- Internal quality assurance should include monitoring of groups, file review, records that monitor treatment progress, observation of groups with feedback to facilitators, and formal offender feedback via satisfaction surveys.
- Observation of direct service with feedback to staff should occur once every group cycle or once per quarter (for staff providing individual sessions) and formal feedback should be provided to the facilitator/staff member.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning substance use and abuse. Currently, a pre-post test is given on drug education only.

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Overall Program Rating

Looking Glass received an overall score of **66.7** percent on the CPC-DC. This falls into the **Highly Effective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **72.2** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **67.7** percent, which falls into the **Highly Effective** category.

FINDINGS - CENTER FOR FAMILY DEVELOPMENT OUTPATIENT PROGRAM

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	85.7%	Highly Effective
Quality Assurance	75.0%	Highly Effective
Offender Assessment	50.0%	Needs Improvement
Treatment	51.9%	Needs Improvement
Overall Capacity	**83.3%**	**Highly Effective**
Overall Content	**51.6%**	**Needs Improvement**
Overall Score	**63.3%**	**Effective**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- The program director is involved in providing direct services via assessments and group treatment with youth in the program.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the criminal justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by the juvenile drug court and other stakeholders.
- Program funding is adequate and stable to deliver the program as designed.

Recommendations for Improvement:

- Staff should be regularly evaluated with regard to service delivery skills. The program director or clinical supervisor should observe sessions and provide constructive feedback at least once per cycle or once per quarter (for those staff delivering individual sessions).
- Staff should receive formal training on the interventions/curriculum being used and at least 40 hours of ongoing training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.

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Client Assessment

Strengths:

- The program targets higher risk and higher need youth for admittance via drug court referrals.

Recommendations for Improvement:

- The agency should have exclusionary criteria that are written and followed to ensure only youth who are appropriate for the program are admitted. Currently, the program accepts every youth who is referred to them.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools (at least two factors should be examined). Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, or the Massachusetts Youth Screening Instrument (MAYSI). Since the drug court uses the MASYI, the program can access those results and then assess for another responsivity factor to meet this CPC criterion.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The groups and sessions start and end on-time.
- The group facilitators and counselors are knowledgeable about the materials discussed in group and individual sessions.
- The group facilitators and counselors encourage participation in the groups and sessions.
- Session norms/rules are established, documented, and reviewed with the youth regularly.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change.
- Treatment groups are always conducted and monitored by staff.
- Group size is appropriate and averages 12 youth per facilitator. When groups have more than 12 youth in them, a co-facilitator should be used.
- The types of rewards used by the program appear appropriate. For example, staff use verbal praise, pizza parties, and gift cards. Rewards also outweigh punishers by a ratio of 4:1. This is a sufficient ratio to illicit behavioral change.
- Staff have good rapport with youth and families.
- Facilitators/counselors avoid arguments with participants and roll with resistance.
- Identifying underlying thoughts and values is built into the program. For example, the identification of thoughts and values takes place via a "values chart" that the clients fill out and then discusses.
- Relapse prevention plans are developed with each youth throughout their treatment process. This plan is reviewed extensively toward the end of treatment, and a copy is provided to the youth.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social

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learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play which needs to be implemented in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. While staff reported using cognitive behavioral interventions, interviews with clients revealed that they were never asked to role play or practice skills, a hallmark of cognitive-behavioral therapy.

- Homework should be a regular part of the treatment process and the counselor should review completed homework every time homework is assigned.
- The Center for Family Development has created its own manuals and curriculums for this program. However, the manuals do not guide the individual sessions or how much time is devoted to each topic. It is important to have these things established so that the structure of the program is the same for every youth. Additionally, the family component does not have a structured manual or curriculum. One should be developed or purchased for use in order to guide the family group.
- The program and group facilitators should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- The program should use punishers to discourage negative behavior. Currently, the program relies on the court to implement punishers. The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should also include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator.
- Facilitators and counselors should consistently (almost every group or individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback, and finally, they should include graduated practice of new skills in increasingly difficult situations.
- While staff work to identify underlying antisocial thoughts or values, participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms. Quality assurance includes quarterly file review and client satisfaction surveys.
- A pre-post test is used to measure client progress on target behaviors.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once every group cycle or once every quarter and formal feedback

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should be provided to the staff member. Currently, only groups are observed and groups are only monitored every six months.

Overall Program Rating

The Center for Family Development's Outpatient program received an overall score of **63.3** percent on the CPC-DC. This falls into the **Effective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **83.3** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **51.6** percent, which falls into the **Needs Improvement** category.

FINDINGS - CENTER FOR FAMILY DEVELOPMENT DAY TREATMENTPROGRAM

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	71.4%	Highly Effective
Quality Assurance	75.0%	Highly Effective
Offender Assessment	75.0%	Highly Effective
Treatment	58.6%	Effective
Overall Capacity	**77.8%**	**Highly Effective**
Overall Content	**60.6%**	**Effective**
Overall Score	**66.6%**	**Highly Effective**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- The program director is involved in providing direct services via assessments and group treatment with youth in the program.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the criminal justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by the juvenile drug court and other stakeholders.
- Program funding is adequate and stable.

Recommendations for Improvement:

- Staff should be regularly evaluated with regard to service delivery skills. The program director or clinical supervisor should observe group and provide constructive feedback at least once per group cycle. Currently, there is no formal evaluation process in place.

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- Staff should receive formal training on the curriculum and interventions being used by the program and at least 40 hours of ongoing training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.

Client Assessment

Strengths:

- The agency follows written exclusionary criteria for admittance to their program. Programs who are not appropriate for intensive services are not admitted into the program.
- The program targets higher risk and need youth for admittance. Staff reported that 100% of youth in the program are high or moderate risk.

Recommendations for Improvement:

- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools (at least two factors should be examined). Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, or the Massachusetts Youth Screening Instrument (MAYSI). Since the drug court uses the MASYI, the program can access those results and then assess for another responsivity factor to meet this CPC criterion.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The treatment groups are gender specific.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Homework is a regular part of the treatment process and is regularly reviewed with the youth.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change.
- Sessions have a set manual or curriculum that is consistently followed and the Pathways curriculum has been modified slightly to include role playing.
- Treatment groups are always conducted and monitored by staff.
- Group size is appropriate and averages no more than eight youth per facilitator.
- The types of rewards used by the program appear appropriate. A wide range of rewards are utilized, including raffle tickets, graduation ceremonies, pick-a-prize and verbal praise. Rewards are administered individually and are specifically tied to the positive behavior. Rewards also outweigh punishers at least a 4:1 ratio.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.
- Staff are consistent in their attempts to identify and replace antisocial attitudes and thoughts with prosocial attitudes and thoughts.

Recommendations for Improvement:

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- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play which needs to be implemented in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. While the program states using a combination of motivational interviewing, cognitive-behavioral therapy and family systems models, observation of group and interviews with clients revealed that they were rarely asked to role play or practice skills, a hallmark of cognitive-behavioral therapy.
- Treatment groups should start on-time and end on-time, breaks should be limited to 5-10 minutes, and the check-in process should not take up the majority of the treatment session or be the focus of the treatment session.
- Homework should be a regular part of the treatment process and the counselor should review completed homework every time homework is assigned.
- When a co-facilitator is present in group, they should be actively participating in the teaching process. Co-facilitators should not simply be there to monitor behavior or for technical assistance.
- The program and group facilitators should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- The program should use punishers to discourage negative behavior. Currently, the program predominately relies on the court to implement punishers. The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should also include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator.
- Facilitators should consistently (almost every group session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback, and finally, facilitators should include graduated practice of new skills in increasingly difficult situations.
- While risk prevention plans are a requirement to complete the program, clients should have to regularly review and practice the coping skills listed on the plan with a staff member.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms, including file reviews.
- Supervisors sit in on sessions and provide feedback to counselors, specifically noting adherence to the curriculum and dealing with group dynamics.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

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- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning substance abuse and/or other treatment targets.

Overall Program Rating

Center for Family Development: Day Treatment received an overall score of **66.6** percent on the CPC-DC. This falls into the **Highly Effective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **77.8** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **60.6** percent, which falls into the **Effective** category.

CONCLUSION

Researchers at the University of Cincinnati have assessed 512 programs nationwide and have developed a large database on correctional intervention programs.[2] Approximately 7 percent of the programs assessed have been classified as HIGHLY EFFECTIVE, 17 percent have been classified as EFFECTIVE, 31 percent have been classified as NEEDS IMPROVEMENT, and 45 percent have been classified as INEFFECTIVE.

Graphs representing the results of this assessment are provided below. The first graph or set of graphs compares the drug court or referral agency score in the capacity domain, content domain, and overall score with the average scores from all 512 programs evaluated by the University of Cincinnati. The final graph shows the drug court score and an average of the scores from all referral agencies used by the drug court compared to the average of all programs evaluated by the University of Cincinnati.

Recommendations have been made in each of the four CPC domains for the Lane County Juvenile Drug Court. These recommendations should assist the program in making necessary changes to increase program effectiveness. Certainly, care should be taken not to attempt to address all "areas needing improvement" at once. Programs that find the assessment process most useful are those that prioritize need areas and develop action plans to systematically address such needs. Previous programs have also been successful at improving the provision of services by formulating committees charged with developing strategies for delivering evidence-based programming.

This report also provides the drug court with a snapshot of the referral agencies where its youth are receiving treatment in the community. This evaluation should assist the drug court in determining what type of treatment is effective when working with juvenile drug court clients. It should also assist the referral agencies with ways they can improve the services they provide to drug court youth

[2] Several versions of the CPAI were used prior to the development of the CPC. Scores and averages have been adjusted as needed.

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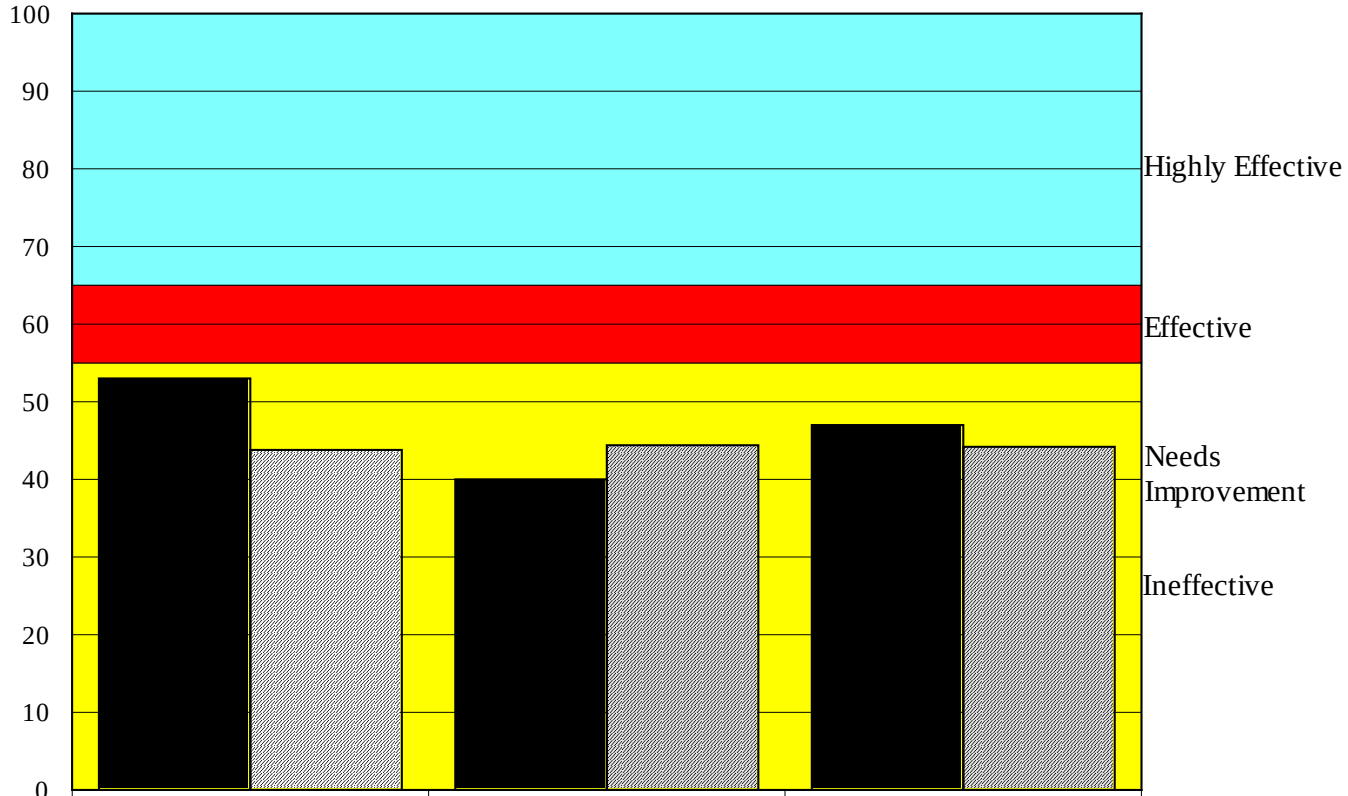
FIGURE 1:
Lane County Juvenile Drug Court CPC-DC Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Lane County	43.8	44.4	44.2

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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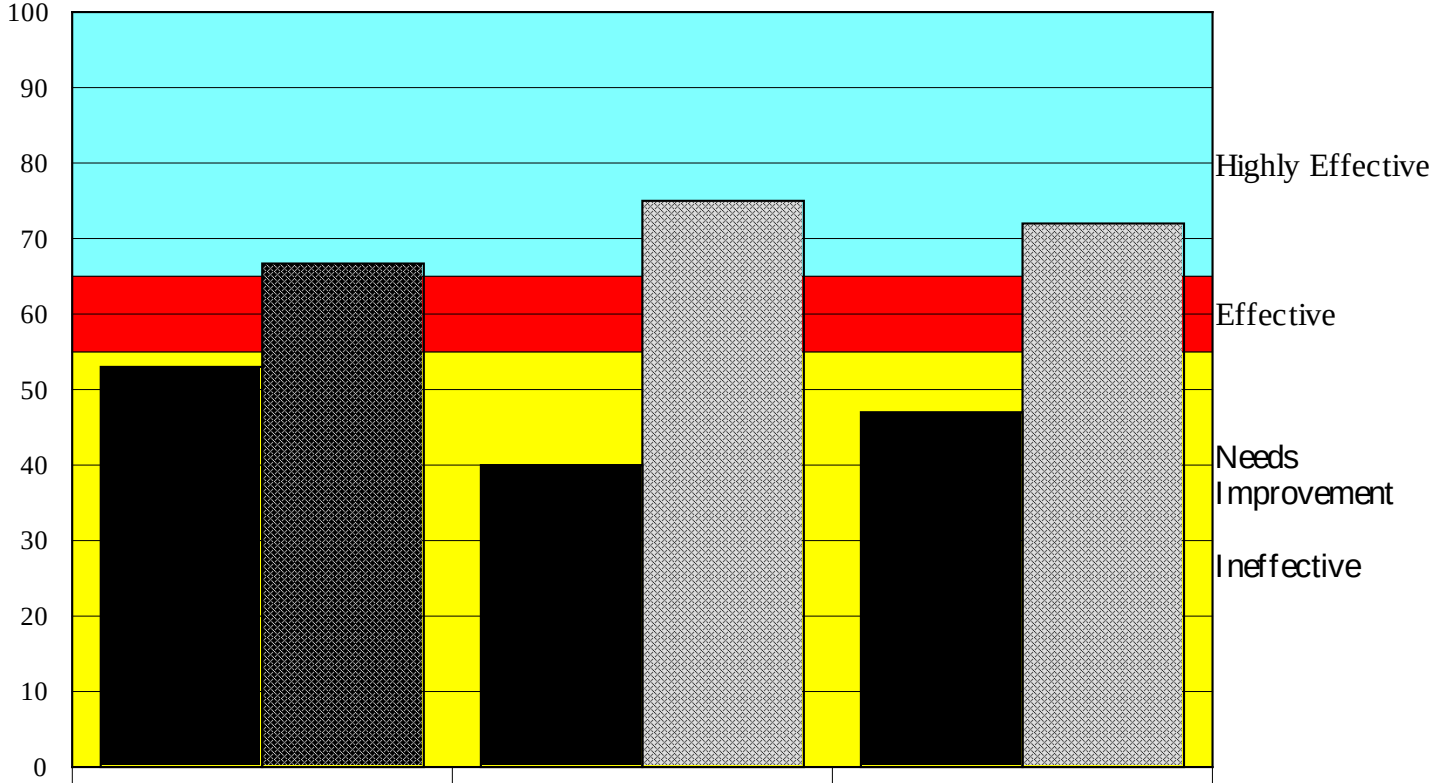
FIGURE 2:
Phoenix CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Phoenix	66.7	75	72

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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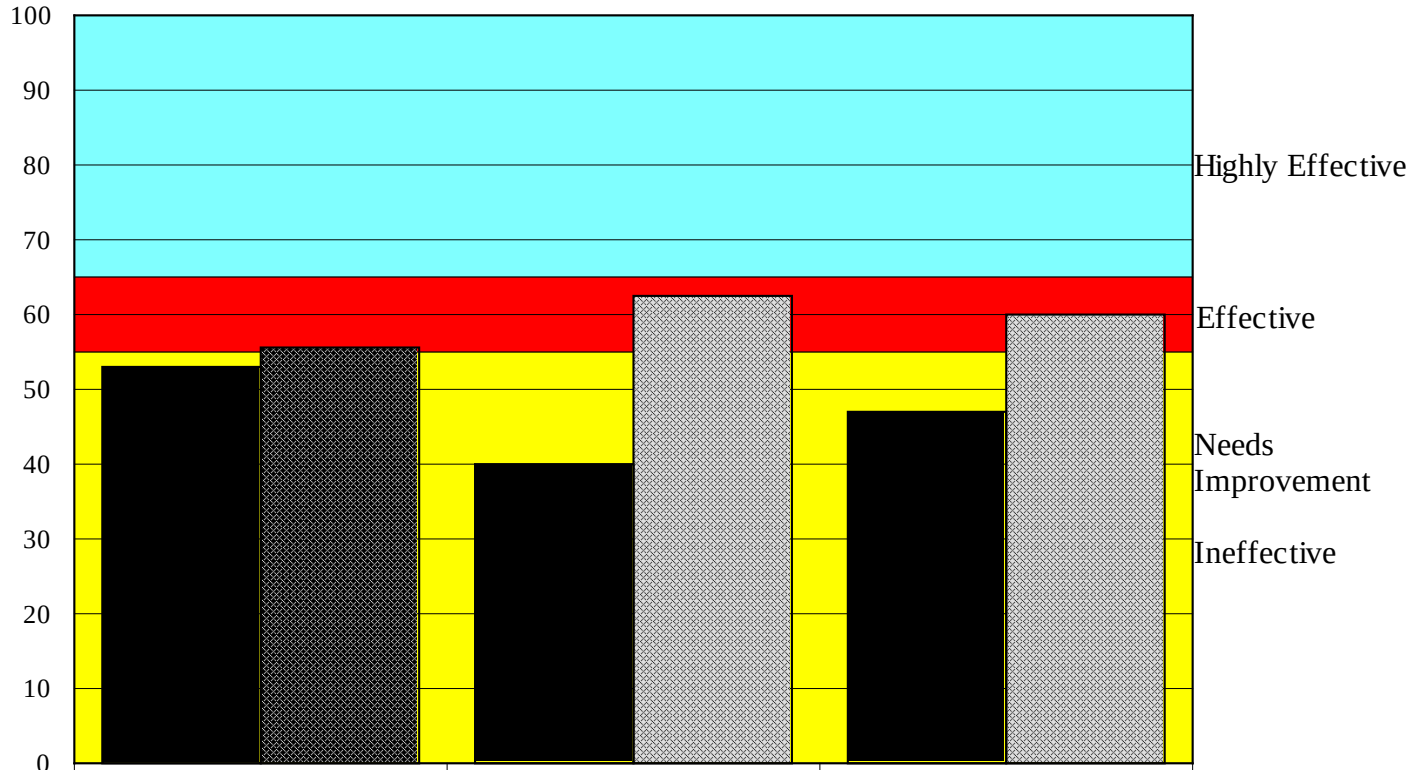
FIGURE 3:
Pathways CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Pathways	55.6	62.5	60

* The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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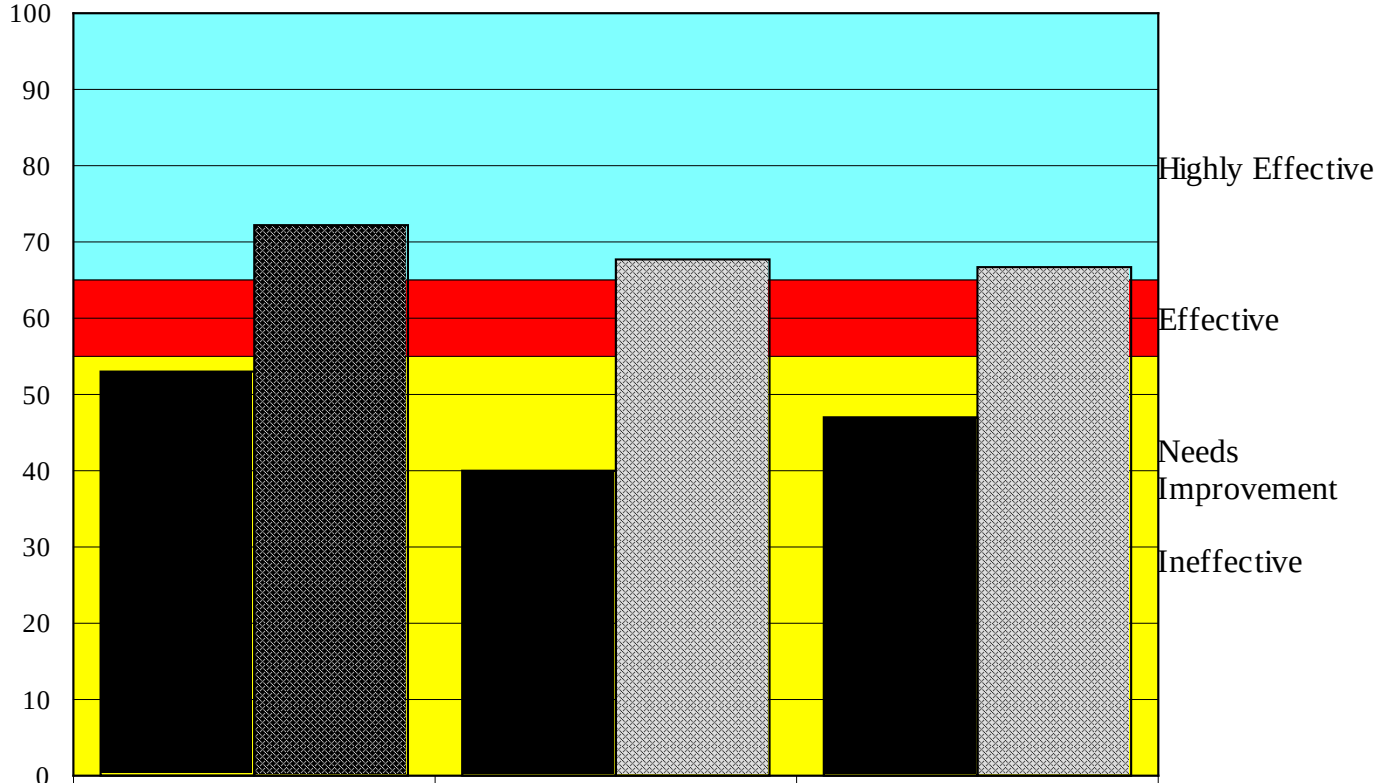
FIGURE 4:
Looking Glass CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Looking Glass	72.2	67.7	66.7

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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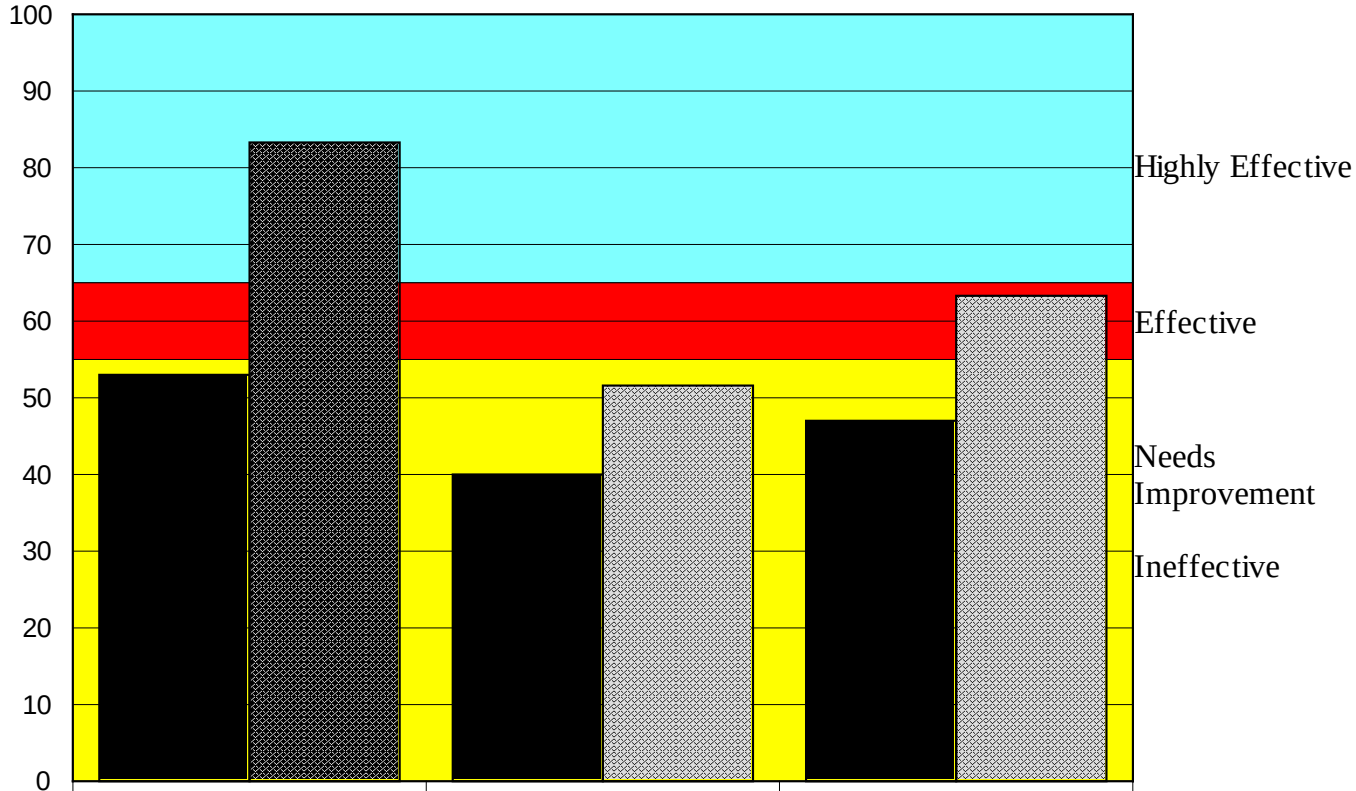
FIGURE 5:
CFD - Outpatient CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
CFD - Outpatient	83.3	51.6	63.3

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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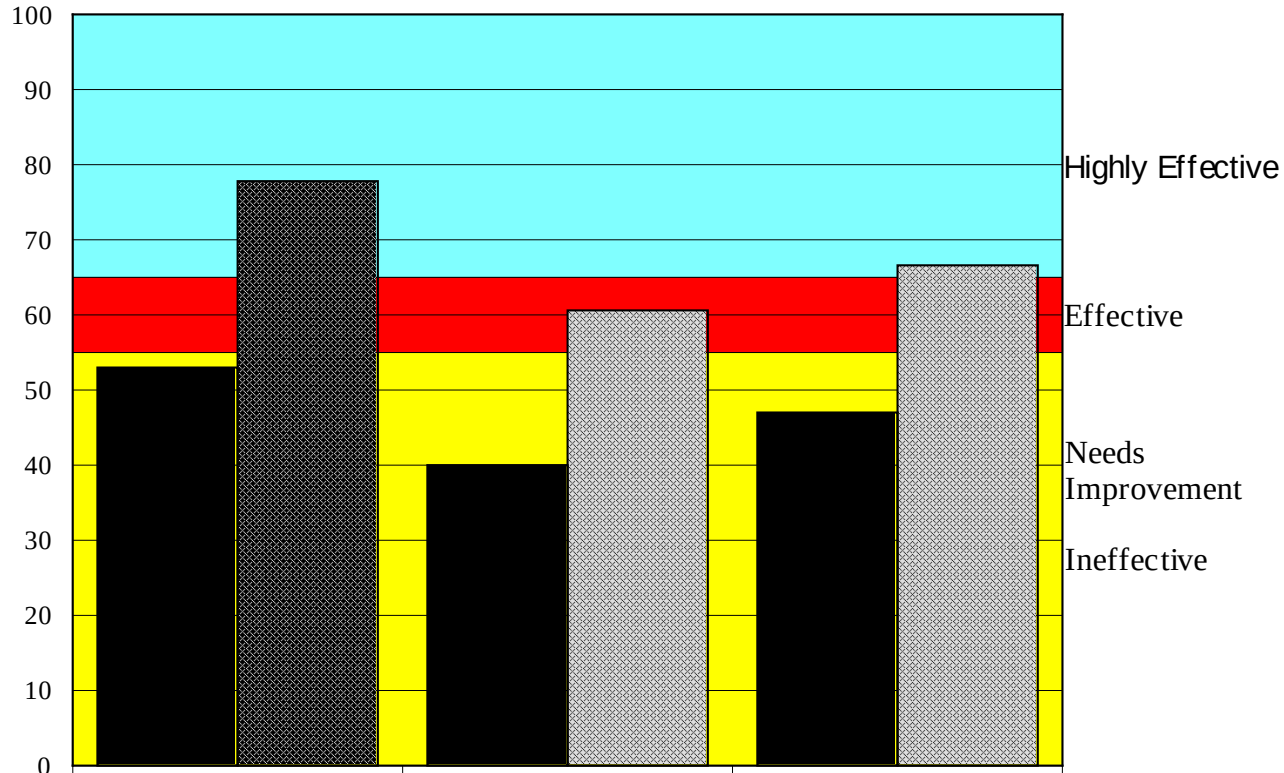
FIGURE 6:
CFD - Day Treatment CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
CFD - Day Treatmen	77.8	60.6	66.6

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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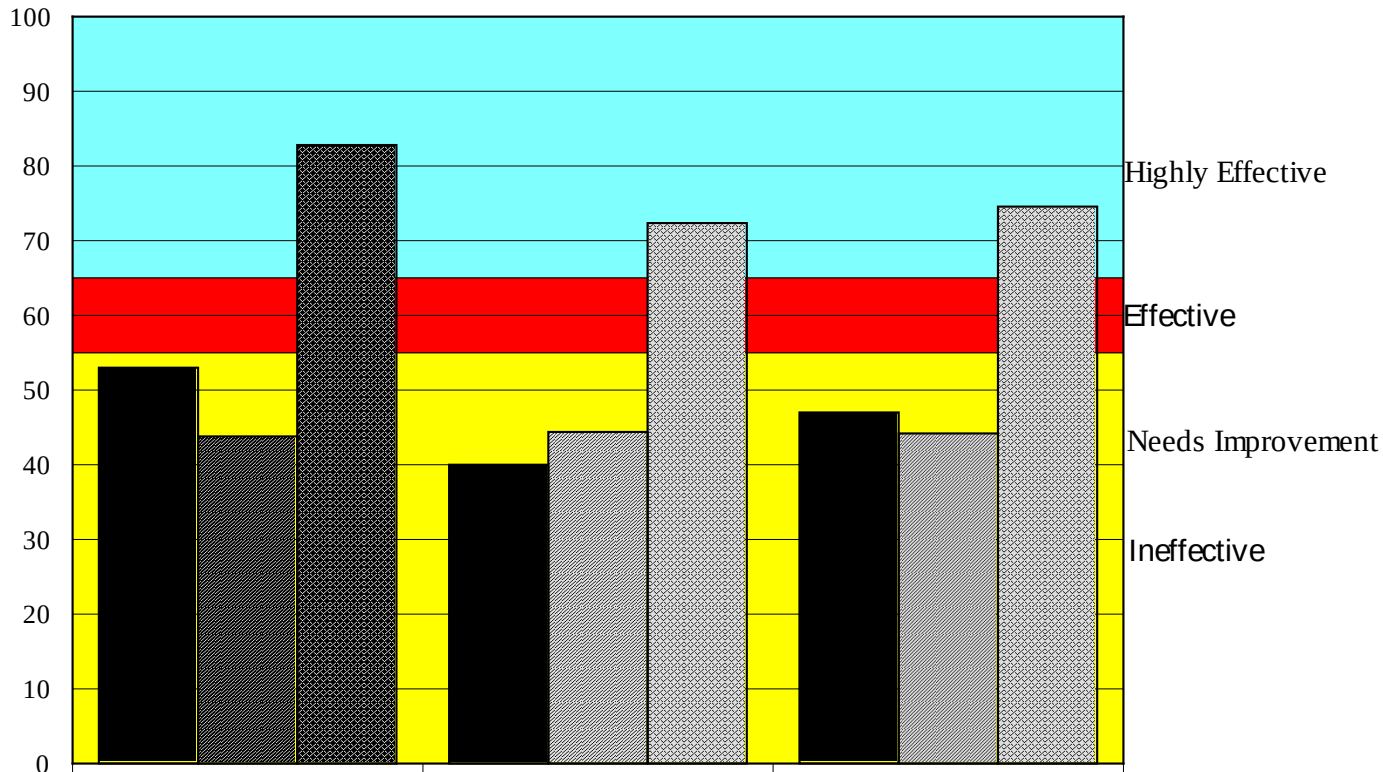
FIGURE 7:
Lane County Juvenile Drug Court CPC-DC Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Lane County	43.8	44.4	44.2
Agency Average	82.8	72.36	74.56

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST – DRUG COURT (CPC-DC) SYNOPSIS OF FINDINGS

Performed as part of the OJJDP study Outcome and Process Evaluation of Juvenile Drug Courts

Lucas County Juvenile Drug Court

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OUTCOME AND PROCESS EVALUATION OF JUVENILE DRUG COURTS STUDY

This project is funded by a grant received from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The purpose of this study is to evaluate a national sample of juvenile drug court programs. The goals of this research are: (1) To determine if there is a reduction in recidivism and substance abuse associated with participation in a juvenile drug court program; (2) to determine if there are improvements in social functioning (e.g. school performance, employment, and family functioning) related to participating in juvenile drug court programs; (3) to identify the characteristics of successful juvenile drug court participants; (4) to determine if juvenile drug courts are operating in a manner consistent with an evidence-based approach; (5) to identify the programmatic characteristics of effective juvenile drug courts; and (6) to provide information to policymakers about the effectiveness of drug courts for juvenile offenders.

This study includes both an outcome and a process evaluation. The outcome portion of the study examines outcomes of youth participating in drug courts as compared to similar youth who are on probation. The process evaluation explores the effectiveness of the drug court and drug court programming and is the focus of this report. Ten drug courts from across the country participated in this four-year study, nine of which participated in both the process and outcome evaluation pieces. The final report for the Outcome and Process Evaluation of Juvenile Drug Courts study will offer outcome and process evaluation findings across all nine drug court sites and is expected to be submitted to OJJDP in December 2012.

CONTEXT AND SCOPE OF THIS EVALUATION

The following report is part of a larger national project centered on the effectiveness of juvenile drug court programs and provides a synopsis of findings from the process evaluation, as well as recommendations to enhance the effectiveness of the services delivered by the Lucas County Juvenile Drug Court. Programs that adhere to the principles of effective intervention are more likely to impact criminal reoffending (see Andrews & Bonta, 2003 for a review). Specifically, correctional research suggests that cognitive behavioral and social learning models of treatment are associated with considerable reductions in recidivism (Gendreau, 1996; Smith, Goggin & Gendreau, 2002). As such, the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) was used to evaluate the juvenile drug courts participating in the Outcome and Process Evaluation of Juvenile Drug Courts study. The objectives of this assessment are to conduct a detailed review of services and program materials of the juvenile drug courts and the agencies they refer youth to and to compare their current practices with the literature on "best practices" in corrections.

PROCEDURES

Description of the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC)

The Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) is a tool that the University of Cincinnati developed for assessing drug court programs. It is used to determine how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. The CPC-DC was modified from the Evidence-Based Correctional Program Checklist (CPC) [1] and includes important indicators from drug court meta-analyses (see Shaffer, 2006). The CPC

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has been validated by several recent studies conducted by the University of Cincinnati. These studies found strong correlations between outcome and both domain areas and individual items (Holsinger, 1999; Lowenkamp, 2003; Lowenkamp and Latessa, 2003, Lowenkamp & Latessa, 2005a; Lowenkamp and Latessa, 2005b; Shaffer, 2006). As part of the larger national study, the indicators on the CPC-DC will be validated using the outcome data collected on the drug court participants.

The CPC-DC consists of two instruments: one for the formal drug court (CPC-DC) and the other for the major referral agencies (CPC-DC: RA) involved in providing treatment and services to drug court clients. Each of these tools is divided into two basic areas: Content and Capacity. The capacity area is designed to measure whether the drug court and its referral agencies have the capability to deliver evidence-based interventions and services to offenders. There are two domains in the capacity area: 1) Development, Coordination, Staff and Support, and 2) Quality Assurance. The content area focuses on the substantive aspect of the drug court and its referral agencies, and also includes two areas: 1) Assessment Practices, and 2) Treatment. This area examines the extent to which the drug court and its referral agencies meet the principles of risk, need, responsivity, and treatment.

The Drug Court tool includes 41 indicators, worth 43 total points. The Referral Agency tool has 49 indicators worth a total of 51 points. Each area and all domains are scored and rated as “highly effective” (65% to 100%); “effective” (55% to 64%); “needs improvement” (46% to 54%); or “ineffective” (45% to 0%). The scores in all domains are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the domains are given equal weight. Further, some items may be considered "not applicable," in which case they are not included in the scoring. Data are collected through structured interviews with selected program staff and program participants, as well as through observation of groups and services. In some instances, surveys may be used to gather additional information. Other sources of information include policy and procedure manuals, schedules, treatment materials, curricula, case files, and other selected program materials. Once the information is gathered and reviewed, the program is scored. The following report highlights strengths, areas that need improvement, and recommendations for each of the areas for both the drug court and the referral agencies.

There are several limitations to the CPC-DC that should be noted. First, as with any research process, objectivity and reliability are an issue. Although steps are taken to ensure that the information gathered is accurate and reliable, decisions about the information gathered are invariably made by the assessors. Second, the process is time specific. That is, the assessment is based on the program at the time of the assessment. Though changes or modifications may be planned for the future, only those activities and processes that were present at the time of the review in September and October 2009 are considered for scoring. Third, the process does not take into account all system issues that can affect program integrity (i.e., political climate of the court). Finally, the process does not address the reasons that a problem exists within a program or why certain practices do or do not take place. Rather, the process is designed to determine the overall integrity of the program.

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[1] The CPC is modeled after the Correctional Program Assessment Inventory developed by Gendreau and Andrews. However, only those indicators that were found to be positively correlated with outcome were retained. In addition, the CPC includes a number of items not contained in the CPAI.

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Despite these limitations, there are a number of advantages to this process. First, the criteria are based on empirically derived principles of effective programs, and all of the indicators included in the CPC-DC are correlated with reductions in recidivism. Second, it allows researchers to get inside the "black box" of a drug court and its referral agencies, something that an outcome study alone does not provide. This means researchers are able to measure the degree to which programs are meeting evidence-based standards. Third, the CPC-DC enables researchers to "quantify" the quality of a program through a scoring process. This allows for comparisons across programs, the setting of benchmarks, and for reassessment to measure progress. Fourth, it identifies both the strengths and weaknesses of a program and provides specific recommendations for program improvement.

Assessment Process

The assessment process consisted of a series of structured interviews with staff members and program participants during an on-site visit to Lucas County Juvenile Drug Court on September 16th and October 29th, 2009. Additionally, ten files (five open and five closed) as well as other relevant program materials (e.g., treatment manuals, assessments, training protocol, ethical guidelines, and staff evaluations) were examined. Finally, two treatment groups were observed: "Parent Group" and "Aftercare." Three evaluators conducted the various interviews, observations and file reviews. Data from the various sources were then combined to generate a consensus CPC-DC score and the specific recommendations.

SUMMARY OF THE DRUG COURT

The Lucas County Juvenile Drug Court has been in operation since 2004. At the time of the assessment, the drug court was funded for four years by a Bureau of Justice Assistance grant. Youth range in age from fourteen to seventeen and a half and must evidence drug abuse issues. Parents are also court ordered to participate. At the time of assessment, Denise Cubbon was the drug court judge, Laurie Bayles was the juvenile treatment court coordinator and Dan Pompa was the court administrator.

The drug court requires clients to progress through three phases of treatment lasting a minimum of six months, with an average of eight to nine months. Throughout the drug court program, youth must attend two sober support group meetings per week, as well as any additional treatment to which they are referred. Additional components to the program follow a step-down approach. In Phase 1, youth and parents must attend weekly court hearings, and parents must attend weekly parenting groups. In Phase 2, youth and parents must attend court hearings every other week, and parents must attend parenting groups bimonthly. In the final Phase (3), youth and parents must attend court hearings every three weeks, and parents must continue to attend parenting groups bimonthly. The drug court relies on the following techniques to supervise youth in the program: curfew, drug and alcohol testing, home and school visits, and attendance at court. The drug court utilizes one referral agency for substance abuse counseling, Unison Behavioral Health Group. The drug court also provides the following treatment components: Parents Helping Parents, Parent Project, youth AA meetings, and various family counseling.

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FINDINGS – DRUG COURT

CPC-DC SECTIONS	SCORE	RATING
Development, Coordination, Staff, and Support	55.6%	Effective
Quality Assurance	0.0%	Ineffective
Offender Assessment	44.4%	Ineffective
Treatment	38.9%	Ineffective
Overall Capacity	**31.3%**	**Ineffective**
Overall Content	**40.7%**	**Ineffective**
Overall Score	**37.2%**	**Ineffective**

Development, Coordination, Staff, and Support

Strengths:

- There is a program coordinator who has overall responsibility for oversight and management of the program.
- Regular staff meetings are held to discuss clients in the drug court.
- Drug court staff provide direct case management and supervision services to the youth in the drug court.
- Funding for the drug court is adequate, and there have been no changes in the level of funding in the past two years.

Recommendations for Improvement:

- The program coordinator should have a more direct role in selecting, approving, and supervising the counselors hired to provide treatment.
- Drug court staff should be trained on drug court programming and receive at least 40 hours of on-going training a year. Staff training should relate to the theory and practice of interventions used by the program, including effective correctional practices and the cognitive-behavioral model.
- Ethical guidelines should dictate staff boundaries and interactions with drug court participants.
- The drug court accepts a mix of pre- and post-conviction/adjudication. Drug courts have more impact on outcomes when they accept only youth who are pre-conviction/adjudication and the youth's charges are held in abeyance (or sealed), dropped, or reduced if the youth successfully completes drug court.

Offender Assessment

Strengths:

- There are established criteria for the exclusion of certain types of offenders. The policy is written and followed, and clients were deemed appropriate for drug court by the majority of staff.
- Violent offenders are excluded from participating in the drug court.
- Domain specific needs are assessed with the So-Quick, which assesses substance abuse issues (and mental health).

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- Low risk youth are screened out of the drug court. It is recommended that the drug court continue to ensure that low risk youth make up no more than 5% of drug court clients.

Recommendations for Improvement:

- Risk, as well as a range of criminogenic need factors, should be assessed using a validated, standardized, and objective instrument. At the time of the assessment, youth were assessed using a home grown instrument, which does not meet the criteria for assessing criminogenic need factors. However, the drug court has since adopted the Ohio Youth Assessment System (OYAS), which has been validated in Ohio.
- The drug court should assess factors that directly affect youth's engagement in the drug court and treatment programming. Additionally, there should be evidence that clinical or staffing decisions are made based on these responsivity factors. At least two major factors such as personality, motivation for change, or mental illness should be assessed. While the drug court uses the So-Quick which measures mental health, it does not measure a range of responsivity factors. Examples of appropriate responsivity instrumentation include the TCU Client Self-Rating scale, Jesness Inventory, Beck's Depression, Massachusetts Youth Screening Instrument (MAYSI), and IQ tests.
- Drug court should target moderate and high risk youth. Because the drug court was not using a validated assessment instrument, assessors were unable to guarantee that the clients were high and moderate risk.
- Assessments should be freely shared with everyone on the drug court team, including referral agencies.

Treatment Characteristics

Strengths:

- The Lucas County Juvenile Drug Court targets a wide range of criminogenic needs and meets criteria that at least 75% of drug court interventions should focus on criminogenic needs. The drug court team consistently stated the following criminogenic needs were targeted: antisocial peer associations; school or work; family affection/communication; and family monitoring and supervision.
- The average length in drug court is six-nine months. It is recommended that the majority of youth graduate in less than 12 months.
- Drug court participants spend an adequate amount of time in structured activities.
- The drug court has an appropriate reward structure including phase advancement, gift certificates, special activities, choosing a prize from a fish bowl, and praise from drug court staff and the drug court judge.
- Staff reported a ratio of rewards to punishers at 4:1. This ratio is consistent with evidence-based practices.
- The drug court responds to noncompliance appropriately including community service, house arrest and detention.
- The drug court randomly drug tests participants on a regular basis during all three Phases.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive

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restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.

- Youth should be assigned to groups and services that match their style of learning and other responsivity factors. The drug court should use responsivity instruments to assess which services/groups are best for which client.
- Intensity of the drug court programming should vary by risk level. High risk youth should receive higher intensity and/or duration of service than moderate risk youth. Moderate risk youth should receive higher intensity and/or duration of service than low risk youth.
- The drug court should have measurable completion criteria which determine how well a youth has progressed in acquiring prosocial behaviors. While phase advancement is used, other methods should be incorporated such as reassessment on risk/need or other formalized processes which track progress over time.
- The completion rate should be between 65% and 85%. At the time of the assessment, the completion rate was around 50%.
- While the drug court stated that the Parent Project was being used to facilitate the family group, there was no evidence the curriculum was used often. The observed group was structured more as a support group for parents. As part of drug court, the family/caregivers should be trained to provide support, including the ability to identify high risk situations for their youth and strategies for managing their environment using prosocial skills. Family groups should therefore target prosocial behavior, and participation should be mandatory. The format for the Parent Project curriculum should be fully incorporated or other options for formalizing this component should be explored. Examples of evidence-based family/caregiver curriculum include: Common Sense Parenting, Strengthening Families Program, and Parenting Wisely.
- After the formal treatment is completed, the drug court should include a high-quality aftercare component. The aftercare should be a formal component in which supervision/meetings are required and an evidence-based model is used.
- The Lucas County Juvenile Drug Court requires youth to participate in AA/NA. Youth in drug court should not be required to attend self-help meetings. There is no evidence that these meetings are beneficial to youth and may in fact be harmful.

Quality Assurance

Strengths: None.

Recommendations for Improvement:

- The drug court should have a management audit system in place to evaluate internal and external service providers. This includes site visits, monitoring of groups, regular process reports, and file review.
- Participant satisfaction with the drug court and treatment programming should be measured with an exit survey.
- Offender reassessment should be completed to determine progress on meeting target behaviors. This can be achieved through a pre-post test that measures criminal thinking or through reassessment on validated risk and need instruments. Examples of a proper pre-post tests for criminal thinking are the Pride in Delinquency Scale (PID), TCU Criminal

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Thinking Scale (TCU-CTS), How I Think Questionnaire (HIT), and the Criminal Sentiments Scale – Modified (CSS-M).

- Youth re-arrest, re-conviction, or re-incarceration data should be examined regularly to evaluate outcomes at least six months post-graduation. The drug court should review this information regularly.
- The drug court should go through a formal evaluation every five years comparing treatment outcome with a risk-control comparison group. Effectiveness is supported if there is some reduction in recidivism in the drug court group versus the comparison group.
- A program evaluator should be available (on staff or contract) to assist with research and evaluation of the drug court. Regular reports should be provided to the drug court.

OVERALL PROGRAM RATING

Lucas County Juvenile Drug Court received an overall score of **37.2** percent on the CPC-DC. This falls into the **Ineffective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **31.3** percent, which falls into the **Ineffective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **40.7** percent, which falls into the **Ineffective** category.

FINDINGS - UNISON

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	78.6%	Highly Effective
Quality Assurance	75.0%	Highly Effective
Offender Assessment	25.0%	Ineffective
Treatment	55.2%	Effective
Overall Capacity	**77.8%**	**Highly Effective**
Overall Content	**51.5%**	**Needs Improvement**
Overall Score	**60.8%**	**Effective**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the criminal justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Staff are regularly evaluated with regard to service delivery skills. The program director sits in on groups and offers feedback. Regular peer reviews and file reviews are also conducted.
- Ethical guidelines dictate staff boundaries and interactions with youth.

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- The agency consistently reported being supported by the juvenile drug court and other stakeholders.
- Program funding is rated by staff as adequate and stable.

Recommendations for Improvement:

- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- Staff should receive formal training on the curriculum being used and at least 40 hours of on-going training per year. The majority of the on-going training should be related to clinical skills used to deliver effective programming.

Client Assessment

Strengths:

- The agency follows appropriate exclusionary criteria to ensure clients are appropriate for the treatment provided to them.

Recommendations for Improvement:

- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, or the Massachusetts Youth Screening Instrument (MAYSI).
- Only clients who are high risk and moderate risk should receive intensive treatment services. Also, low risk clients should not be mixed with high risk clients in treatment groups. The agency should utilize the risk assessment used by the court, or conduct its own risk assessment, to determine the risk level of their referrals from drug court.
- The program should serve high and moderate need youth; based on file reviews it is unclear if the program reserved these services for drug court clients with higher levels of dependency issues.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The treatment groups are gender specific.
- The groups start and end on time.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- When there is a co-facilitator in group, both facilitators are actively participating.
- Length of treatment for drug court youth is appropriate. Group sessions meet four times per week for almost two hours. Treatment lasts for four weeks, with two weeks of follow-up sessions.
- Sessions have a set manual or curriculum that is consistently followed.
- Treatment groups are always conducted and monitored by staff.

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- Group size averages between six to twelve clients, and a co-facilitator is always present. The recommended ratio of group members to facilitators is eight to one.
- The types of rewards used by the program appear appropriate and are appropriately applied.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.

Recommendations for Improvement:

- The program uses the Matrix curricula and brings in motivational interviewing, cognitive-behavioral interventions, and pieces from the stages of change. While some of these approaches meet the criteria of evidence-based practices, others do not. The program should have a consistent model, and treatment interventions should ensure that both cognitive restructuring and structured skill building are regularly taking place.
- Homework should be regularly assigned to participants, and the homework should be reviewed by the facilitator and constructive feedback should be provided to the participants.
- The program should address and respond to the learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- The program should use punishers to discourage negative behavior. Currently, the program relies on the probation officers to implement punishers. Punishers should be used to extinguish antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client, and provide feedback. Finally, facilitators should include graduated practice of new skills in increasingly difficult situations.
- Participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to help participants recognize antisocial/distorted thinking and replace those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be developed and clients should regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms via a quality assurance staff member. Quality assurance includes monthly peer and file review and client satisfaction surveys.
- Supervisors sit in on sessions and provide formal feedback to counselors regularly.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

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- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning substance use/abuse.

Overall Program Rating

Unison received an overall score of **60.8** percent on the CPC-DC. This falls into the **Effective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **77.8** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **51.5** percent, which falls into the **Needs Improvement** category.

CONCLUSION

Researchers at the University of Cincinnati have assessed 512 programs nationwide and have developed a large database on correctional intervention programs.[2] Approximately 7 percent of the programs assessed have been classified as HIGHLY EFFECTIVE, 17 percent have been classified as EFFECTIVE, 31 percent have been classified as NEEDS IMPROVEMENT, and 45 percent have been classified as INEFFECTIVE.

Graphs representing the results of this assessment are provided below. The first graph or set of graphs compares the drug court or referral agency score in the capacity domain, content domain, and overall score with the average scores from all 512 programs evaluated by the University of Cincinnati. The final graph shows the drug court score and an average of the scores from all referral agencies used by the drug court compared to the average of all programs evaluated by the University of Cincinnati.

Recommendations have been made in each of the four CPC domains for the Lucas County Juvenile Drug Court. These recommendations should assist the program in making necessary changes to increase program effectiveness. Certainly, care should be taken not to attempt to address all "areas needing improvement" at once. Programs that find the assessment process most useful are those that prioritize need areas and develop action plans to systematically address such needs. Previous programs have also been successful at improving the provision of services by formulating committees charged with developing strategies for delivering evidence-based programming.

This report also provides the drug court with a snapshot of the referral agency where its youth are receiving treatment in the community. This evaluation should assist the drug court in determining what type of treatment is effective when working with juvenile drug court clients. It should also assist the referral agencies with ways they can improve the services they provide to drug court youth.

[2] Several versions of the CPAI were used prior to the development of the CPC. Scores and averages have been adjusted as needed.

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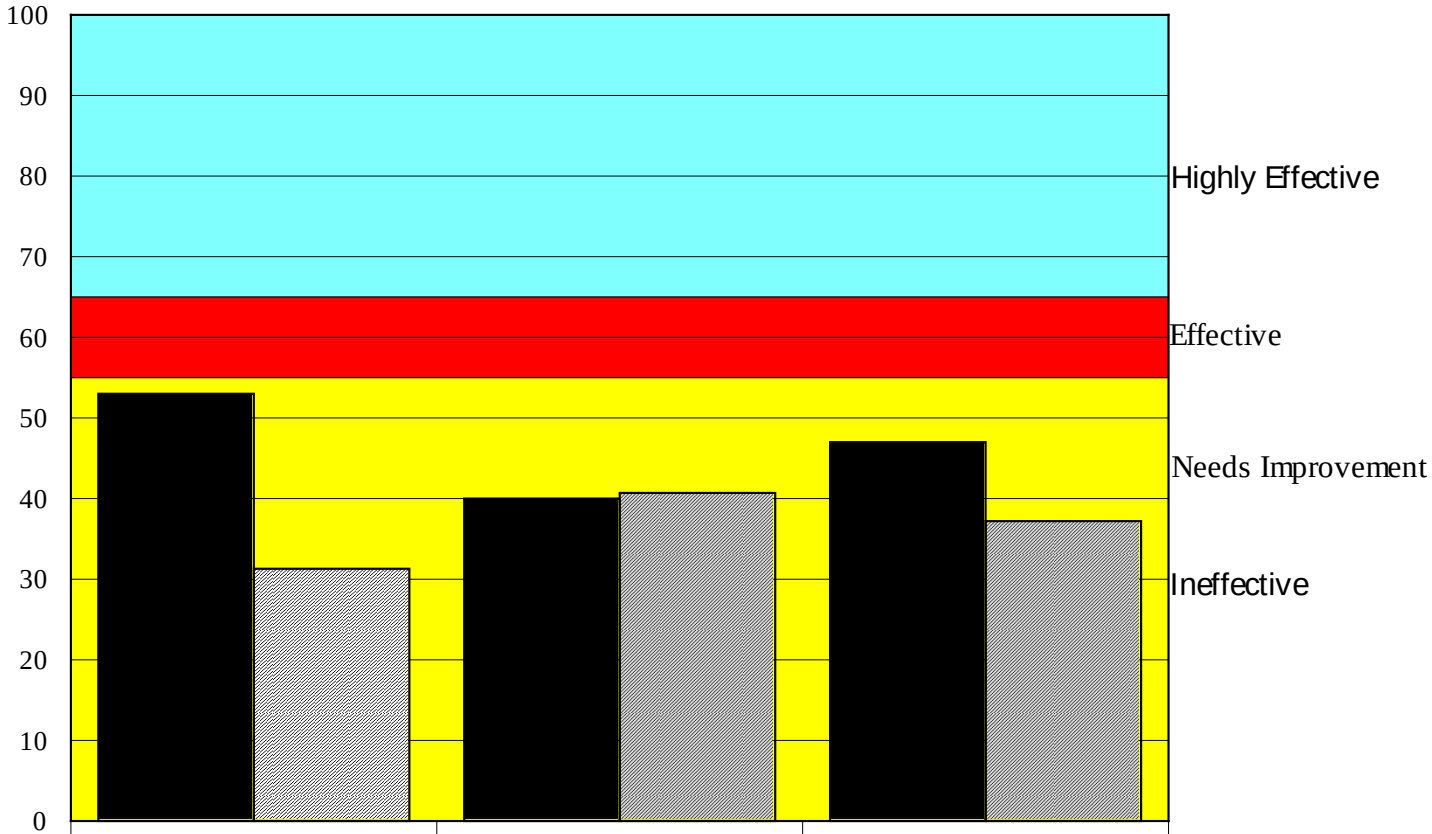
FIGURE 1:
Lucas County Juvenile Drug Court CPC-DC Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Lucas County	31.3	40.7	37.2

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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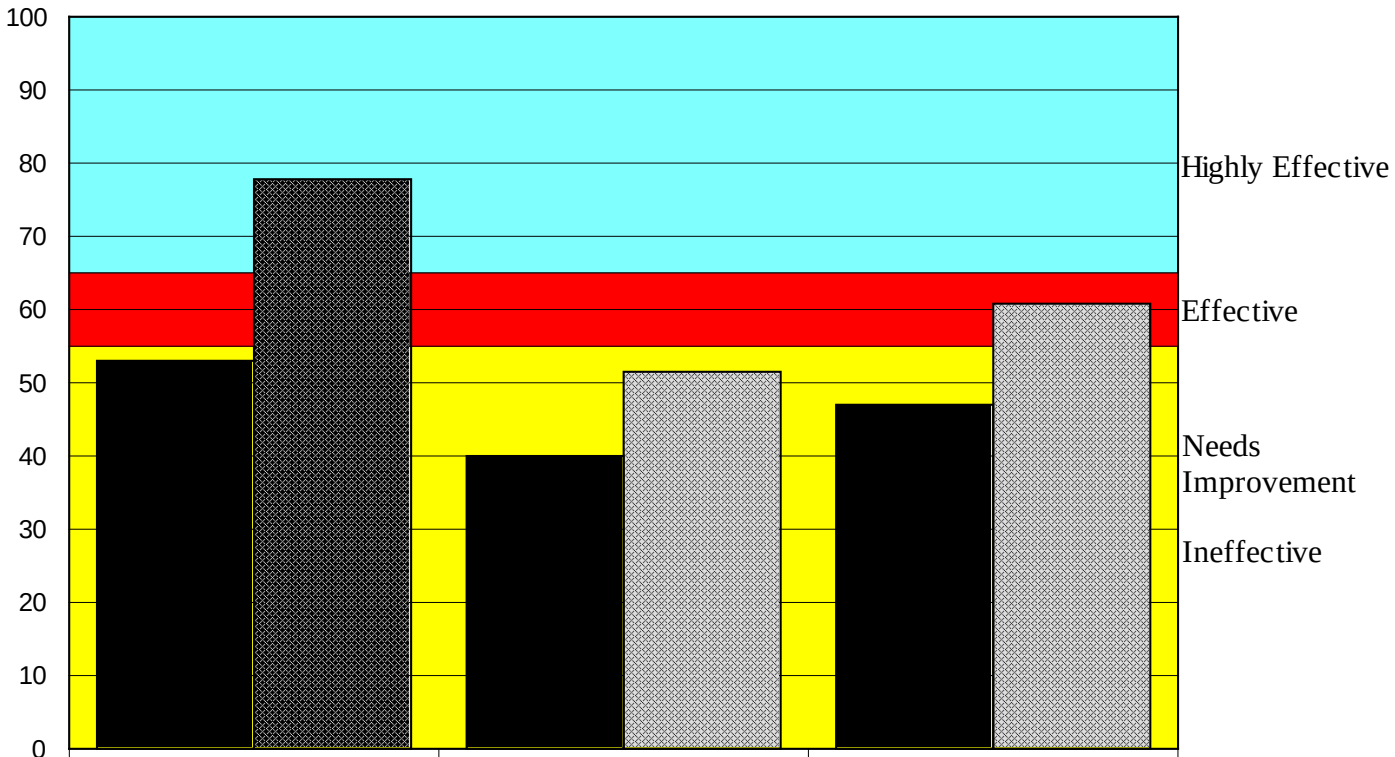
FIGURE 2:
Unison CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Unison	77.8	51.5	60.8

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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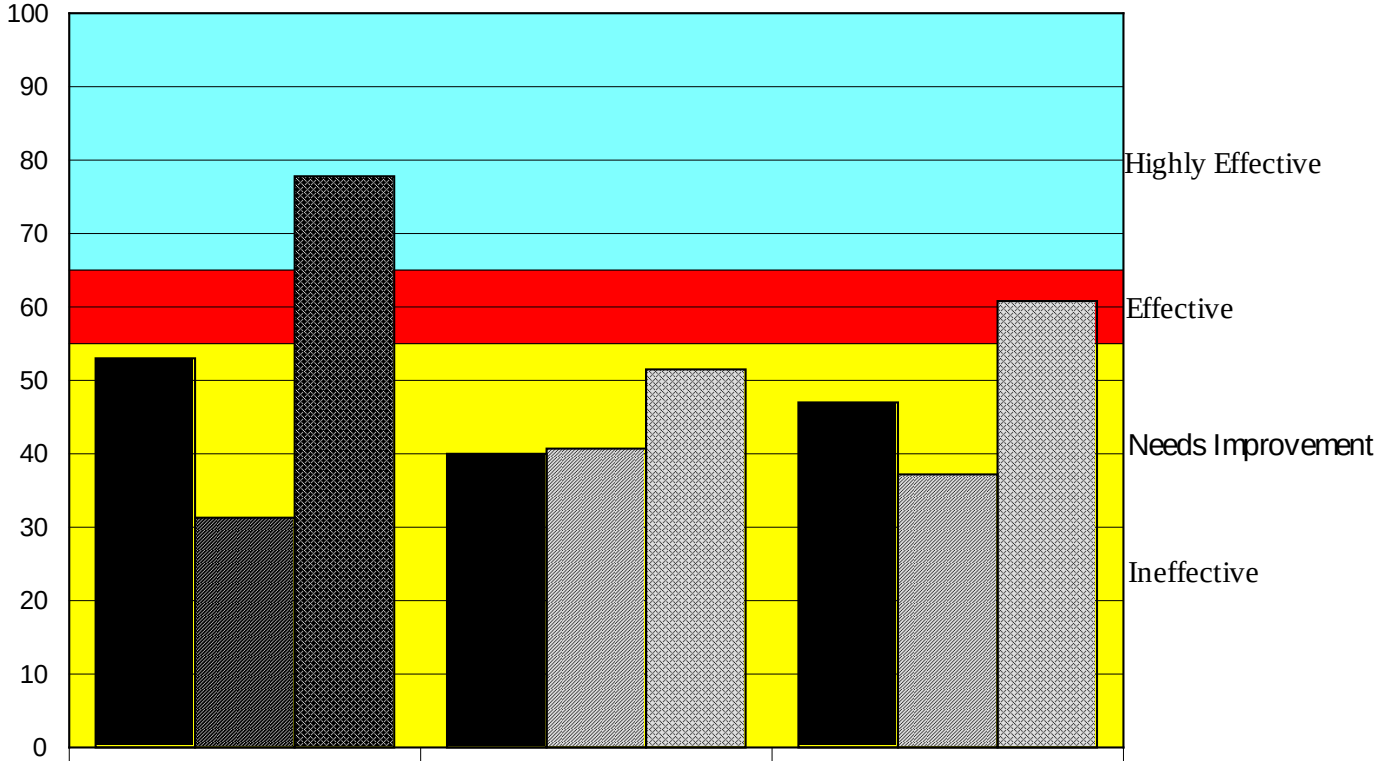
FIGURE 3:
Lucas County Juvenile Drug Court CPC-DC Scores



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EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST – DRUG COURT (CPC-DC) SYNOPSIS OF FINDINGS

Performed as part of the OJJDP study Outcome and Process Evaluation of Juvenile Drug Courts

Medina County Juvenile Drug Court

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OUTCOME AND PROCESS EVALUATION OF JUVENILE DRUG COURTS STUDY

This project is funded by a grant received from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The purpose of this study is to evaluate a national sample of juvenile drug court programs. The goals of this research are: (1) To determine if there is a reduction in recidivism and substance abuse associated with participation in a juvenile drug court program; (2) to determine if there are improvements in social functioning (e.g. school performance, employment, and family functioning) related to participating in juvenile drug court programs; (3) to identify the characteristics of successful juvenile drug court participants; (4) to determine if juvenile drug courts are operating in a manner consistent with an evidence-based approach; (5) to identify the programmatic characteristics of effective juvenile drug courts; and (6) to provide information to policymakers about the effectiveness of drug courts for juvenile offenders.

This study includes both an outcome and a process evaluation. The outcome portion of the study examines outcomes of youth participating in drug courts as compared to similar youth who are on probation. The process evaluation explores the effectiveness of the drug court and drug court programming and is the focus of this report. Ten drug courts from across the country participated in this four-year study, nine of which participated in both the process and outcome evaluation pieces. The final report for the Outcome and Process Evaluation of Juvenile Drug Courts study will offer outcome and process evaluation findings across all nine drug court sites and is expected to be submitted to OJJDP in December 2012.

CONTEXT AND SCOPE OF THIS EVALUATION

The following report is part of a larger national project centered on the effectiveness of juvenile drug court programs and provides a synopsis of findings from the process evaluation, as well as recommendations to enhance the effectiveness of the services delivered by the Medina County Juvenile Drug Court. Programs that adhere to the principles of effective intervention are more likely to impact criminal reoffending (see Andrews & Bonta, 2003 for a review). Specifically, correctional research suggests that cognitive behavioral and social learning models of treatment are associated with considerable reductions in recidivism (Gendreau, 1996; Smith, Goggin & Gendreau, 2002). As such, the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) was used to evaluate the juvenile drug courts participating in the Outcome and Process Evaluation of Juvenile Drug Courts study. The objectives of this assessment are to conduct a detailed review of services and program materials of the juvenile drug courts and the agencies they refer youth to and to compare their current practices with the literature on "best practices" in corrections.

PROCEDURES

Description of the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC)

The Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) is a tool that the University of Cincinnati developed for assessing drug court programs. It is used to determine how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. The CPC-DC was modified from the Evidence-Based Correctional Program Checklist (CPC) [1] and includes important indicators from drug court meta-anlyses (see Shaffer, 2006). The CPC has been

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validated by several recent studies conducted by the University of Cincinnati. These studies found strong correlations between outcome and both domain areas and individual items (Holsinger, 1999; Lowenkamp, 2003; Lowenkamp and Latessa, 2003, Lowenkamp & Latessa, 2005a; Lowenkamp and Latessa, 2005b; Shaffer, 2006). As part of the larger national study, the indicators on the CPC-DC will be validated using the outcome data collected on the drug court participants.

The CPC-DC consists of two instruments: one for the formal drug court (CPC-DC) and the other for the major referral agencies (CPC-DC: RA) involved in providing treatment and services to drug court clients. Each of these tools is divided into two basic areas: Content and Capacity. The capacity area is designed to measure whether the drug court and its referral agencies have the capability to deliver evidence-based interventions and services to offenders. There are two domains in the capacity area: 1) Development, Coordination, Staff and Support, and 2) Quality Assurance. The content area focuses on the substantive aspect of the drug court and its referral agencies, and also includes two areas: 1) Assessment Practices, and 2) Treatment. This area examines the extent to which the drug court and its referral agencies meet the principles of risk, need, responsivity, and treatment.

The Drug Court tool includes 41 indicators, worth 43 total points. The Referral Agency tool has 49 indicators worth a total of 51 points. Each area and all domains are scored and rated as “highly effective” (65% to 100%); “effective” (55% to 64%); “needs improvement” (46% to 54%); or “ineffective” (45% to 0%). The scores in all domains are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the domains are given equal weight. Further, some items may be considered "not applicable," in which case they are not included in the scoring. Data are collected through structured interviews with selected program staff and program participants, as well as through observation of groups and services. In some instances, surveys may be used to gather additional information. Other sources of information include policy and procedure manuals, schedules, treatment materials, curricula, case files, and other selected program materials. Once the information is gathered and reviewed, the program is scored. The following report highlights strengths, areas that need improvement, and recommendations for each of the areas for both the drug court and the referral agencies.

There are several limitations to the CPC-DC that should be noted. First, as with any research process, objectivity and reliability are an issue. Although steps are taken to ensure that the information gathered is accurate and reliable, decisions about the information gathered are invariably made by the assessors. Second, the process is time specific. That is, the assessment is based on the program at the time of the assessment. Though changes or modifications may be planned for the future, only those activities and processes that were present at the time of the review in July 2009 are considered for scoring. Third, the process does not take into account all system issues that can affect program integrity (i.e., political climate of the court). Finally, the process does not address the reasons that a problem exists within a program or why certain practices do or do not take place. Rather, the process is designed to determine the overall integrity of the program.

Despite these limitations, there are a number of advantages to this process. First, the criteria are based on empirically derived principles of effective programs, and all of the indicators included in

[1] The CPC is modeled after the Correctional Program Assessment Inventory developed by Gendreau and Andrews. However, only those indicators that were found to be positively correlated with outcome were retained. In addition, the CPC includes a number of items not contained in the CPAI.

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the CPC-DC are correlated with reductions in recidivism. Second, it allows researchers to get inside the "black box" of a drug court and its referral agencies, something that an outcome study alone does not provide. This means researchers are able to measure the degree to which programs are meeting evidence-based standards. Third, the CPC-DC enables researchers to "quantify" the quality of a program through a scoring process. This allows for comparisons across programs, the setting of benchmarks, and for reassessment to measure progress. Fourth, it identifies both the strengths and weaknesses of a program and provides specific recommendations for program improvement.

Assessment Process

The assessment process consisted of a series of structured interviews with staff members and program participants during an on-site visit to Medina County Juvenile Drug Court on July 15th, 16th, and 17th 2009. Additionally, data were gathered via the examination of ten representative files (five open and five closed) as well as other relevant program materials (e.g., treatment manuals, assessments, training protocol, ethical guidelines, and staff evaluations). Finally, three treatment groups were observed: "Non-Intensive Care (NIC)," "Intensive Care (IC)," and "Parent Project". Five evaluators conducted the various interviews, observations and file reviews. Data from the various sources were then combined to generate a consensus CPC-DC score and the specific recommendations in what follows.

SUMMARY OF THE DRUG COURT

The Medina County Juvenile Drug Court has been in operation since 2004. At the time of the assessment, the drug court was funded by the state of Ohio RECLAIM and Medina County Drug Abuse Commission grants. Youth range in age from thirteen to eighteen and must have a drug-related charge or test positive for drug use, if a not a drug-related case. Only Medina County residents are eligible for the program, and drug trafficking, violent and sex offenders are excluded from participation. At the time of assessment, John Lohn was the drug court judge, Phillip Titterington was the drug court coordinator, Jaclyn Balliet was the drug court intake officer, Tony Miller was the drug court case manager, and Misty Hanson and John Wiencek were the drug court probation officers.

The drug court has two separate tracks: the Non-Intensive Component (NIC) and the Intensive Component (IC). NIC requires clients to progress through three phases of treatment lasting an average of four months. Phase 1 includes individual counseling and four hours weekly of group counseling, as specified by an Individual Service Plan. Phase 2 includes individual counseling and two hours weekly of group counseling, as specified by an Individual Service Plan. In Phase 3, Graduation Phase, youth have not formal counseling schedule, but it is available. IC clients progress through three phases, averaging 11 total months in length. Phase 1 youth spend an average of five hours in drug court programming per week, plus family involvement in parent classes. Phase 2 youth spend an average of three hours in drug court programming per week, plus parental involvement. In Phase 3, Graduation Phase, youth are not required to attend counseling of any kind (unless otherwise specified). Youth in both components must complete an aftercare interview three months after graduation. The drug court relies on the following techniques to supervise youth in the program: curfew, drug and alcohol testing, participation in school or work, and attendance at court. Treatment for youth in the drug court is provided by outside referral agencies. The referral agencies included in this report are Solutions Behavior Healthcare – Outpatient Services (substance abuse and mental health treatment),

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Solutions Equine Therapy (equine-assisted psychotherapy), and Camp Integrity (after school program serving at-risk youth).

FINDINGS – DRUG COURT

CPC-DC SECTIONS	SCORE	RATING
Development, Coordination, Staff and Support	77.8%	Highly Effective
Quality Assurance	28.6%	Ineffective
Offender Assessment	88.9%	Highly Effective
Treatment	50.0%	Needs Improvement
Overall Capacity	**56.3%**	**Effective**
Overall Content	**63.0%**	**Effective**
Overall Score	**60.5%**	**Effective**

Development, Coordination, Staff and Support

Strengths:

- There is a program coordinator who has overall responsibility for oversight and management of the program.
- The program coordinator has a direct role in selecting and approving the individuals hired to provide treatment.
- Regular staff meetings are held to discuss clients in the drug court.
- Drug court staff provide direct case management and supervision services to the youth in the drug court.
- Funding for the drug court is adequate, and there have been no changes in the level of funding in the last two years.
- The drug court has leverage over the youth; the drug court will dismiss the youth's legal charges once the youth completes drug court.

Recommendations for Improvement:

- Drug court staff should be trained on drug court programming and receive at least 40 hours of on-going training a year. Staff training should relate to the theory and practice of interventions used by the drug court and referral agencies and should include effective correctional practices and the cognitive-behavioral model.
- Ethical guidelines should dictate staff boundaries and interactions with drug court youth.

Offender Assessment

Strengths:

- There are established criteria for the exclusion of certain types of offenders. The policy is written and followed, and clients are deemed appropriate for drug court programming by the majority of staff.
- Violent offenders are excluded from participating in the drug court.
- Risk, as well as a range of criminogenic needs, are assessed using the Youthful Level of Service/Case Management Inventory (YLS/CMI). Since the evaluation, Medina County has switched to using the Ohio Youth Assessment System (OYAS).
- Domain specific needs are assessed with the Practical Adolescent Dual Diagnostic Interview (PADDI).

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- Responsivity is assessed using the Jesness Inventory which measures values, immaturity, autism, aggression, withdrawal, depression, social anxiety, and other factors. At the time of the assessment, the drug court was using the Jesness Inventory because an intern was collecting data for her Master's thesis. The drug court should continue to use the Jesness Inventory.
- The drug court targets relevant higher need youth. The file review indicated that 70% were high need for substance abuse and 30% were moderate need for substance abuse.
- Assessments are shared with everyone on the drug court team.

Recommendations for Improvement:

- Drug courts should target moderate and high risk youth, and low risk youth should be screened out. Although moderate to high risk youth are assigned to "Intensive Care," low risk youth are serviced in the "Non-Intensive Care" treatment. Low risk youth are not appropriate for intensive services and should make up no more than 5% of the total drug court participant population.

Treatment Characteristics

Strengths:

- The Medina County Juvenile Drug Court targets a wide range of criminogenic needs and meets criteria that at least 75% of drug court interventions should focus on criminogenic needs. The drug court targets the following criminogenic needs: alcohol/drug abuse; conflict resolution; family affection/communication; family monitoring and supervision; and family problem solving skills.
- The average length in drug court for "Intensive Care" youth is ten months with a range of eight to twelve months. "Non-Intensive Care" youth average four months in drug court. It is recommended that the majority of youth graduate in less than 12 months.
- Drug court participants spend an adequate amount of time in structured activities.
- The drug court completion rate is approximately 75% which falls within the acceptable range.
- The drug court has an appropriate reward structure including verbal praise, phase advancement, candy bars, board games, various gift cards, clothing, and reinstatement of privileges.
- The ratio of rewards to punishers at 4:1. This is consistent with evidence-based practices.
- As part of drug court, the family/caregivers should be trained to provide support, including the ability to identify high risk situations for their youth and strategies for managing their environment using prosocial skills. The drug court meets this criterion by requiring parent participation in a Parent Project group as a formal part of the drug court.
- Youth in the drug court are not required to participate in AA. Youth in drug court should not be required to attend self-help meetings. There is no evidence that these meetings are beneficial to youth and may in fact be harmful.
- The drug court drug tests youth on a regular basis. Non-Intensive Component youth are drug tested at least once every two weeks. Intensive Component youth are drug tested weekly in Phase 1, twice monthly in Phase 2 and randomly as needed in Phase 3.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Observation of groups and interviews with youth in the drug court revealed that little to no cognitive restructuring or role play/practicing of skills took place during group treatment. Instead, groups appeared to be unstructured, using more of a "talk therapy" approach and tended to focus on self-esteem rather than criminogenic needs.

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- Clients should be assigned to groups and services that match their style of learning and other responsivity factors. Since the drug court is using responsivity instruments, those results should be tied to these decisions.
- Intensity of the drug court programming should vary by risk level. High risk youth should receive higher intensity and/or duration of service than moderate risk youth. Moderate risk youth should receive higher intensity and/or duration of service than low risk youth. However, low risk youth should make up no more than 5% of the youth in drug court.
- The drug court should have measurable completion criteria which determine how well a youth has progressed in acquiring prosocial behaviors. While phase advancement is used, other methods should be incorporated such as reassessment on risk/need instruments or other formalized processes which track progress over time.
- The drug court does not appropriately respond to noncompliance. For example, infractions such as being late, missing groups or a drug court session, and using substances need to be addressed consistently across participants. Appropriate punishers include disapproval and response cost – loss of privileges, points, levels, or extra homework. Offenders should be aware of the possible consequences concerning noncompliance.
- After formalized treatment is completed, the drug court should include a high quality aftercare component. The aftercare should be a formal component in which supervision/meetings are required and an evidence-based model is used.

Quality Assurance

Strengths:

- Participant satisfaction with the drug court and treatment programming is measured as part of the graduation process.
- Youth re-arrest, re-conviction, or re-incarceration data is examined regularly by the drug court staff.

Recommendations for Improvement:

- The drug court should have a management audit system in place to evaluate internal and external service providers. This should include site visits, monitoring of sessions or groups, regular progress reports, and file review.
- Offender reassessment should be completed to determine progress on meeting target behaviors. This can be achieved through a pre-post test that measures criminal thinking or through reassessment on validated risk and need instruments (OYAS and PADDI). Examples of a proper pre-post tests for criminal thinking are the Pride in Delinquency Scale (PID), TCU Criminal Thinking Scale (TCU-CTS), How I Think Questionnaire (HIT), and the Criminal Sentiments Scale – Modified (CSS-M).
- The drug court should go through a formal evaluation every five years comparing treatment outcome with a risk-control comparison group. Effectiveness would be supported should there be some reduction in recidivism in the drug court group versus the comparison group.
- A program evaluator should be available (on staff or contract) to assist with research and evaluation of the drug court. Regular reports should be provided to the drug court.

OVERALL PROGRAM RATING

Medina County Juvenile Drug Court received an overall score of 60.5 percent on the CPC-DC. This just falls into the Effective category.

The overall CAPACITY score, designed to measure whether the program has the capability to deliver evidence-based interventions and services for offenders, is 56.3 percent, which falls into the Effective

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category. The overall CONTENT score, which focuses on the substantive domains of assessment and treatment, is 63.0 percent, which falls into the Effective category.

FINDINGS - SOLUTIONS EQUINE THERAPY

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	71.4%	Highly Effective
Quality Assurance	0.0%	Ineffective
Offender Assessment	75.0%	Highly Effective
Treatment	22.2%	Ineffective
Overall Capacity	**55.6%**	**Effective**
Overall Content	**29.0%**	**Ineffective**
Overall Score	**38.8%**	**Ineffective**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the criminal justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by the juvenile drug court and other stakeholders.
- Program funding is adequate and stable.

Recommendations for Improvement:

- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients on a routine basis. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- Staff should be regularly evaluated with regard to service delivery skills. The program director or clinical supervisor should observe group and provide constructive feedback at least once per group cycle.
- Staff should receive formal initial training on the interventions being used by the program and at least 40 hours of on-going training per year, with the majority of training related to clinical skills used to deliver effective programming to offenders.

Client Assessment

Strengths:

- The agency follows written exclusionary criteria for admittance into the program.
- The program has access to the results of the responsivity assessment used by the drug court (Jesness Inventory).

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- Since the group is not targeting criminogenic needs, there is no requirement that the group targets higher risk or higher need youth.

Recommendations for Improvement:

- Since the program is working with youthful offenders, the program should take care to ensure that low risk youth are not mixed into treatment with moderate and high risk youth.

Treatment

Strengths:

- The groups start and end on time.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- Treatment groups are always conducted and monitored by staff.
- Group size is appropriate and averages no more than eight to ten youth per facilitator.

Recommendations for Improvement:

- Treatment should target one or more criminogenic needs, and at least 80% of treatment topics should address these crime producing factors. Examples of criminogenic targets include antisocial attitudes, values and beliefs; antisocial peers; substance abuse; impulsive behavior; and relapse prevention.
- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Homework should be a regular part of the treatment process and should be a formalized component of the services. Homework should be assigned at the end of a session and reviewed at the beginning of the next session. The counselor should consistently review homework with the youth.
- Treatment groups should have a set curriculum or manual that is consistently followed so that the content of each session remains consistent across groups and facilitators. The curriculum/manual should allow for a sufficient number of sessions to achieve change in the target behavior.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Since the drug court assesses youth with Jesness Inventory, the program should use these results to address and respond to individual client barriers.
- The program does not have an array of rewards to use to increase target behavior. Also, rewards should outweigh punishers by a ratio of at least 4:1. The staff report a ratio of no more than 3:1, at the highest.
- The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should also include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator.
- Facilitators should consistently (almost every group or individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.

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- The rapport between the facilitator and participants is lacking. Staff should work on developing strong collaborative relationship with the program participants.
- Facilitators do not work to avoid arguments with participants and do not address resistance appropriately (i.e., utilizing redirection or extinction).
- Juvenile offenders should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths: None.

Recommendations for Improvement:

- The program should incorporate a management audit system that consists of monitoring of groups by a clinical supervisor with feedback for improvement, file review, problem oriented records to monitor treatment progress, and formal offender and parent/caregiver feedback on services.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning the target behavior.
- A formal discharge summary should be created for all clients, and the summary should be provided to the court.

Overall Program Rating

Solutions Equine Therapy received an overall score of 38.8 percent on the CPC-DC. This falls into the Ineffective category.

The overall CAPACITY score, designed to measure whether the program has the capability to deliver evidence-based interventions and services for offenders, is 55.6 percent, which falls into the Effective category. The overall Content score, which focuses on the substantive domains of assessment and treatment, is 29.0 percent, which falls into the Ineffective category.

FINDINGS - SOLUTIONS OUTPATIENT PROGRAM*

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	71.4%	Highly Effective
Quality Assurance	50.0%	Needs Improvement
Offender Assessment	75.0%	Highly Effective
Treatment	39.3%	Ineffective
Overall Capacity	**66.7%**	**Highly Effective**
Overall Content	**43.8%**	**Ineffective**
Overall Score	**52.0%**	**Needs Improvement**

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Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by the juvenile drug court and other stakeholders.
- Program funding is adequate and stable.

Recommendations for Improvement:

- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients on a routine basis. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- Staff should be regularly evaluated with regard to service delivery skills. The program director or clinical supervisor should observe group and provide constructive feedback at least once per group cycle.
- Staff should receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of training related to clinical skills used to deliver effective programming to offenders.

Client Assessment

Strengths:

- The agency follows appropriate exclusionary criteria to ensure clients are appropriate for the treatment provided to them. For example, youth must fall within a certain age range.
- Responsivity is measured by the program by accessing the results of the Jesness Inventory used by the drug court and also through the So-Quick.

*Findings for Solutions Outpatient Program include both the Non-Intensive Component and the Intensive Component.

- The program targets higher risk youth by requiring that clients be a certain risk level as determined by the Youthful Level of Service/Case Management Inventory (YLS/CMI) that is used by the drug court.

Recommendations for Improvement:

- The program should target relevant higher need youth. Currently, any youth with identified substance use is admitted to the program. The program should consider implementing a minimum score on the PADDI (which the drug court uses) to make sure that only youth who need intensive services are admitted to the program.

Treatment

Strengths:

- The groups start and end on time.
- The group facilitators are knowledgeable about the materials discussed in group.

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- The group facilitators encourage participation in the group.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- For drug court youth, groups meet for two hours once per week for a minimum of eight sessions. This length of treatment is sufficient to impact the target behavior.
- Treatment groups are always conducted and monitored by staff.
- Group size averages between eight and ten youth. When there are twelve or more participants, a co-facilitator is present and active in group.
- The program uses a range of reinforcers, including choices in group structure, verbal praise and snacks.
- The program uses appropriate punishers for noncompliance, including additional program requirements and not counting the current session towards phase advancement.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance in group.

Recommendations for Improvement:

- Treatment should target one or more criminogenic needs, and at least 80% of treatment topics should address these needs. Examples of criminogenic targets include antisocial attitudes, values and beliefs; antisocial peers; substance abuse; impulsive behavior; and relapse prevention.
- Treatment modalities that have been determined effective in changing offender behavior should be utilized. The program uses the Hazelton Experiential Learning Program, but group observation evidenced that the facilitators did not follow the curriculum. Groups are mostly talk therapy. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e. teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Males and females are more productive in treatment sessions when they attend treatment separately. Treatment groups should be gender specific.
- Homework should be regularly assigned to participants as part of treatment groups, and the homework should be reviewed by the facilitator and constructive feedback should be provided to the participants. Homework is extremely important so that youth are provided additional opportunities to practice the skill or concept learned in the group.
- Groups should have a set curriculum or manual that is consistently followed. While staff state that the Hazelton curriculum is followed, group observation found that it is not regularly followed.
- The program and group facilitators should address and respond to the different learning styles and barriers of the participants in the group. The program should ensure that the results of the drug court responsivity assessment are integrated into programming.
- While the program has an array of appropriate rewards to use to encourage positive behavior, appropriate application of rewards is lacking. Rewards should be contingent on the youth displaying appropriate behavior before the reward is administered. Rewards should also outweigh punishers by a ratio of at least 4:1.
- Similarly, while appropriate punishers are used to help extinguish negative behavior, appropriate application of punishers is lacking. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator.
- Facilitators should consistently (almost every group or individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.

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- Participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be developed and clients should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms via monthly file review and participant satisfaction surveys.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- Internal quality assurance could be improved by providing observation of direct service with feedback to staff. Observation should occur once every group cycle, and formal feedback should be provided to the facilitator.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning substance use and abuse. Currently, a pre-post test is given on drug education only.

Overall Program Rating

Solutions Outpatient program received an overall score of 52.0 percent on the CPC-DC. This falls into the Needs Improvement category.

The overall CAPACITY score, designed to measure whether the program has the capability to deliver evidence-based interventions and services for offenders, is 66.7 percent, which falls into the Highly Effective category. The overall Content score, which focuses on the substantive domains of assessment and treatment, is 43.8 percent, which falls into the Ineffective category.

FINDINGS – CAMP INTEGRITY

CPC-DC: RA SECTIONS	SCORE	RATING
Program Leadership & Development	50.0%	Needs Improvement
Staff Characteristics	36.4%	Ineffective
Offender Assessment	53.3%	Needs Improvement
Treatment Characteristics	12.1%	Ineffective
Quality Assurance	0.0%	Ineffective
Overall Capacity	**33.3%**	**Ineffective**
Overall Content	**25.0%**	**Ineffective**
Overall Score	**28.4%**	**Ineffective**

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Overall Program Rating

Prior to this assessment for the Outcome and Process Evaluation of Juvenile Drug Courts, Camp Integrity had been evaluated by Paula Smith and Myrinda Schweitzer, of the University of Cincinnati Corrections Institute. This evaluation took place in May 2009 using the full Evidence-Based Correctional Program Checklist (CPC). Therefore, Camp Integrity was not re-assessed for this current project.

On the full CPC, Camp Integrity received an overall score of 28.4 percent on the CPC-DC. This falls into the Ineffective category. The overall CAPACITY score, designed to measure whether the program has the capability to deliver evidence-based interventions and services for offenders, is 33.3 percent, which falls into the Ineffective category. The overall Content score, which focuses on the substantive domains of assessment and treatment, is 25.0 percent, which falls into the Ineffective category.

The Medina County Juvenile Drug Court should obtain a copy of the full CPC report from Camp Integrity if it would like the full results of the assessment.

CONCLUSION

Researchers at the University of Cincinnati have assessed 512 programs nationwide and have developed a large database on correctional intervention programs.[2] Approximately 7 percent of the programs assessed have been classified as HIGHLY EFFECTIVE, 17 percent have been classified as EFFECTIVE, 31 percent have been classified as NEEDS IMPROVEMENT, and 45 percent have been classified as INEFFECTIVE.

Graphs representing the results of this assessment are provided below. The first graph or set of graphs compares the drug court or referral agency score in the capacity domain, content domain, and overall score with the average scores from all 512 programs evaluated by the University of Cincinnati. The final graph shows the drug court score and an average of the scores from all referral agencies used by the drug court compared to the average of all programs evaluated by the University of Cincinnati.

Recommendations have been made in each of the four CPC domains for the Medina County Juvenile Drug Court. These recommendations should assist the program in making necessary changes to increase program effectiveness. Certainly, care should be taken not to attempt to address all "areas needing improvement" at once. Programs that find the assessment process most useful are those that prioritize need areas and develop action plans to systematically address such needs. Previous programs have also been successful at improving the provision of services by formulating committees charged with developing strategies for delivering evidence-based programming.

This report also provides the drug court with a snapshot of the referral agencies where its youth are receiving treatment in the community. This evaluation should assist the drug court in determining what type of treatment is effective when working with juvenile drug court clients. It should also assist the referral agencies with ways they can improve the services they provide to drug court youth.

[2] Several versions of the CPAI were used prior to the development of the CPC. Scores and averages have been adjusted as needed.

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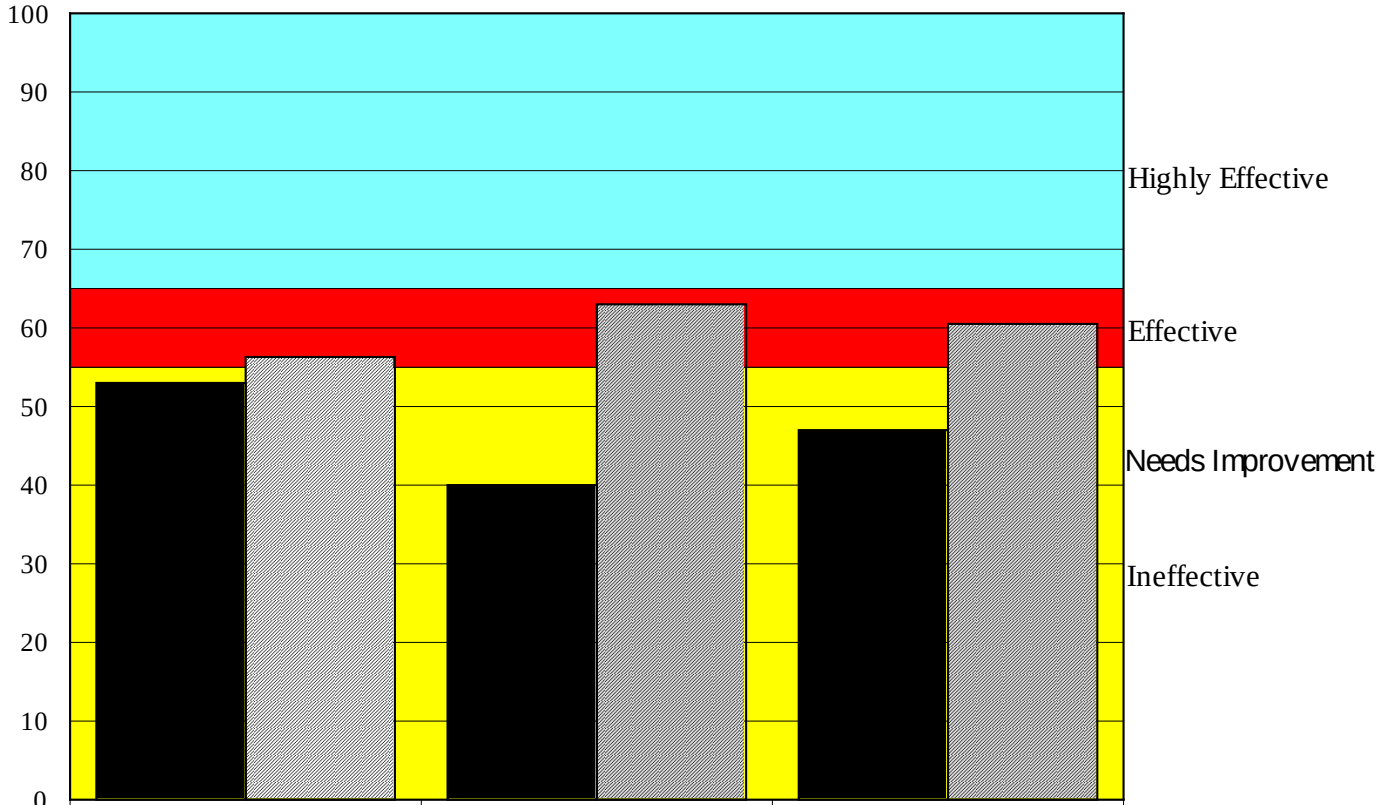
FIGURE 1:
Medina County Juvenile Drug Court CPC-DC Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Medina County	56.3	63	60.5

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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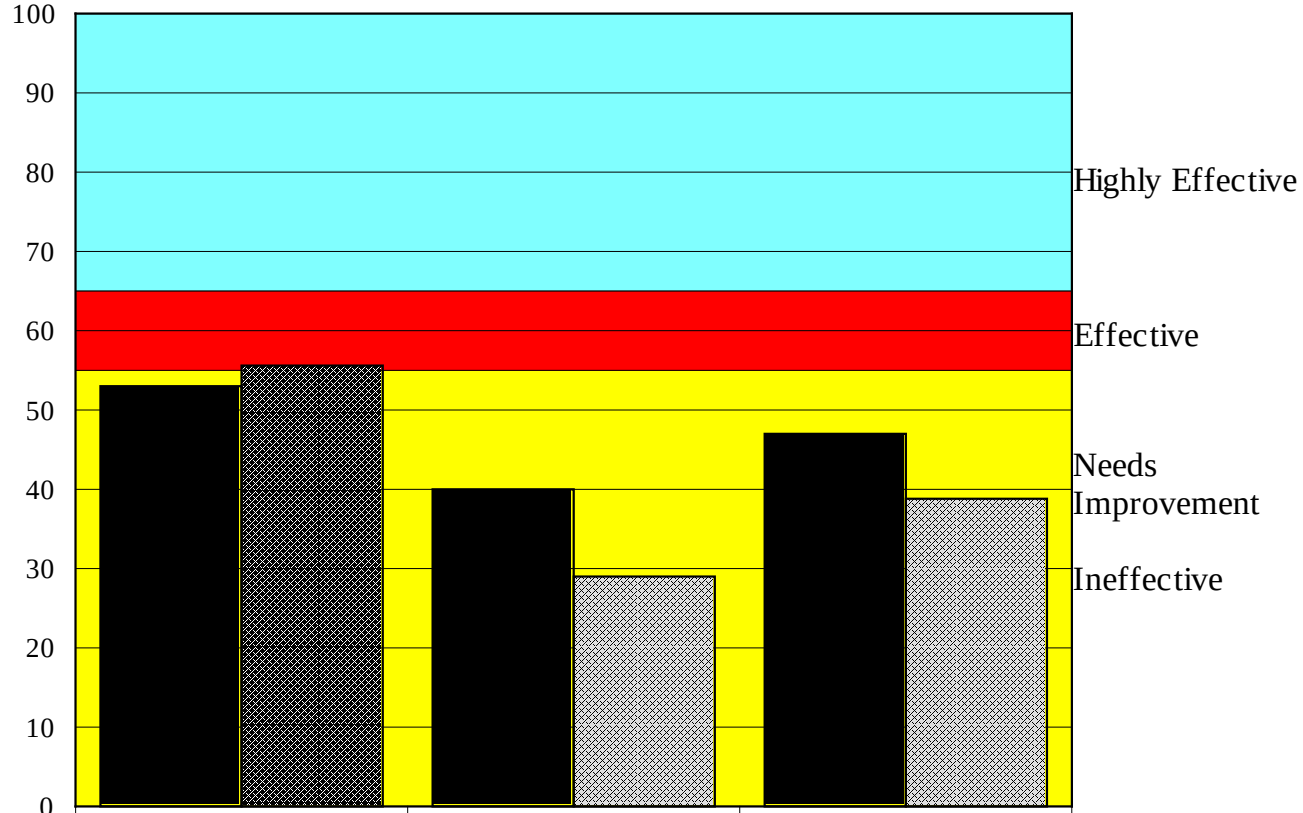
FIGURE 2:

Solutions Equine Therapy CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Solutions Equine Therapy	55.6	29	38.8

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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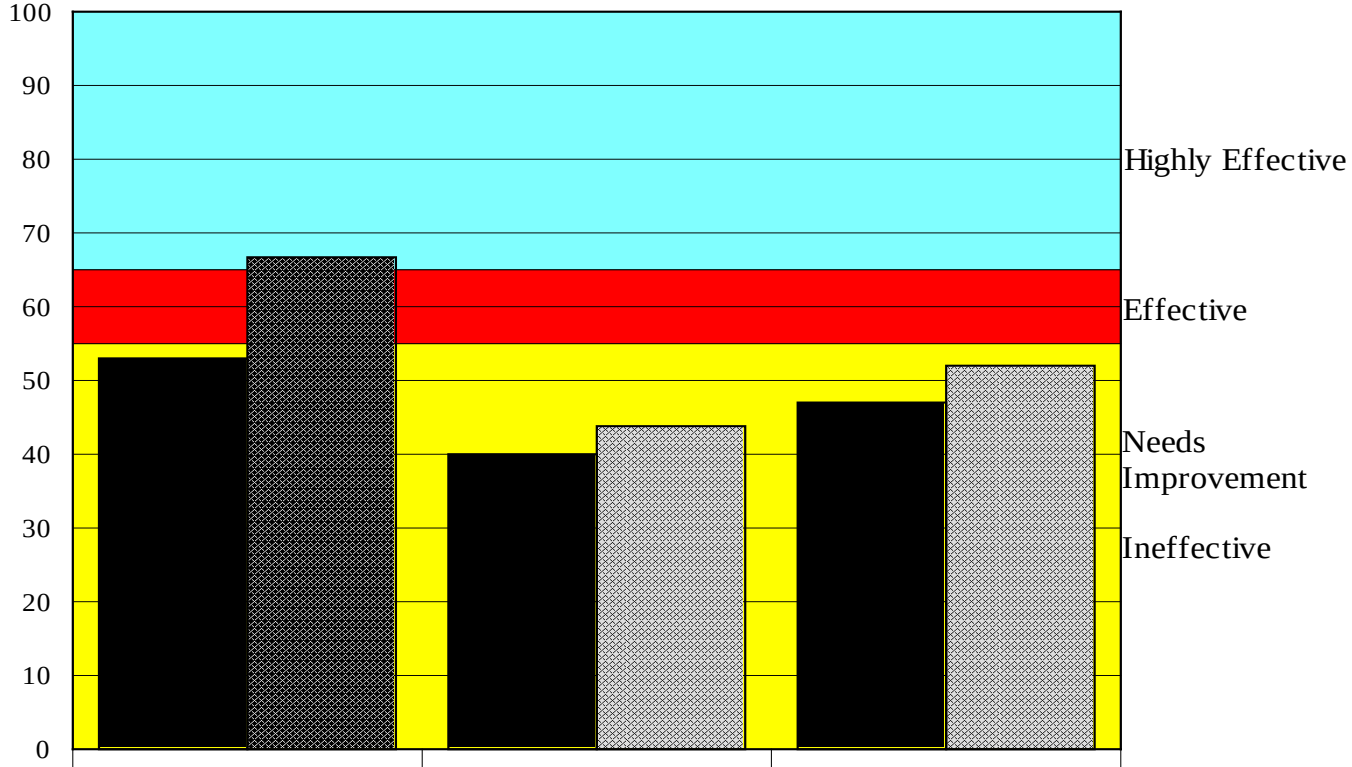
FIGURE 3:

Solutions Outpatient CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Solutions Outpatient	66.7	43.8	52

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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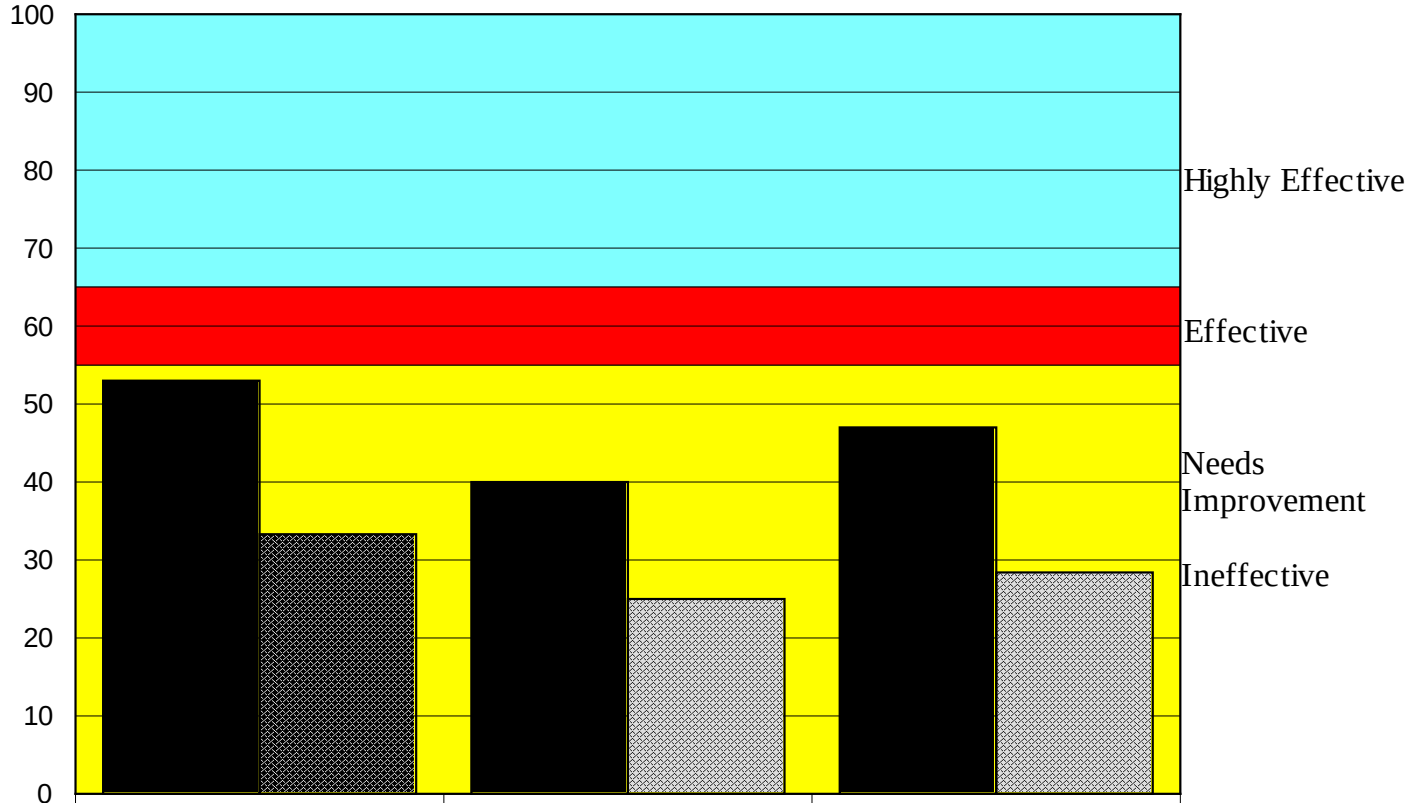
FIGURE 4:
Camp Integrity CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Camp Integrity	33.3	25	28.4

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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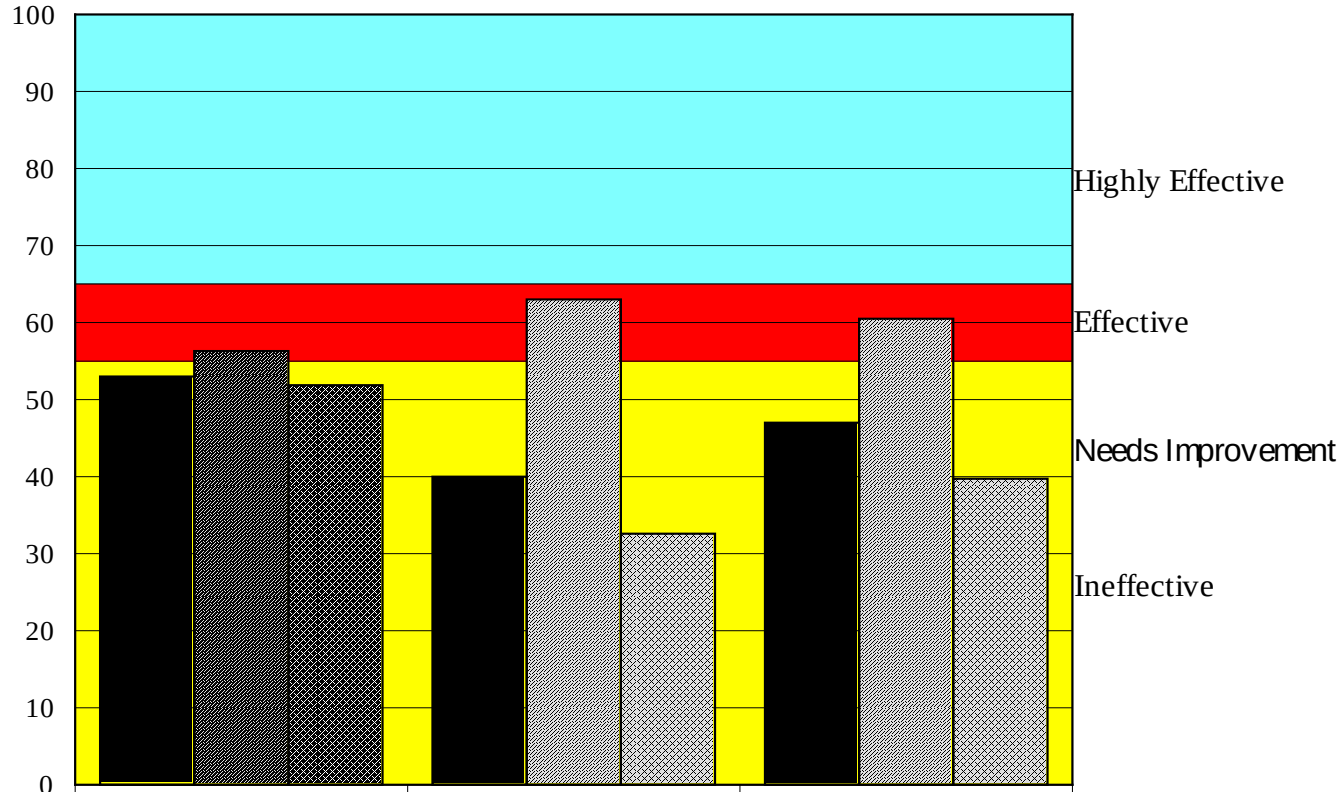
FIGURE 5:
Medina County Juvenile Drug Court Overall



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Medina County	56.3	63	60.5
Referral Agency Average	51.87	32.6	39.73

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST – DRUG COURT (CPC-DC) SYNOPSIS OF FINDINGS

Performed as part of the OJJDP study Outcome and Process Evaluation of Juvenile Drug Courts

Rhode Island County Juvenile Drug Court

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Final Report Submitted: March 2012

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OUTCOME AND PROCESS EVALUATION OF JUVENILE DRUG COURTS STUDY

This project is funded by a grant received from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The purpose of this study is to evaluate a national sample of juvenile drug court programs. The goals of this research are: (1) To determine if there is a reduction in recidivism and substance abuse associated with participation in a juvenile drug court program; (2) to determine if there are improvements in social functioning (e.g. school performance, employment, and family functioning) related to participating in juvenile drug court programs; (3) to identify the characteristics of successful juvenile drug court participants; (4) to determine if juvenile drug courts are operating in a manner consistent with an evidence-based approach; (5) to identify the programmatic characteristics of effective juvenile drug courts; and (6) to provide information to policymakers about the effectiveness of drug courts for juvenile offenders.

This study includes both an outcome and a process evaluation. The outcome portion of the study examines outcomes of youth participating in drug courts as compared to similar youth who are on probation. The process evaluation explores the effectiveness of the drug court and drug court programming and is the focus of this report. Ten drug courts from across the country participated in this four-year study, nine of which participated in both the process and outcome evaluation pieces. The final report for the Outcome and Process Evaluation of Juvenile Drug Courts study will offer outcome and process evaluation findings across all nine drug court sites and is expected to be submitted to OJJDP in December 2012.

CONTEXT AND SCOPE OF THIS EVALUATION

The following report is part of a larger national project centered on the effectiveness of juvenile drug court programs and provides a synopsis of findings from the process evaluation, as well as recommendations to enhance the effectiveness of the services delivered by the Rhode Island County Juvenile Drug Court. Programs that adhere to the principles of effective intervention are more likely to impact criminal reoffending (see Andrews & Bonta, 2003 for a review). Specifically, correctional research suggests that cognitive behavioral and social learning models of treatment are associated with considerable reductions in recidivism (Gendreau, 1996; Smith, Goggin & Gendreau, 2002). As such, the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) was used to evaluate the juvenile drug courts participating in the Outcome and Process Evaluation of Juvenile Drug Courts study. The objectives of this assessment are to conduct a detailed review of services and program materials of the juvenile drug courts and the agencies they refer youth to and to compare their current practices with the literature on "best practices" in corrections.

PROCEDURES

Description of the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC)

The Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) is a tool that the University of Cincinnati developed for assessing drug court programs. It is used to determine how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. The CPC-DC was modified from the Evidence-Based Correctional Program Checklist (CPC) [1] and includes important indicators from drug court meta-analyses (see Shaffer, 2006). The CPC

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has been validated by several recent studies conducted by the University of Cincinnati. These studies found strong correlations between outcome and both domain areas and individual items (Holsinger, 1999; Lowenkamp, 2003; Lowenkamp and Latessa, 2003, Lowenkamp & Latessa, 2005a; Lowenkamp and Latessa, 2005b; Shaffer, 2006). As part of the larger national study, the indicators on the CPC-DC will be validated using the outcome data collected on the drug court participants.

The CPC-DC consists of two instruments: one for the formal drug court (CPC-DC) and the other for the major referral agencies (CPC-DC: RA) involved in providing treatment and services to drug court clients. Each of these tools is divided into two basic areas: Content and Capacity. The capacity area is designed to measure whether the drug court and its referral agencies have the capability to deliver evidence-based interventions and services to offenders. There are two domains in the capacity area: 1) Development, Coordination, Staff and Support, and 2) Quality Assurance. The content area focuses on the substantive aspect of the drug court and its referral agencies, and also includes two areas: 1) Assessment Practices, and 2) Treatment. This area examines the extent to which the drug court and its referral agencies meet the principles of risk, need, responsivity, and treatment.

The Drug Court tool includes 41 indicators, worth 43 total points. The Referral Agency tool has 49 indicators worth a total of 51 points. Each area and all domains are scored and rated as “highly effective” (65% to 100%); “effective” (55% to 64%); “needs improvement” (46% to 54%); or “ineffective” (45% to 0%). The scores in all domains are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the domains are given equal weight. Further, some items may be considered "not applicable," in which case they are not included in the scoring. Data are collected through structured interviews with selected program staff and program participants, as well as through observation of groups and services. In some instances, surveys may be used to gather additional information. Other sources of information include policy and procedure manuals, schedules, treatment materials, curricula, case files, and other selected program materials. Once the information is gathered and reviewed, the program is scored. The following report highlights strengths, areas that need improvement, and recommendations for each of the areas for both the drug court and the referral agencies.

There are several limitations to the CPC-DC that should be noted. First, as with any research process, objectivity and reliability are an issue. Although steps are taken to ensure that the information gathered is accurate and reliable, decisions about the information gathered are invariably made by the assessors. Second, the process is time specific. That is, the assessment is based on the program at the time of the assessment. Though changes or modifications may be planned for the future, only those activities and processes that were present at the time of the review in September 2009 are considered for scoring. Third, the process does not take into account all system issues that can affect program integrity (i.e., political climate of the court). Finally, the process does not address the reasons that a problem exists within a program or why certain practices do or do not take place. Rather, the process is designed to determine the overall integrity of the program.

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[1] The CPC is modeled after the Correctional Program Assessment Inventory developed by Gendreau and Andrews. However, only those indicators that were found to be positively correlated with outcome were retained. In addition, the CPC includes a number of items not contained in the CPAI.

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Despite these limitations, there are a number of advantages to this process. First, the criteria are based on empirically derived principles of effective programs, and all of the indicators included in the CPC-DC are correlated with reductions in recidivism. Second, it allows researchers to get inside the "black box" of a drug court and its referral agencies, something that an outcome study alone does not provide. This means researchers are able to measure the degree to which programs are meeting evidence-based standards. Third, the CPC-DC enables researchers to "quantify" the quality of a program through a scoring process. This allows for comparisons across programs, the setting of benchmarks, and for reassessment to measure progress. Fourth, it identifies both the strengths and weaknesses of a program and provides specific recommendations for program improvement.

Assessment Process

The assessment process consisted of a series of structured interviews with staff members and program participants during an on-site visit to the Rhode Island County Juvenile Drug Court in September 2009. Additionally, ten files (five open and five closed) as well as other relevant program materials (e.g., treatment manuals, assessments, training protocol, ethical guidelines, and staff evaluations) were examined. Finally, nine referral programs were reviewed: The Providence Center, All Things Considered, three programs run by Phoenix House of New England, Providence Community Action (ProCAP), Thompson Resources Limited, and individual treatment programs with Robert O'Neil and Nicole Hebert. Three evaluators conducted the various interviews, observations and file reviews. Data from the various sources were then combined to generate a consensus CPC-DC score and the specific recommendations in what follows.

SUMMARY OF THE DRUG COURT

The Rhode Island County Juvenile Drug Court has been in operation since 2000. The drug court is funded by the state and operates out of several locations across the state. Youth range in age from thirteen to seventeen and must be charged with a drug related offense, or another non-violent offense and have known substance abuse issues. At the time of assessment, Judge Murray was the drug court judge and Kevin Richard was the program director.

The drug court has both a post-adjudication and a pre-adjudication/diversion program. Graduation from drug court depends on the successful completion of all recommended treatment, which varies on a case-by-case basis. Post-adjudication drug court participants must have clean urine screens for six months in order to successfully graduate. Diversion drug court youth must have clean urine screens for three months in order to successfully graduate. An additional distinction between the two types of drug court programs is that diversion youth will have their records sealed upon successful graduation. The drug court relies on the following techniques to supervise youth in the program: curfew, drug and alcohol testing, home and school visits, and attendance at court. The drug court also has the option to assess and provide services to youth through the Rhode Island Juvenile Mental Health Clinic. Approximately a quarter of youth in the drug court are referred to the Rhode Island Juvenile Mental Health Clinic. In these cases the clinic assists the drug court in determining a treatment plan.

The drug court utilizes several referral agencies for treatment. The following agencies were evaluated for this report: Providence Center (Multi-Systemic Therapy); All Things Considered

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(individual outpatient substance abuse treatment); Phoenix Houses of New England (outpatient substance abuse treatment, residential substance abuse treatment, and shelter care); Providence Community Action (ProCAP; outpatient substance abuse treatment); Thompson Resources Limited (individual substance abuse treatment); Robert O'Neil (individual mental health and substance abuse counseling); and Nicole Hebert, LICSW (individual mental health and substance abuse counseling).

FINDINGS – DRUG COURT

CPC-DC SECTIONS	SCORE	RATING
Development, Coordination, Staff and Support	22.2%	Ineffective
Quality Assurance	28.6%	Ineffective
Offender Assessment	22.2%	Ineffective
Treatment	27.8%	Ineffective
Overall Capacity	**25.0%**	**Ineffective**
Overall Content	**25.9%**	**Ineffective**
Overall Score	**25.6%**	**Ineffective**

Development, Coordination, Staff and Support

Strengths:

- There is a program coordinator who has overall responsibility for oversight and management of the program.
- Drug court staff provide direct case management and supervision services to the youth in the drug court.

Recommendations for Improvement:

- The program coordinator should have a direct role in selecting, approving, and supervising the counselors/staff hired to provide treatment. This helps to ensure that all treatment providers are providing evidence-based treatment services to the drug court youth.
- Drug court staff meetings should occur at least bi-monthly, and all referral agencies should be represented at each meeting. Essentially, a drug court team should be assembled and meet regularly in a formal practice to ensure that each youth's progress in the program is discussed and problems addressed.
- Staff who work in the drug court should be formally trained on drug court programming and receive at least 40 hours of on-going training a year. Staff training should relate to the theory and practice of interventions used by the drug court, effective correctional practices, and the cognitive-behavioral model.
- Ethical guidelines should dictate staff boundaries and interactions with drug court youth.
- Funding for the drug court is less than adequate to implement the drug court model as designed. For example, the evaluators were consistently told that the drug court needed additional staff to handle the volume of kids accepted into the drug court's programs. Additionally, the drug court lost its federal funding and now relies on state funding and grants. This has caused some instability in funding the drug court. The program coordinator should work to ensure that drug court funding remains stable.
- The drug court accepts a mix of pre- and post-conviction/adjudication youth. Drug courts have more impact on recidivism rates when they accept only youth who are pre-

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conviction/adjudication and the youth's charges are held in abeyance (or sealed), dropped, or reduced if the youth successfully completes drug court.

Offender Assessment

Strengths:

- There are established criteria for the exclusion of certain types of offenders. The policy is written and followed, and clients were deemed appropriate for drug court by the majority of staff.
- Violent offenders are excluded from participating in the drug court.

Recommendations for Improvement:

- Risk, as well as a range of criminogenic need factors should be assessed using a validated, standardized, and objective instrument. Examples of proper instrumentation include the COMPAS Youth, Positive Achievement Change Tool (PACT), Youth Level of Service/Case Management Inventory (YLS/CMI), Youth Assessment and Screening Instrument (YASI), and the Ohio Youth Assessment System (OYAS).
- Domain specific needs, especially substance abuse, should be assessed using a validated, standardized, and objective instrument. Examples of proper instrumentation for substance abuse include the Adolescent Substance Abuse Subtle Screening Inventory (SASSI) and the Juvenile Automated Substance Abuse Evaluation (JASAE). Use of a substance abuse assessment will ensure that only youth with a need for substance abuse services will be accepted into the drug court.
- The drug court should assess factors that directly affect engagement in the drug court or treatment programming. Additionally, there should be evidence that clinical or staffing decisions are made based upon these responsivity factors. While the Rhode Island Mental Health Clinic does assess for responsivity using the MAYSI-2, Voice DISC, CBCL/YSR, K-BIT-2, WRAT-4, and the MMPI-A, only a quarter of drug court youth are receiving these assessments. As all of these assessments are not needed to meet CPC criterion, the drug court should consider assessing at least two major factors, such as personality, motivational level/readiness for change, or mental illness, for each youth in the drug court. In addition to the responsivity instrumentation that the clinic is using, the TCU Client Self-Rating scale, Jesness Inventory, Beck's Depression, and IQ tests could be used.
- Drug courts should target moderate and high risk youth. It is recommended that low risk youth make up no more than 5% of drug court clients. Since, at the time of this assessment, the drug court was not using a validated assessment instrument, assessors cannot guarantee the clients are high and moderate risk. The use of a risk and need assessment will help ensure that only high and moderate risk youth are accepted into the drug court.
- Assessments should be freely shared with everyone on the drug court team, including referral agencies.

Treatment Characteristics

Strengths:

- The Rhode Island County Juvenile Drug Court targets a wide range of criminogenic needs and meets criteria that at least 75% of drug court interventions should focus on criminogenic

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needs. The drug court targets the following criminogenic needs: alcohol or drug abuse; school/work; family affection/communication; and family monitoring and supervision.

- Over the past ten years, the completion rate for the Rhode Island County Juvenile Drug Court is approximately 70%. This falls into the recommended completion rate range.
- The Rhode Island County Juvenile Drug Court does not require youth to participate in AA. There is no evidence that these meetings are beneficial to youth and may in fact be harmful.
- The drug court randomly drug tests youth on a regular basis.

Recommendations for Improvement:

- Although the Rhode Island County Juvenile Drug Court uses some evidence-based treatment models (i.e., MST) to address criminogenic needs, the majority of the agencies targeting criminogenic needs (substance abuse and family) are not employing evidence-based treatment approaches. Treatment modalities that have been determined effective in changing offender behavior should be employed by all referral agencies. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- While the average length of drug court is four to six months for pre-adjudication youth and eight to ten months for post-adjudication youth, a lot of drug court youth stay involved in drug court for up to two years due to education requirements. It is recommended that the majority of youth graduate in less than 12 months.
- Drug court participants do not spend enough time in structured activities. Staff consistently report that drug court youth only spend about an hour per week in structured activities outside of school. It is recommended that 40-70% of a youth's time in drug court be spent in structured, supervised activities. These include, court, treatment, school, and other formal activities designed to reduce crime producing factors.
- Clients should be assigned to groups and services that match their style of learning and other responsivity factors. The drug court should use a responsivity instrument to assess which groups are best for which client. See the listing under the Offender Assessment category for specific responsivity instrument recommendations.
- Intensity of the drug court programming should vary by risk level. High risk youth should receive higher intensity and/or duration of services (both supervision and treatment) than moderate risk youth. Moderate risk youth should receive higher intensity and/or duration of services than low risk youth. Low risk youth should make up no more than 5% of the youth in drug court.
- The drug court should have measurable completion criteria which determine how well a youth has progressed in acquiring prosocial behaviors. These criteria should be objective and standardized. Examples of measurable completion criteria are behavioral assessment instruments, checklists of behaviors and/or attitudes, completion of a detailed treatment plan, phase advancement, and the acquisition of new skills and behaviors while in the drug court.
- The drug court should have an identified pool of appropriate rewards to use to encourage program participation and reward progress in drug court. Appropriate rewards include earning privileges, certificates of completion, praise/acknowledgement, points/tokens, gift

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certificates, and reduction in time. Additionally, staff should be trained in the use of rewards, and there should be a written policy on the use of rewards.

- The ratio of rewards to punishers should be at least 4:1. The drug court staff report a ratio of 1:1 at most. The use of rewards should be significantly increased.
- The drug court does not appropriately respond to noncompliance. For example, infractions such as being late, missing groups or a drug court session, and using substances needs to be addressed consistently across participants. Appropriate punishers include disapproval and response cost – loss of privileges, points, levels, or extra homework. Offenders should be aware of the possible consequences of noncompliance.
- As part of drug court, the family/caregivers should be trained to provide support, including the ability to identify high risk situations for their youth and strategies for managing their environment using prosocial skills. Family groups should therefore target prosocial behavior, and participation should be mandatory. Currently, there is no requirement for parent participation beyond court appearances, and only a very few select youth and families participate in MST. Examples of evidence-based family/caregiver curriculum include: The Parent Project, Common Sense Parenting, Strengthening Families Program, and Parenting Wisely.
- After formalized treatment is completed, the drug court should include a high quality aftercare component. The aftercare should be a formal component in which supervision/meetings are required and an evidence-based model is used.

Quality Assurance

Strengths:

- Youth re-arrest, re-conviction, or re-incarceration data is examined regularly by the drug court staff.
- A formal program evaluation was completed by the National Center for State Courts in 2005.

Recommendations for Improvement:

- The drug court should have a management audit system in place to evaluate internal and external service providers. This should include site visits, monitoring of groups, regular progress reports, and file review.
- Participant satisfaction with the drug court and treatment programming should be measured with an exit survey.
- Offender reassessment should be completed to determine progress on meeting target behaviors. This can be achieved through a pre-post test that measures criminal thinking or through reassessment on validated risk and need instruments. Examples of a proper pre-post tests for criminal thinking are the Pride in Delinquency Scale (PID), TCU Criminal Thinking Scale (TCU-CTS), How I Think Questionnaire (HIT), and the Criminal Sentiments Scale – Modified (CSS-M).
- While the Rhode Island Juvenile Drug Court underwent an evaluation by the National Center for State Courts in 2005, a comparison group was not used to assess the effectiveness of the drug court. The drug court should go through a formal evaluation every five years comparing treatment outcome with a risk-control comparison group. Effectiveness would be supported should there be some reduction in recidivism in the drug court group versus the comparison group.

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- A program evaluator should be available (on staff or contract) to assist with research and evaluation of the drug court. Regular reports should be provided to the drug court.

OVERALL PROGRAM RATING

Rhode Island Juvenile Drug Court received an overall score of **25.6** percent on the CPC-DC. This falls into the **Ineffective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **25.0** percent, which falls into the **Ineffective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **25.9** percent, which falls into the **Ineffective** category.

FINDINGS – PROVIDENCE CENTER

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	78.6%	Highly Effective
Quality Assurance	50.0%	Needs Improvement
Offender Assessment	25.0%	Ineffective
Treatment	66.7%	Highly Effective
Overall Capacity	**72.2%**	**Highly Effective**
Overall Content	**61.4%**	**Effective**
Overall Score	**62.7%**	**Effective**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Staff are regularly evaluated with regard to service delivery skills. Multi-Systemic Therapy (MST) service providers are evaluated on service delivery via Therapist Adherence Measures (TAMS), which meets the criteria for staff evaluation.
- MST providers are given five days of initial training, with eight hour booster sessions every quarter thereafter. Individual trainings are offered as well.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by stakeholders, including the juvenile drug court.
- Program funding is adequate and stable.

Recommendations for Improvement:

- While the program director is involved in selecting and supervising the treatment staff, the program director should also have a significant role in training staff.

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- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients on a routine basis. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.

Client Assessment

Strengths:

- The agency assesses responsivity via an initial child and family assessment and a number of other assessments, including mental status , educational risks, and safety risks.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts almost every referral that the juvenile drug court makes to the program. While staff indicated that youth with severe mental health issues are not accepted into the program, there should be a written policy on how clients are deemed appropriate for the services provided by the program.
- The program should serve high and moderate risk youth, and low risk youth should not be placed in intensive treatment services. Since the drug court is not using a risk assessment, it is incumbent upon the referral agency to determine risk level. Examples of proper instrumentation include the COMPAS Youth, Positive Achievement Change Tool (PACT), Youth Level of Service/Case Management Inventory (YLS/CMI), Youth Assessment and Screening Instrument (YASI), and the Ohio Youth Assessment System (OYAS).
- The program should serve high and moderate need youth/families. While the program assesses for this in general terms, a standardized and objective instrument that determines the need for MST services in a structured way should be used to ensure that only those youth/families that need the service are accepted into the program.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The program used Multi-Systemic Therapy (MST), which meets the criteria for evidence-based practices.
- As access was not granted to clients, their files or treatment sessions, the reviewers used their best judgment via provider interviews and knowledge of MST to determine the following: sessions start and end on time; facilitators are knowledgeable about the materials discussed; facilitators encourage participation; and homework (called goals) is given and reviewed with clients on a regular basis. Providers also work to establish session rules and norms.
- Providers consistently stated they spend three to five hours per week with each client and their family. Treatment intensity is stepped down as client's progress in treatment.
- Facilitators address responsivity issues by simplifying the information, repetition and visual aids.
- The types of rewards and punishers used by the program appear appropriate and are appropriately applied. However, rewards and punishers are not always immediately

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administered as the agency sometimes relies on the parents or the drug court to reward behavior.

- Program participants (both youth and caregivers) are regularly taught to observe and anticipate problem situations through modeling by the facilitator and through practice with corrective feedback.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.
- Participants are taught to recognize and explore their underlying antisocial thoughts and values.

Recommendations for Improvement:

- While MST provides manuals and structured session plans, the agency uses these mostly for training purposes, and they are only occasionally used with clients. Providers should follow the MST manual closely in individual sessions.
- The program should use punishers to discourage negative behavior. Currently, the program relies on the drug court and the parents to implement punishers. The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.
- Treatment should include graduated practice of new skills in increasingly difficult situations.
- While providers work to identify antisocial attitudes and thoughts, attempts to replace antisocial attitudes and thoughts with prosocial attitudes and thoughts are not made consistently across MST counselors. While Fit Circles can be an appropriate technique to complete this task, not all counselors use this technique. Other techniques such as cost-benefit analysis, functional analysis, rules tools, and thinking reports can help to ensure the replacement of antisocial thoughts and attitudes with prosocial thoughts and attitudes.
- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan with their MST clinician.

Quality Assurance

Strengths:

- Supervisors and/or MST trainers sit in on sessions or view videotaped sessions and provide formal feedback to counselors once per month for each client.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- While the agency has a quality assurance director, feedback from clients and families should be solicited and utilized to improve programming as well.
- Although the agency determines offender progress through attainment of goals, a more formal pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors that the program is targeting for change.

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Overall Program Rating

The Providence Center received an overall score of **62.7** percent on the CPC-DC. This falls into the **Effective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **72.2** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **61.4** percent, which falls into the **Effective** category.

FINDINGS – ALL THINGS CONSIDERED

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	75.0%	Highly Effective
Quality Assurance	25.0%	Ineffective
Offender Assessment	0.0%	Ineffective
Treatment	40.7%	Ineffective
Overall Capacity	**62.5%**	**Effective**
Overall Content	**35.5%**	**Ineffective**
Overall Score	**44.7%**	**Ineffective**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director provides direct services on a regular basis.
- Both service providers are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the criminal justice system.
- Service providers receive over 40 hours of clinical training per year.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by the juvenile drug court and other stakeholders.
- Program funding is adequate and stable.

Recommendations for Improvement:

- Staff meetings should be held at least bi-monthly to discuss cases and service delivery issues.
- Service providers should be regularly evaluated with regard to service delivery skills. The program director should observe sessions and provide constructive feedback at least once per year as part of an annual evaluation.

Client Assessment

Strengths: None.

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Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral that the juvenile drug court makes to the program. There should be a written policy on how clients are deemed appropriate for the services provided by the program.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, the Massachusetts Youth Screening Instrument (MAYSI), or IQ tests.
- Only clients who are high risk and moderate risk for re-offending should be receiving intensive treatment services. Since the drug court does not use a risk assessment, the agency should conduct a validated risk assessment to determine the risk level of the referrals from drug court. Currently, only a bio-psycho-social assessment is done, and staff consistently report that they feel their clients are generally low risk. Examples of proper instrumentation include the COMPAS Youth, Positive Achievement Change Tool (PACT), Youth Level of Service/Case Management Inventory (YLS/CMI), Youth Assessment and Screening Instrument (YASI), and the Ohio Youth Assessment System.
- The program should target relevant higher need youth. Currently, any youth with identified substance use is admitted to the program. The program should implement a standardized need assessment instrument to ensure that only youth who need substance abuse services are accepted into the program. Examples of proper assessments for substance abuse include the Adolescent Substance Abuse Subtle Screening Inventory (SASSI) and the Juvenile Automated Substance Abuse Evaluation (JASAE).

Treatment

Strengths:

- The sessions start and end on time.
- The staff are knowledgeable about the materials discussed with clients.
- The clinicians encourage participation in the session.
- Facilitators address common client barriers by simplifying the information when necessary.
- Clinicians regularly role-play new skills with their clients and provide corrective feedback.
- The facilitators have good rapport with participants.
- Facilitators avoid arguments with participants and roll with resistance.
- Participants are taught to recognize and explore their underlying antisocial thoughts and values.
- Relapse prevention plans are developed with each youth throughout their treatment process. These plans are written on index cards and given to the client. Clients are required to practice their relapse prevention plans with their counselor.

Recommendations for Improvement:

- Since the program reports targeting numerous things for change in the youth, at least 80% of treatment topics should address criminogenic factors. Examples of criminogenic targets include antisocial attitudes, values and beliefs; antisocial peers; substance abuse; impulsive behavior; and relapse prevention. While the program targets some of these criminogenic needs, the ratio of criminogenic targets needs to be increased.
- Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social

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learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all individual sessions. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Interviews with clinicians indicated mostly talk therapy and drug education is used, neither of which have been shown through research to change offender behavior.

- Homework should be a regular part of the treatment process and the counselor should consistently review homework with the youth. Staff indicated that homework is occasionally assigned, but not required.
- Session norms and rules should be established early on in treatment, and staff should hold the youth accountable for meeting the session norms and rules.
- Clients are seen for one hour per week for a total of 12 weeks. Treatment duration should be increased to ensure that a sufficient dosage is being received to facilitate long-term offender change.
- Clinicians should have a manual to follow that structures their time with their clients. This will ensure consistency across counselors.
- Service providers should utilize a range of rewards to reinforce offender behavior. Rewards should outweigh punishers by a ratio of at least 4:1. The procedure by which offenders are reinforced should meet the following criteria: rewards should be immediate; seen as valuable for shaping behavior; consistently applied; and individualized.
- The program should use punishers to discourage negative behavior. Currently, the program relies on the drug court to implement punishers. The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing youth that behavior has consequences. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.
- While it was indicated that role plays are frequently used with clients, counselors should first explain to the clients the importance of learning the new skill and model the skill for the client. After the role play, feedback should be provided to the youth. Also, counselors should include graduated practice of new skills in increasingly difficult situations.
- While staff work with clients to identify antisocial values and thoughts, participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.

Quality Assurance

Strengths:

- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

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- The agency should have a formal quality assurance process in place. While staff report that files are reviewed, the frequency of file review is not sufficient. Additionally, clients should have an opportunity to provide feedback regarding their satisfaction with treatment services.
- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur at least once per quarter, and formal feedback should be provided to the staff member.
- A pre- post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in behaviors and/or attitudes concerning substance use/abuse. The SASSI or JASAE would be an appropriate measure to incorporate.

Overall Program Rating

All Things Considered received an overall score of **44.7** percent on the CPC-DC. This falls just inside the **Ineffective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **62.5** percent, which falls into the **Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **35.5** percent, which falls into the **Ineffective** category.

FINDINGS – PHOENIX HOUSES OF NEW ENGLAND OUTPATIENT SERVICES

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	64.3%	Effective
Quality Assurance	50.0%	Needs Improvement
Offender Assessment	0.0%	Ineffective
Treatment	32.1%	Ineffective
Overall Capacity	**61.1%**	**Effective**
Overall Content	**28.1%**	**Ineffective**
Overall Score	**40.0%**	**Ineffective**

Leadership, Staff, and Support

Strengths:

- The program director has a significant role in selecting, training, and supervising staff.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the criminal justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- The agency reports being supported by stakeholders, including the juvenile drug court.
- Program funding is adequate and stable.

Recommendations for Improvement:

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- While the program director has the requisite experience in working with offending populations, the program director lacks formal education in a helping profession. The program director should have at least a baccalaureate degree in a helping profession.
- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients on a routine basis. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- While staff service delivery skills are assessed via review of charts and case notes and weekly supervision meetings, the program director should sit in on groups as part of an annual evaluation. Formal feedback should be given at least annually to help facilitators improve their service delivery.
- Staff should receive formal training on the curriculum/manuals being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming. Currently, staff are informally trained initially on program interventions and are only required to complete 20 hours of on-going training per year. Most of that on-going training is not related to service delivery.
- While the agency has ethical guidelines in place, these guidelines should specifically direct appropriate boundaries and interactions with youth.

Client Assessment

Strengths: None.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral that the juvenile drug court makes to the program. Some of the clients were deemed inappropriate by program staff, because the clients needed a higher level of care than the program offered or had mental health issues that made them inappropriate for group services.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, the Massachusetts Youth Screening Instrument (MAYSI), and IQ tests.
- Only clients who are high risk and moderate risk should receive intensive treatment services. Also, low risk clients should not be mixed with higher risk clients in treatment groups. Since the drug court does not use a risk assessment instrument, it is incumbent upon the agency to conduct its own risk assessment in order to determine the risk level of the referrals from drug court. Examples of proper instrumentation include the COMPAS Youth, Positive Achievement Change Tool (PACT), Youth Level of Service/Case Management Inventory (YLS/CMI), Youth Assessment and Screening Instrument (YASI), and the Ohio Youth Assessment System.
- Similarly, the program should serve youth who are high and moderate need for substance abuse services, and low need youth should not receive intensive treatment services. Since the drug court does not conduct a needs assessment, it is incumbent upon the agency to conduct its own needs assessment. Examples of proper assessments for substance abuse include the Adolescent Substance Abuse Subtle Screening Inventory (SASSI) and the Juvenile Automated Substance Abuse Evaluation (JASAE).

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Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Treatment groups are always conducted and monitored by staff.
- Group size averages between four to five clients and never exceeds eight clients per facilitator.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.
- As part of the curriculum used in group, participants are taught to recognize and explore their underlying antisocial thoughts and values.

Recommendations for Improvement:

- While the agency uses an adapted Matrix model to guide the groups, there is no evidence that evidence-based practices are being utilized in the groups. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Interviews with clinicians indicated mostly talk therapy and pieces of drug education are used, neither of which have been shown through research to change offender behavior.
- Males and females are more productive in treatment sessions when they attend treatment separately. As such, treatment groups should be gender specific.
- Treatment groups should start on time and end on time, breaks should be limited to 5-10 minutes, and the check-in process should not take up the majority of the treatment session or be the focus of the treatment session.
- Homework should be regularly assigned to participants, and the homework should be reviewed by the facilitator and constructive feedback should be provided to the participants.
- Norms/rules should be established and followed with each group. Expectations should be reviewed and understood by all participants.
- Clients receive 12 hours of treatment. Treatment duration should be increased to ensure that a sufficient dosage is being received to facilitate long-term offender change.
- While the agency uses a Matrix model, it is modified and a manual is not used during group. Facilitators should have a manual to follow that structures the time in group so that groups are consistent across facilitators and time.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- Although facilitators use verbal praise to reinforce appropriate behavior, service providers should utilize a wider range of rewards. Additionally, rewards should outweigh punishers by a ratio of at least 4:1. The procedure by which offenders are reinforced should meet the following criteria: rewards should be immediate; seen as valuable for shaping behavior; consistently applied; and individualized.

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- The program should use punishers to discourage negative behavior. Currently, the program relies on the drug court to implement punishers. The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- While participants are taught to recognize antisocial thoughts, participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be developed and clients should have to regularly practice the coping skills listed on the plan with their counselor. While relapse plans were consistently found in the client files, clients are not required to rehearse their plans with their counselors.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms via the program director. Quality assurance includes periodic file review and client satisfaction surveys at discharge.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once per group cycle, and formal feedback should be provided to the facilitator.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in behaviors and/or attitudes concerning substance use/abuse. The SASSI or JASAE would be an appropriate measure to incorporate.

Overall Program Rating

Phoenix Houses of New England – Outpatient Services received an overall score of **40.0** percent on the CPC-DC. This falls into the **Ineffective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **61.1** percent, which falls into the

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Effective category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **28.1** percent, which falls into the **Ineffective** category.

FINDINGS – PHOENIX HOUSES OF NEW ENGLAND RESIDENTIAL TREATMENT

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	85.7%	Highly Effective
Quality Assurance	75.0%	Highly Effective
Offender Assessment	25.0%	Ineffective
Treatment	53.6%	Needs Improvement
Overall Capacity	**83.3%**	**Highly Effective**
Overall Content	**50.0%**	**Needs Improvement**
Overall Score	**62.0%**	**Effective**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- The program director provides direct services on a regular basis, including offender assessments, facilitating groups and carrying a caseload.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Staff are regularly evaluated with regard to service delivery skills. The program director sits in on groups and offers feedback. File reviews and formal staff evaluations are also conducted.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by stakeholders, including the juvenile drug court.
- Program funding is adequate to provide treatment services as designed.

Recommendations for Improvement:

- Staff should receive formal initial training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.
- While funding is adequate to implement the programming as designed, the agency's state funding recently decreased. Unstable funding sources impact program capacity in a number of areas. The agency should work to ensure that funding remains stable.

Client Assessment

Strengths:

- The agency has formalized written exclusionary criteria and follows the criteria in all cases.

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Recommendations for Improvement:

- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, the Massachusetts Youth Screening Instrument (MAYSI), and IQ tests.
- Only clients who are high risk and moderate risk should be receiving intensive treatment services. Since the drug court does not use a risk assessment instrument, it is incumbent upon the agency to conduct its own risk assessment in order to determine the risk level of the referrals from drug court. While the agency uses a risk assessment tool, it does not provide levels of risk. Examples of proper risk tools that are standardized and provide levels of risk include the COMPAS Youth, Positive Achievement Change Tool (PACT), Youth Level of Service/Case Management Inventory (YLS/CMI), Youth Assessment and Screening Instrument (YASI), and the Ohio Youth Assessment System (OYAS).
- Similarly, the program should serve youth who are high and moderate need for substance abuse services, and low need youth should not receive intensive treatment services. Since the drug court does not conduct a needs assessment, it is incumbent upon the agency to conduct its own need assessment. Examples of proper assessments for substance abuse include the Adolescent Substance Abuse Subtle Screening Inventory (SASSI) and the Juvenile Automated Substance Abuse Evaluation (JASAE).

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The treatment groups are gender specific.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- The youths' time in residential treatment is very structured. The program's average length is appropriate, with residential treatment ranging from four to six months.
- Treatment groups are always conducted and monitored by staff.
- The types of rewards used by the program appear appropriate and are appropriately applied.
- Staff use a variety of punishments and apply them appropriately. Types of punishments include written essays, loss of outings, and dropping a progress level.
- The counselors and group facilitators have good rapport with participants.
- Facilitators avoid arguments with participants and roll with resistance.
- Participants are taught to recognize and explore their underlying antisocial thoughts and values.
- Relapse prevention plans are developed as part of the youth's completion pack. These plans are reviewed with the counselor, and the youth has to practice the coping skills listed on the plan.

Recommendations for Improvement:

- The program uses a combination therapeutic community, motivational interviewing, and cognitive-behavioral therapy. While some of these approaches meet the criteria of evidence-based practices, others do not. The program should have a consistent model, and treatment interventions should ensure that both cognitive restructuring and structured skill building are regularly taking place.

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- Treatment groups should start on time and end on time, breaks should be limited to 5-10 minutes, and the check-in process should not take up the majority of the treatment session or be the focus of the treatment session.
- Homework should be a regular part of the treatment process, and the counselor should consistently review homework with the youth. Currently, only one group regularly assigns homework to participants.
- Norms/rules should be established and followed with each group. Expectations should be reviewed and understood by all participants.
- While the agency has manuals for each of their groups, two out of three of the therapists interviewed did not use them on a regular basis. Manuals should be used as designed to ensure consistency and fidelity across groups.
- The average group size is 16 with only one facilitator. The ratio of youth to staff should be no more than 12:1. The program should use a co-facilitator when the group size exceeds 12.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- While punishers are applied appropriately, a prosocial alternative to the behavior should always be offered following punishment.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- While facilitators work with clients to identify antisocial values and thoughts, participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms. Quality assurance includes monthly peer and file review and client satisfaction surveys throughout treatment.
- Supervisors sit in on sessions and provide formal feedback to counselors regularly.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning substance use/abuse. The SASSI or JASAE are appropriate to use.

Overall Program Rating

Phoenix Houses of New England – Residential Treatment received an overall score of **62.0** percent on the CPC-DC. This falls into the **Effective** category.

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The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **83.3** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **50.0** percent, which falls into the **Needs Improvement** category.

FINDINGS – PHOENIX HOUSES OF NEW ENGLAND SHELTER CARE

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	64.3%	Effective
Quality Assurance	50.0%	Needs Improvement
Offender Assessment	0.0%	Ineffective
Treatment	57.1%	Effective
Overall Capacity	**61.1%**	**Effective**
Overall Content	**50.0%**	**Needs Improvement**
Overall Score	**54.0%**	**Needs Improvement**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- All staff have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Regular meetings take place between the program director and program staff.
- Staff are regularly evaluated with regard to service delivery skills. The program director sits in on groups and offers feedback.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by stakeholders, including the juvenile drug court.
- Program funding is adequate to provide treatment as designed.

Recommendations for Improvement:

- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients on a routine basis. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- While the staff have adequate experience working with youthful offenders, staff are lacking in formal education. At least 75% of all treatment staff should have a baccalaureate degree in a helping profession.
- Direct care staff should be selected for skills and values conducive to offender treatment, such as being able to be firm but fair, empathetic, have good problem solving skills, and believe that rehabilitation is a worthwhile ideal. Currently, staff are not hired based on these important qualities.

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- Staff should receive formal initial training on the interventions used in the program and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming. The program does not currently have sufficient initial or on-going training efforts.
- While funding is adequate to implement the programming as designed, the agency experienced major funding losses in February 2008. The agency should work to ensure stable funding.

Client Assessment

Strengths: None.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral that the juvenile drug court makes to the program. There should be a written policy on how clients are deemed appropriate for the services provided by the program.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, the Massachusetts Youth Screening Instrument (MAYSI), and IQ tests.
- The agency should be aware of the risk level of the clients accepted into shelter care. The program should use risk level information to ensure low risk youth are separated from moderate and high risk youth (especially for treatment services). Since the drug court does not conduct a risk assessment, it is incumbent upon the program to assess for risk level. Examples of proper instrumentation include the COMPAS Youth, Positive Achievement Change Tool (PACT), Youth Level of Service/Case Management Inventory (YLS/CMI), Youth Assessment and Screening Instrument (YASI), and the Ohio Risk Assessment System (OYAS).

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The treatment groups are gender specific.
- The groups start and end on time.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Homework is a regular part of the treatment process and is regularly reviewed with the youth.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- Sessions have a set manual or curriculum that is consistently followed.
- Treatment groups are always conducted and monitored by staff.
- Group size averages between four to eight clients. The recommended ratio of group members to facilitators is 8:1.
- The types of rewards used by the program appear appropriate and a wide range of rewards are used, including a level system of advancement, verbal praise and pizza parties.

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- Staff use a variety of punishments and apply them appropriately. Types of punishments include docking points and losing privileges.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.

Recommendations for Improvement:

- Staff consistently report that they use "strength-based" treatment techniques. Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- Although staff reported using more rewards than punishers, the ratio reported was about 3:2. Rewards should outweigh punishers by a ratio of at least 4:1. The procedure by which offenders are reinforced should meet the following criteria: rewards should be immediate; seen as valuable for shaping behavior; consistently applied; and individualized.
- While punishers are applied appropriately, a prosocial alternative to the behavior should always be offered following punishment.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- Participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost -benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms. Quality assurance includes weekly file review and client satisfaction surveys. Staff reported that some changes have been made to the program due to feedback from clients.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once per group cycle, and formal feedback should be provided to the facilitator.

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- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning the treatment targets of the program.

Overall Program Rating

Phoenix Houses of New England – Shelter Care received an overall score of **52.9** percent on the CPC-DC. This falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **61.1** percent, which falls into the **Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **48.5** percent, which falls into the **Needs Improvement** category.

FINDINGS – ProCAP

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	71.4%	Highly Effective
Quality Assurance	75.0%	Highly Effective
Offender Assessment	0.0%	Ineffective
Treatment	48.3%	Needs Improvement
Overall Capacity	**72.2%**	**Highly Effective**
Overall Content	**42.4%**	**Ineffective**
Overall Score	**52.9%**	**Needs Improvement**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this program.
- The program director has a significant role in selecting, training, and supervising staff.
- All staff have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Regular meetings take place between the program director and program staff.
- Staff are regularly evaluated with regard to service delivery skills. The clinical supervisor does regular chart reviews and has recently started sitting in on groups three times per year.
- Staff receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- Program funding is adequate and stable.

Recommendations for Improvement:

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- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- While the staff have adequate experience working with youthful offenders, staff are lacking in formal education. At least 75% of all treatment staff should have a baccalaureate degree in a helping profession.
- Direct care staff should be selected for skills and values conducive to offender treatment, such as being able to be firm but fair, empathetic, have good problem solving skills, and believe that rehabilitation is a worthwhile ideal.
- Program staff report that they are not supported by the juvenile court or juvenile probation. For example, the program used to receive a lot of referrals, but now receive next to none.

Client Assessment

Strengths: None.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral that the juvenile drug court makes to the program. There should be a written policy on how clients are deemed appropriate for the services provided by the program.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, the Massachusetts Youth Screening Instrument (MAYSI), and IQ tests.
- Only clients who are high risk and moderate risk should receive intensive treatment services. Also, low risk clients should not be mixed with high risk clients in treatment groups. Since the drug court does not use a risk assessment instrument, it is incumbent upon the agency to conduct its own risk assessment in order to determine the risk level of the referrals from drug court. Examples of proper instrumentation include the COMPAS Youth, Positive Achievement Change Tool (PACT), Youth Level of Service/Case Management Inventory (YLS/CMI), Youth Assessment and Screening Instrument (YASI), and the Ohio Youth Assessment System (OYAS).
- Similarly, the program should serve youth who are high and moderate need for substance abuse services, and low need youth should not receive intensive treatment services. Since the drug court does not conduct a needs assessment, it is incumbent upon the agency to conduct its own need assessment. Examples of proper assessments for substance abuse include the Adolescent Substance Abuse Subtle Screening Inventory (SASSI) and the Juvenile Automated Substance Abuse Evaluation (JASAE).

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- Despite receiving no formal training in the interventions used by the program, group facilitators are knowledgeable about the materials discussed in group.
- The facilitators encourage participation in the group

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- Homework is a regular part of the treatment process and is regularly reviewed with the youth.
- When there is a co-facilitator in group, both facilitators are actively participating.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change.
- Sessions have a set manual or curriculum that is consistently followed.
- Treatment groups are always conducted and monitored by staff.
- Group size averages six clients, and a co-facilitator is present if the group size exceeds ten. This meets the recommendation that groups should average 8-12 members.
- The types of rewards used by the program appear appropriate, and a wide range of rewards are used, including candy, verbal praise and pizza days.
- Staff use appropriate punishers to extinguish antisocial behaviors, such as warnings, reports to the drug court, assignments, and parental involvement.
- Participants are taught to recognize and explore their underlying antisocial thoughts and values.
- Relapse prevention plans are developed in individual sessions with the youth, and the coping skills listed in the plan are practiced monthly.

Recommendations for Improvement:

- The program uses several different Hazelden materials to guide services: Living in Balance, Setting Rules and Limits Parenting, Real Life Parenting Skills, and Anger Management. These are appropriate to guide treatment services. However, all groups need to contain interventions that have been determined effective in changing offender behavior. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Males and females are more productive in treatment sessions when they attend treatment separately. As such, treatment groups should be gender specific.
- Treatment groups should start on time and end on time, breaks should be limited to five to ten minutes, and the check-in process should not take up the majority of the treatment session or be the focus of the treatment session. Youth should be on time to treatment and should be held accountable when they are not.
- Although group norms are established, they are not regularly followed. For example, youth use cell phones and iPods in group. Also, group norms and rules are not posted. Norms/rules should be established and followed with each group. Expectations should be reviewed and understood by all participants.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- Although the program has appropriate rewards, the application of reinforcers is lacking. For example, facilitators are not consistent in their use of reinforcers, and rewards for positive behavior are not immediately applied. The program sometimes relies on the drug court to administer the rewards.
- As with rewards, the agency is inconsistent with using punishers. The process for punishing should include the following components: punishers should be individualized; considered

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undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.

- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- Facilitators should strive for establishing a rapport with group members to encourage participation and offender change.
- Group facilitators should avoid arguing with clients and use motivational techniques to roll with resistance.
- While facilitators work with clients to identify antisocial values and thoughts, participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms. Quality assurance includes monthly file review, clinical supervision, and client satisfaction surveys at discharge.
- Supervisors regularly sit in on sessions and provide formal feedback to counselors.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning substance use/abuse. The SASSI or JASAE are appropriate to use.

Overall Program Rating

ProCAP received an overall score of **52.9** percent on the CPC-DC. This falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **72.2** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **42.4** percent, which falls into the **Ineffective** category.

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FINDINGS – THOMPSON RESOURCES LIMITED

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	66.7%	Highly Effective
Quality Assurance	25.0%	Ineffective
Offender Assessment	0.0%	Ineffective
Treatment	29.6%	Ineffective
Overall Capacity	**56.3%**	**Effective**
Overall Content	**25.8%**	**Ineffective**
Overall Score	**36.2%**	**Ineffective**

Leadership, Staff, and Support

Strengths:

- Ms. Thompson is professionally trained and has requisite experience to run her own agency.
- Ms. Thompson is sufficiently educated in helping professions and has adequate experience in treatment programs with youth involved in the juvenile justice system.
- Ms. Thompson meets with two different clinic supervisors each month to discuss cases.
- Program funding is adequate and stable.

Recommendations for Improvement:

- While two clinical supervisions are held per month, Ms. Thompson should have someone sit in on her sessions and provide a formal evaluation at least once a year.
- All persons delivering treatment should receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming. Ms. Thompson has recently committed to 40 hours per year of training to meet insurance requirements; therefore, while she does not meet this criterion at this time, she may meet it in the future.
- Ms. Thompson should have written ethical guidelines that clearly dictate staff boundaries and interactions with youth.
- Ms. Thompson reports a very strained relationship with the juvenile drug court. It is important that the agency be supported by stakeholders, including the juvenile drug court. Ms. Thompson should meet with the juvenile drug court team in order to resolve any issues that are interfering with her service delivery.

Client Assessment

Strengths: None.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral that the juvenile drug court makes to the program. There should be a written policy on which clients are deemed appropriate for the services provided by the program.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale,

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Jesness Inventory, Beck's Depression, the Massachusetts Youth Screening Instrument (MAYSI), and IQ tests.

- Only clients who are high risk and moderate risk should receive intensive treatment services. Also, low risk clients should not be mixed with high risk clients in treatment groups. Since the drug court does not use a risk assessment instrument, it is incumbent upon the agency to conduct its own risk assessment in order to determine the risk level of the referrals from drug court. Examples of proper instrumentation include the COMPAS Youth, Positive Achievement Change Tool (PACT), Youth Level of Service/Case Management Inventory (YLS/CMI), Youth Assessment and Screening Instrument (YASI), and the Ohio Youth Assessment System (OYAS).
- Similarly, the program should serve youth who are high and moderate need for substance abuse services, and low need youth should not receive intensive treatment services. Since the drug court does not conduct a needs assessment, it is incumbent upon the agency to conduct its own need assessment. Examples of proper assessments for substance abuse include the Adolescent Substance Abuse Subtle Screening Inventory (SASSI) and the Juvenile Automated Substance Abuse Evaluation (JASAE).

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The sessions start and end on time.
- Ms. Thompson is knowledgeable about the materials discussed in sessions.
- Ms. Thompson encourages participation in the sessions.
- Ms. Thompson has good rapport with group participants.
- Ms. Thompson avoids arguments with participants and rolls with resistance.

Recommendations for Improvement:

- Ms. Thompson does not use any specific curriculum or treatment model with her clients. Treatment modalities that have been determined effective in changing offender behavior should be utilized. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the sessions. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Homework should be a regular part of the treatment process, and Ms. Thompson should consistently review homework with the youth. Homework should be assigned at the end of the session and reviewed at the beginning of the next session.
- Session norms/rules should be established and followed by each client. Expectations should be reviewed and understood by all clients prior to being accepted into the program. For individual counseling, this can be established by having a contract between the client and the service provider which outlines the expectations.
- The length of treatment is determined on a case-by-case basis and insurance coverage. Research has shown that treatment length and dosage needs to be guided by the level of risk and need of the client. Higher risk/need clients should receive a higher dose of treatment for

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a longer period than lower risk/need clients. Level of risk and need should be determined by one of the instruments suggested in the Offender Assessment section above.

- Ms. Thompson reports not using any specific curriculum or manual with clients. It is recommended that a manual be followed that structures time with clients and guides treatment sessions.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- Ms. Thompson should utilize a range of rewards to reinforce positive behavior. Rewards should outweigh punishers by a ratio of at least 4:1. The procedure by which offenders are reinforced should meet the following criteria: rewards should be immediate; seen as valuable for shaping behavior; consistently applied; and individualized.
- Ms. Thompson should use punishers to discourage negative behavior. Currently, she relies on the drug court to implement punishers. Ms. Thompson should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by Ms. Thompson.
- Ms. Thompson should consistently (almost session) model prosocial skills, explain to the client the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, she should include graduated practice of new skills in increasingly difficult situations.
- Clients should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the clients in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan with Ms. Thompson.

Quality Assurance

Strengths:

- Ms. Thompson completes a discharge summary for all clients and provides the summary to the drug court (or referral agency).

Recommendations for Improvement:

- Ms. Thompson should incorporate a management audit system that consists of monitoring of sessions by a clinical supervisor with feedback for improvement, file review, problem oriented records to monitor treatment progress, and formal offender and parent/caregiver feedback on services.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning substance use/abuse. The SASSI or JASAE are appropriate to use.

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Overall Program Rating

Thompson Resources Limited received an overall score of **36.2** percent on the CPC-DC. This falls into the **Ineffective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **56.3** percent, which falls into the **Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **25.8** percent, which falls into the **Ineffective** category.

FINDINGS – ROBERT O'NEIL

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	66.7%	Highly Effective
Quality Assurance	0.0%	Ineffective
Offender Assessment	0.0%	Ineffective
Treatment	37.0%	Ineffective
Overall Capacity	**50.0%**	**Needs Improvement**
Overall Content	**32.3%**	**Ineffective**
Overall Score	**36.7%**	**Ineffective**

Leadership, Staff, and Support

Strengths:

- Mr. O'Neil is professionally trained and has requisite experience to run his own agency.
- Mr. O'Neil is sufficiently educated in helping professions and has adequate experience in treatment programs with youth involved in the juvenile justice system.
- Mr. O'Neil has written ethical guidelines that clearly dictate staff boundaries and interactions with youth.
- Program funding is adequate and stable.

Recommendations for Improvement:

- Mr. O'Neil meets with another psychologist once per month for consultation, but meetings should be held at least twice per month to discuss cases.
- While clinical supervision is held once per month, Mr. O'Neil should have someone sit in on his sessions and provide a formal evaluation at least once a year.
- Mr. O'Neil should receive at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.
- Mr. O'Neil reports a strained relationship with the juvenile drug court. It is important that the agency be supported by stakeholders, including the juvenile drug court. Mr. O'Neil should meet with the juvenile drug court team in order to resolve any issues that are interfering with his service delivery.

Client Assessment

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Strengths: None.

Recommendations for Improvement:

- Mr. O'Neil does not have identified exclusionary criteria; he accepts every referral that the juvenile drug court makes to the program. There should be a written policy on how clients are deemed appropriate for the services provided.
- Responsivity is not measured. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, or the Massachusetts Youth Screening Instrument (MAYSI).
- Only clients who are high risk and moderate risk should be receiving intensive treatment services. Mr. O'Neil should conduct his own risk assessment to determine the risk level of his referrals from drug court. Examples of proper instrumentation include the COMPAS Youth, Positive Achievement Change Tool (PACT), Youth Level of Service/Case Management Inventory (YLS/CMI), Youth Assessment and Screening Instrument (YASI), and the Ohio Youth Assessment System (OYAS).
- Mr. O'Neil should serve high and moderate need youth. Examples of proper assessments for substance abuse include the Adolescent Substance Abuse Subtle Screening Inventory (SASSI) and the Juvenile Automated Substance Abuse Evaluation (JASAE).

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The sessions start and end on time.
- Mr. O'Neil is knowledgeable about the materials discussed in sessions.
- Mr. O'Neil encourages participation in the sessions by playing games with clients to get them engaged.
- Length of treatment is sufficient to effect offender change.
- Mr. O'Neil has good rapport with group participants.
- Mr. O'Neil avoids arguments with participants and rolls with resistance.
- Clients are taught to recognize and explore their underlying antisocial thoughts and values.

Recommendations for Improvement:

- Mr. O'Neil uses a psychoanalytic approach to treatment. Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the sessions. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Homework should be a regular part of the treatment process, and Mr. O'Neil should consistently review homework with the youth. Homework should be assigned at the end of the session and reviewed at the beginning of the next session.
- Session norms/rules should be established and followed by each client. Expectations should be reviewed and understood by all clients prior to being accepted into the program. For individual counseling, this can be established by having a contract between the client and the service provider which outlines the expectations.

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- Mr. O'Neil reports not using any specific curriculum or manual with clients. It is recommended that a manual be followed that structures time with clients and guides treatment sessions.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- Mr. O'Neil should utilize a range of rewards to reinforce positive behavior. Rewards should outweigh punishers by a ratio of at least 4:1. The procedure by which offenders are reinforced should meet the following criteria: rewards should be immediate; seen as valuable for shaping behavior; consistently applied; and individualized.
- Mr. O'Neil should use punishers to discourage negative behavior. Currently, the program relies on the drug court to implement punishers. Mr. O'Neil should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by Mr. O'Neil.
- Mr. O'Neil should consistently (almost session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, he should include graduated practice of new skills in increasingly difficult situations.
- While Mr. O'Neil works with clients to identify antisocial values and thoughts, clients should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the clients in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths: None.

Recommendations for Improvement:

- Mr. O'Neil should incorporate a management audit system that consists of monitoring of sessions by a clinical supervisor with feedback for improvement, file review, problem oriented records to monitor treatment progress, and formal offender and parent/caregiver feedback on services.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning substance use/abuse. The SASSI or JASAE are appropriate to use.
- A formal discharge summary should be created for all clients, and the summary should be provided to the drug court.

Overall Program Rating

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Robert O'Neil received an overall score of **34.7** percent on the CPC-DC. This falls into the **Ineffective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **43.8** percent, which falls into the **Ineffective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **32.3** percent, which falls into the **Ineffective** category.

FINDINGS – NICOLE HEBERT, LICSW

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	75.0%	Highly Effective
Quality Assurance	0.0%	Ineffective
Offender Assessment	0.0%	Ineffective
Treatment	44.8%	Ineffective
Overall Capacity	**56.3%**	**Effective**
Overall Content	**38.7%**	**Ineffective**
Overall Score	**44.7%**	**Ineffective**

Leadership, Staff, and Support

Strengths:

- Ms. Hebert is professionally trained and has requisite experience to run her own agency.
- Ms. Hebert is sufficiently educated in helping professions and has adequate experience in treatment programs with youth involved in the juvenile justice system.
- Ms. Hebert receives 40 hours of training related to clinical skills used to deliver effective programming per year.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- Ms. Hebert reports being supported by stakeholders, including the juvenile drug court.
- Program funding is adequate and stable.

Recommendations for Improvement:

- Ms. Hebert should receive clinical supervision from another licensed clinician to discuss specific cases at least two times each month.
- Ms. Hebert should be evaluated in her service delivery abilities annually.

Client Assessment

Strengths: None.

Recommendations for Improvement:

- Ms. Hebert does not have identified exclusionary criteria; she accepts every referral that the juvenile drug court makes to the program. There should be a written policy on how clients are deemed appropriate for the services provided.

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- Responsivity is not measured. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, or the Massachusetts Youth Screening Instrument (MAYSI).
- Only clients who are high risk and moderate risk should be receiving intensive treatment services. Ms. Hebert should conduct her own risk assessment to determine the risk level of the referrals from drug court. Examples of proper instrumentation include the COMPAS Youth, Positive Achievement Change Tool (PACT), Youth Level of Service/Case Management Inventory (YLS/CMI),Youth Assessment and Screening Instrument (YASI), and the Ohio Youth Assessment System (OYAS).
- Ms. Hebert is treating youth for substance abuse and/or mental health issues. She should work to ensure that she serves high and moderate need youth in these areas. Examples of proper assessments for substance abuse include the Adolescent Substance Abuse Subtle Screening Inventory (SASSI) and the Juvenile Automated Substance Abuse Evaluation (JASAE). Examples of appropriate mental health instruments include MAYSI, Adolescent Diagnostic Interview (ADI), and the Millon Adolescent Clinical Inventory.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The sessions start and end on time.
- Ms. Hebert is knowledgeable about the materials discussed with clients.
- Ms. Hebert encourages participation in the session.
- The types of rewards used by Ms. Hebert appear appropriate and are appropriately applied.
- Ms. Hebert has good rapport with clients.
- Ms. Hebert avoids arguments with participants and rolls with resistance.
- Clients are taught to recognize and explore their underlying antisocial thoughts and values.

Recommendations for Improvement:

- Ms. Hebert uses many different approaches to treatment delivery. Treatment modalities that have been determined effective in changing offender behavior should be employed. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the sessions. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Homework should be a regular part of the treatment process, and Ms. Hebert should consistently review homework with the youth. Homework should be assigned at the end of the session and reviewed at the beginning of the next session.
- Session norms/rules should be established and followed by each client. Expectations should be reviewed and understood by all clients prior to being accepted into the program. For individual counseling, this can be established by having a contract between the client and the service provider which outlines the expectations.
- Ms. Hebert only sees her clients for a total of twelve hours. Research has shown that treatment length and dosage needs to be guided by the level of risk and need of the client. Higher risk/need clients should receive a higher dose of treatment for a longer period than

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lower risk/need clients. Level of risk and need should be determined by one of the instruments suggested in the Offender Assessment section above.

- Ms. Hebert reports not using a manual to guide sessions with clients. It is recommended that a manual be followed that structures time with clients and guides treatment sessions.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- Ms. Hebert should use punishers to discourage negative behavior. Currently, the program relies on the drug court to implement punishers. Ms. Hebert should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the provider
- Ms. Hebert should consistently (almost session) model prosocial skills, explain to the client the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, she should include graduated practice of new skills in increasingly difficult situations.
- While Ms. Hebert works with clients to identify antisocial values and thoughts, clients should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost benefit analysis should be used to assist the clients in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan.

Quality Assurance

Strengths: None.

Recommendations for Improvement:

- Ms. Hebert should incorporate a management audit system that consists of monitoring of sessions by a clinical supervisor with feedback for improvement, file review, problem oriented records to monitor treatment progress, and formal offender and parent/caregiver feedback on services.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning substance abuse and mental health issues.
- A formal discharge summary should be created for all clients, and the summary should be provided to the drug court.

Overall Program Rating

Nicole Hebert, LICSW received an overall score of **44.7** percent on the CPC-DC. This falls into the very high end of the **Ineffective** category.

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The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **56.3** percent, which falls into the **Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **38.7** percent, which falls into the **Ineffective** category.

CONCLUSION

Researchers at the University of Cincinnati have assessed 512 programs nationwide and have developed a large database on correctional intervention programs.[2] Approximately 7 percent of the programs assessed have been classified as HIGHLY EFFECTIVE, 17 percent have been classified as EFFECTIVE, 31 percent have been classified as NEEDS IMPROVEMENT, and 45 percent have been classified as INEFFECTIVE.

Graphs representing the results of this assessment are provided below. The first graph or set of graphs compares the drug court or referral agency score in the capacity domain, content domain, and overall score with the average scores from all 512 programs evaluated by the University of Cincinnati. The final graph shows the drug court score and an average of the scores from all referral agencies used by the drug court compared to the average of all programs evaluated by the University of Cincinnati.

Recommendations have been made in each of the four CPC domains for the Rhode Island Juvenile Drug Court. These recommendations should assist the program in making necessary changes to increase program effectiveness. Certainly, care should be taken not to attempt to address all "areas needing improvement" at once. Programs that find the assessment process most useful are those that prioritize need areas and develop action plans to systematically address such needs. Previous programs have also been successful at improving the provision of services by formulating committees charged with developing strategies for delivering evidence-based programming.

This report also provides the drug court with a snapshot of the referral agencies where its youth are receiving treatment in the community. This evaluation should assist the drug court in determining what type of treatment is effective when working with juvenile drug court clients. It should also assist the referral agencies with ways they can improve the services they provide to drug court youth.

[2] Several versions of the CPAI were used prior to the development of the CPC. Scores and averages have been adjusted as needed.

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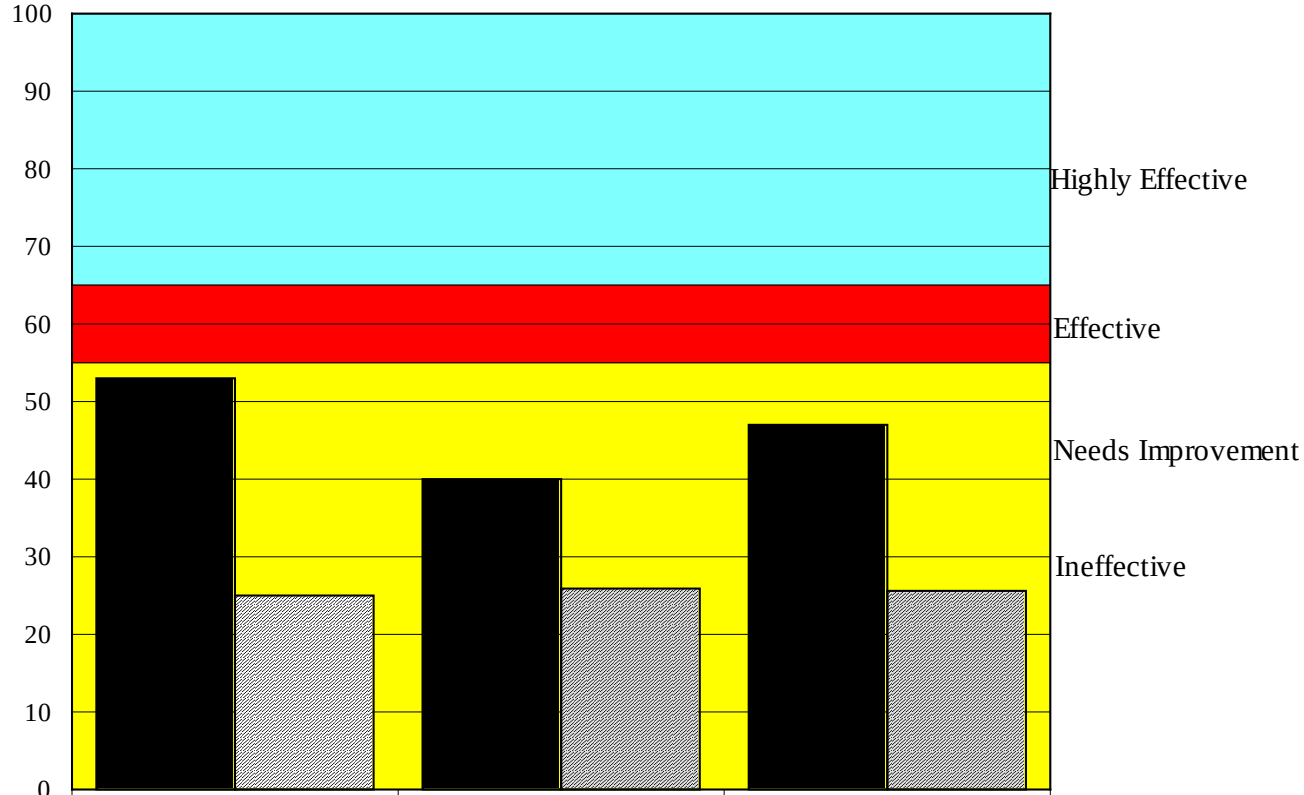
FIGURE 1:
Rhode Island County Juvenile Drug Court CPC-DC Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Rhode Island County	25	25.9	25.6

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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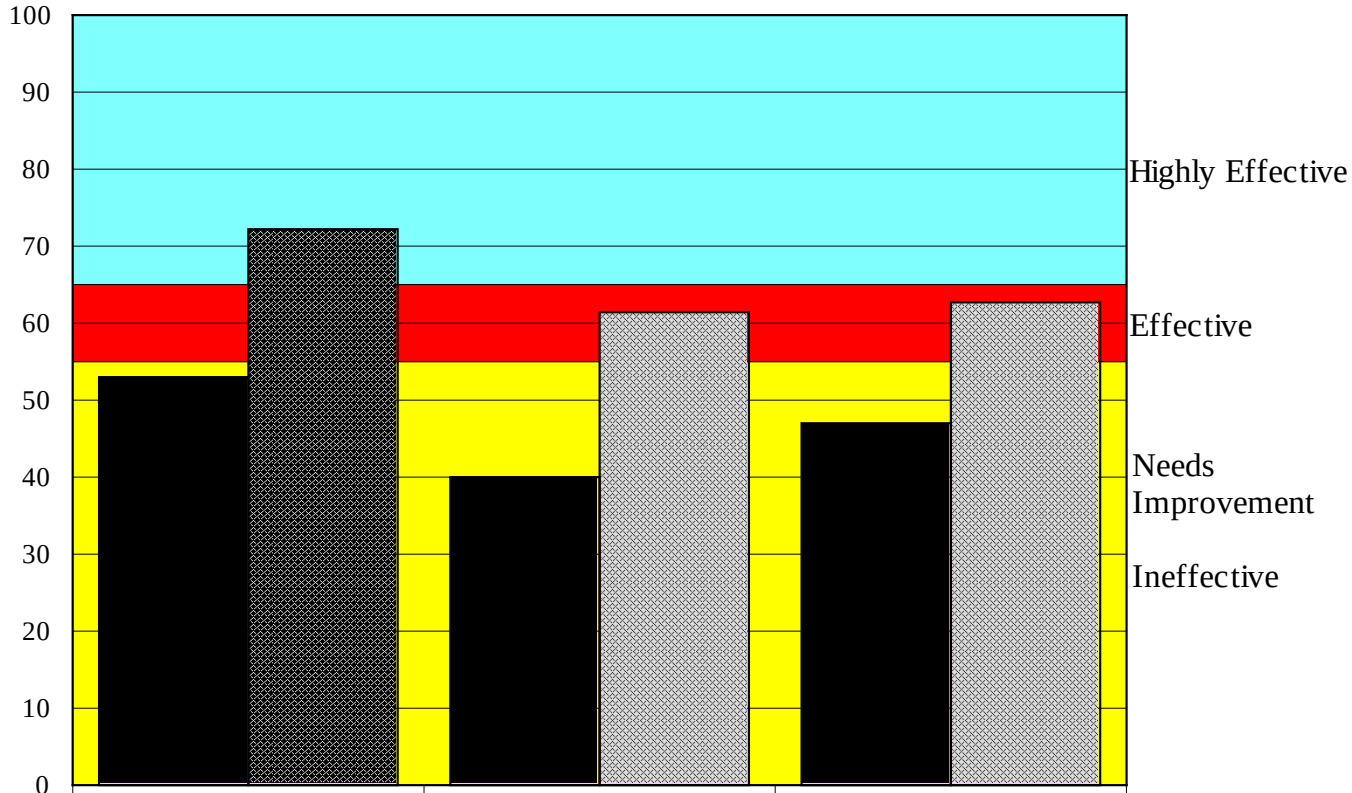
FIGURE 2:
Providence Center CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Providence Center	72.2	61.4	62.7

* The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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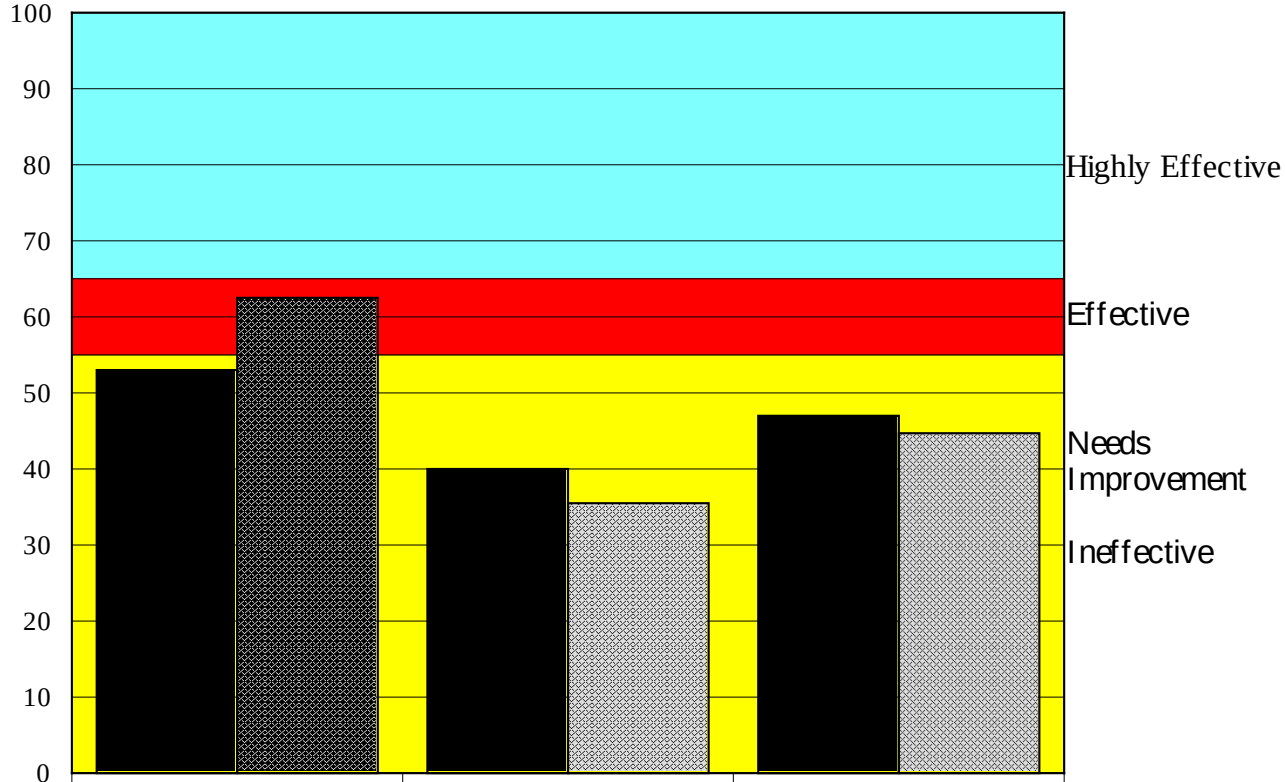
FIGURE 3:

All Things Considered CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
All Things Considered	62.5	35.5	44.7

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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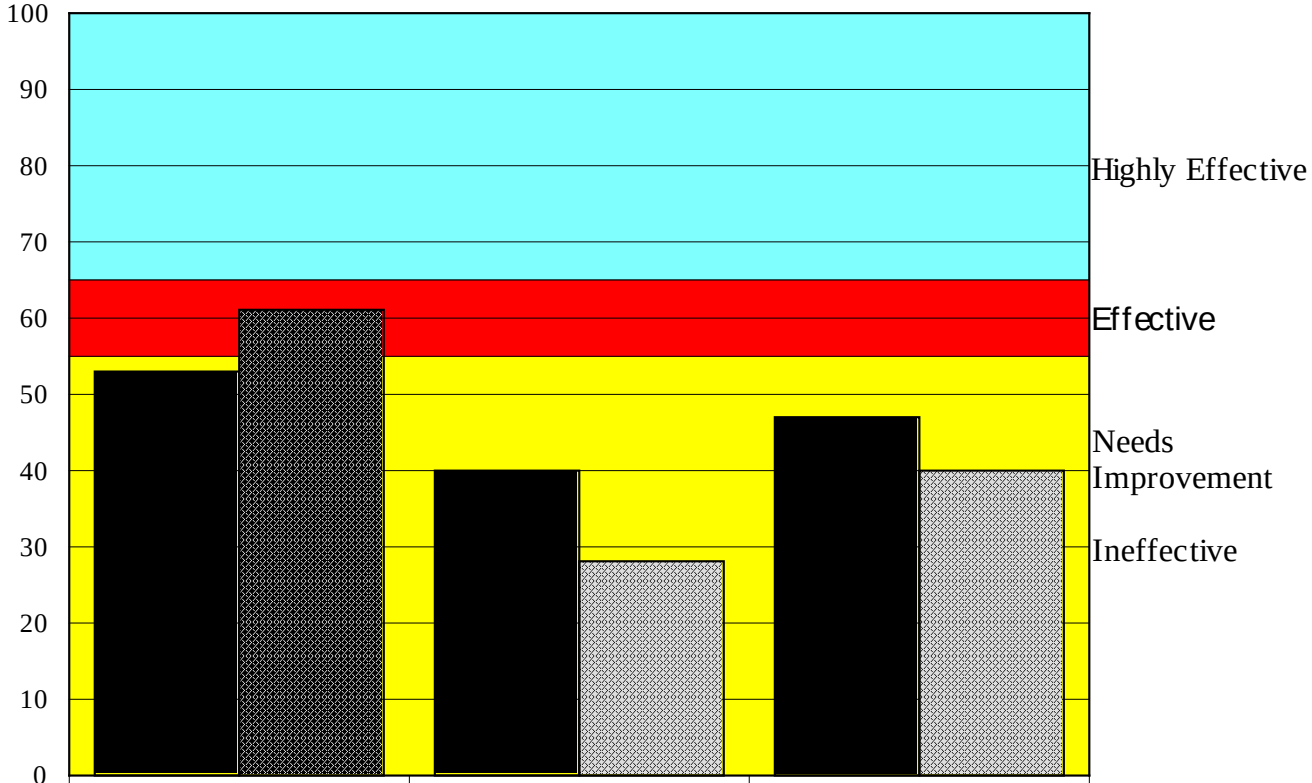
FIGURE 4:

Phoenix Houses of New England - IOP & OP

CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Phoenix - IOP & OP	61.1	28.1	40

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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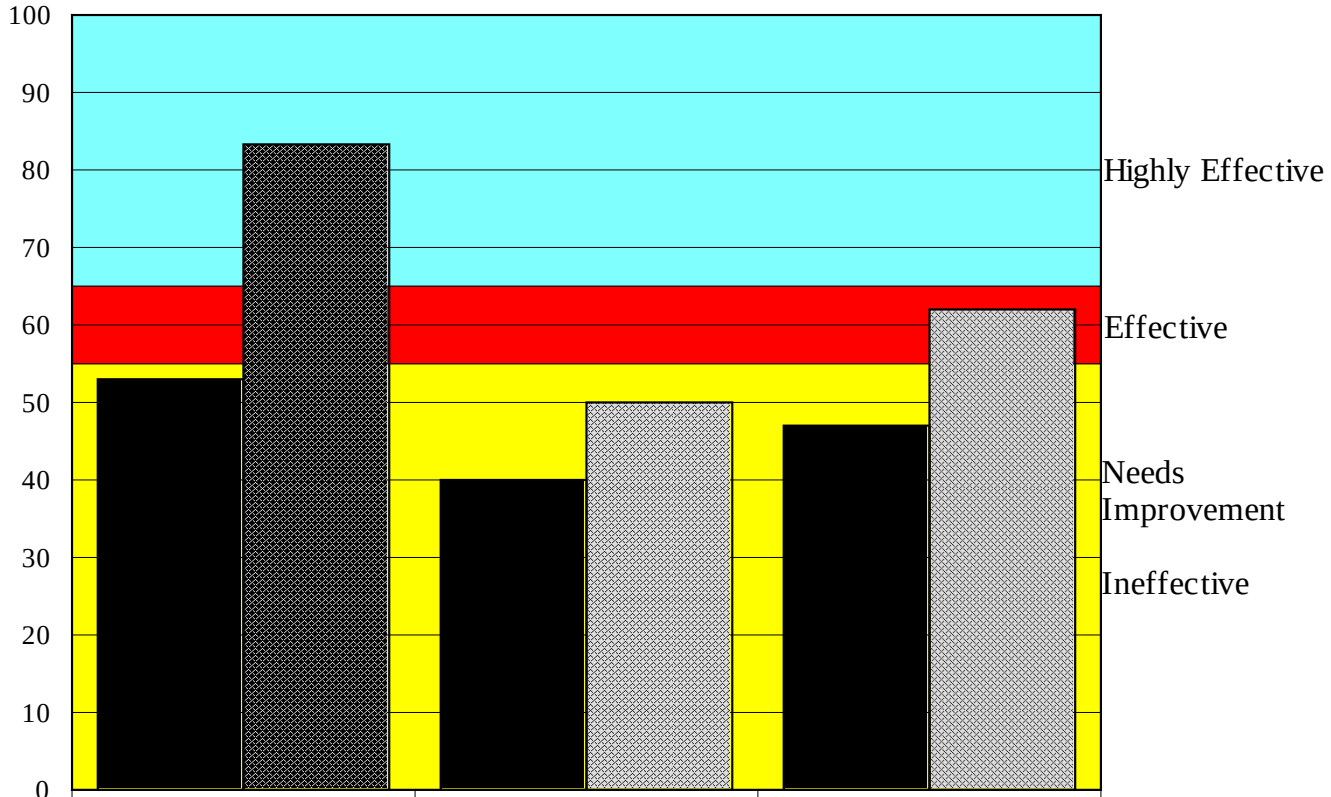
FIGURE 5:
Phoenix Houses of New England - Residential
CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Phoenix - Residential	83.3	50	62

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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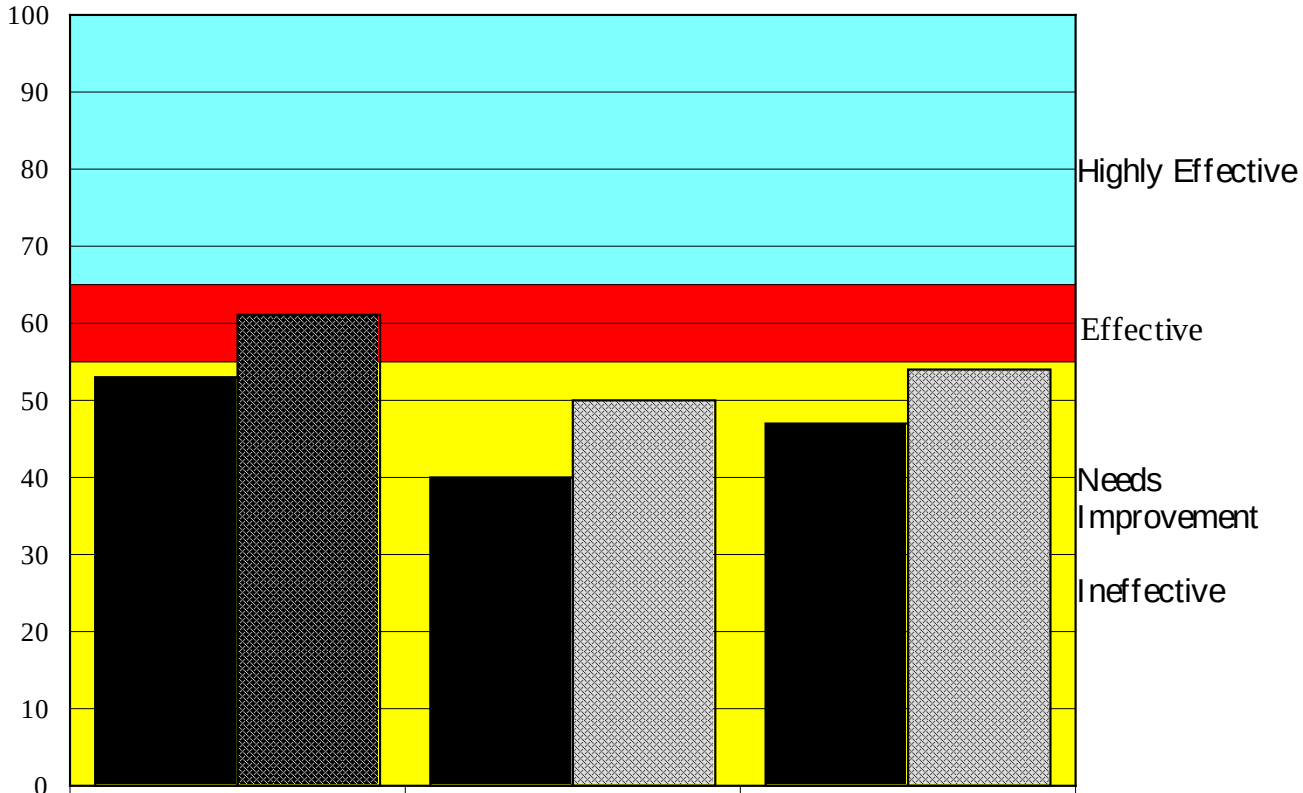
FIGURE 6:
Phoenix Houses of New England - Shelter Care
CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Phoenix - Shelter Care	61.1	50	54

* The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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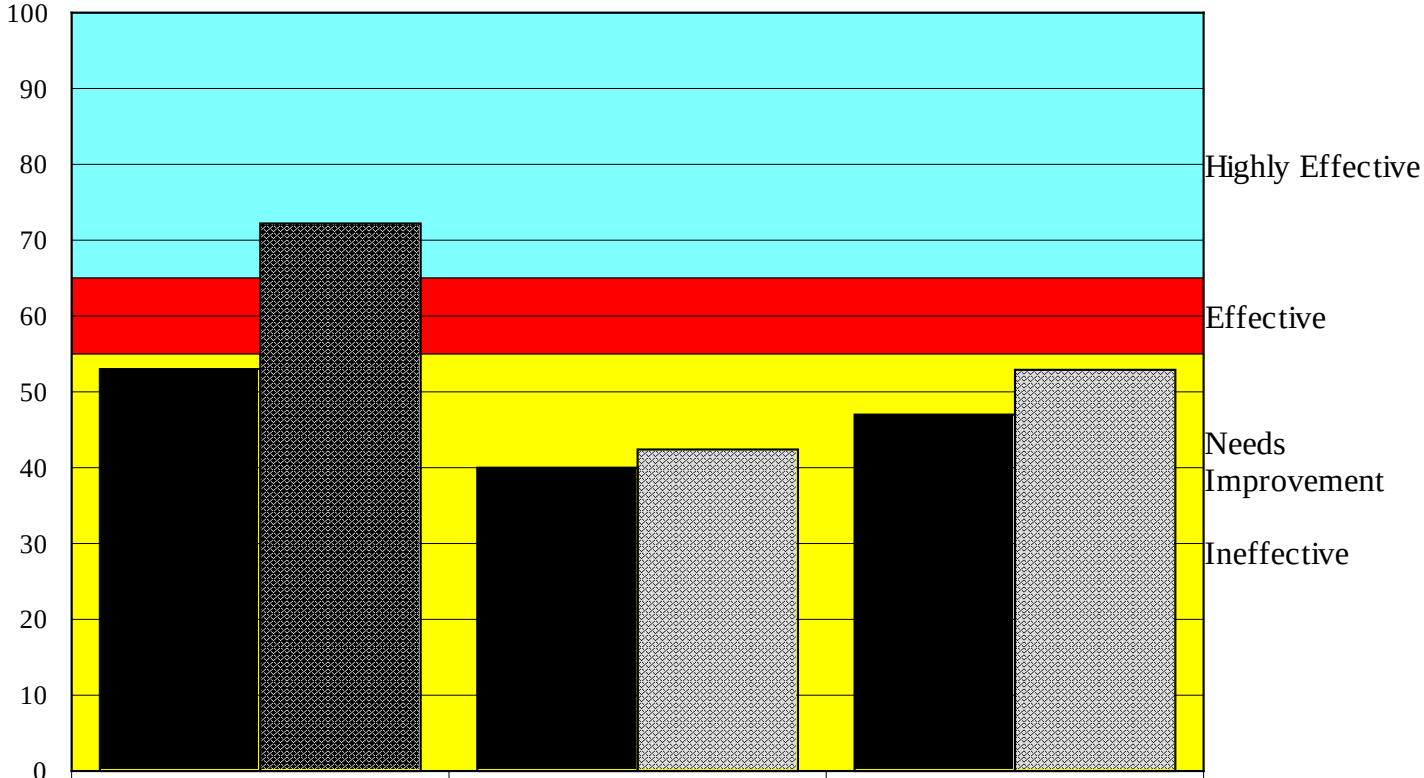
FIGURE 7:
Providence City Action Planning CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
PROCAP	72.2	42.4	52.9

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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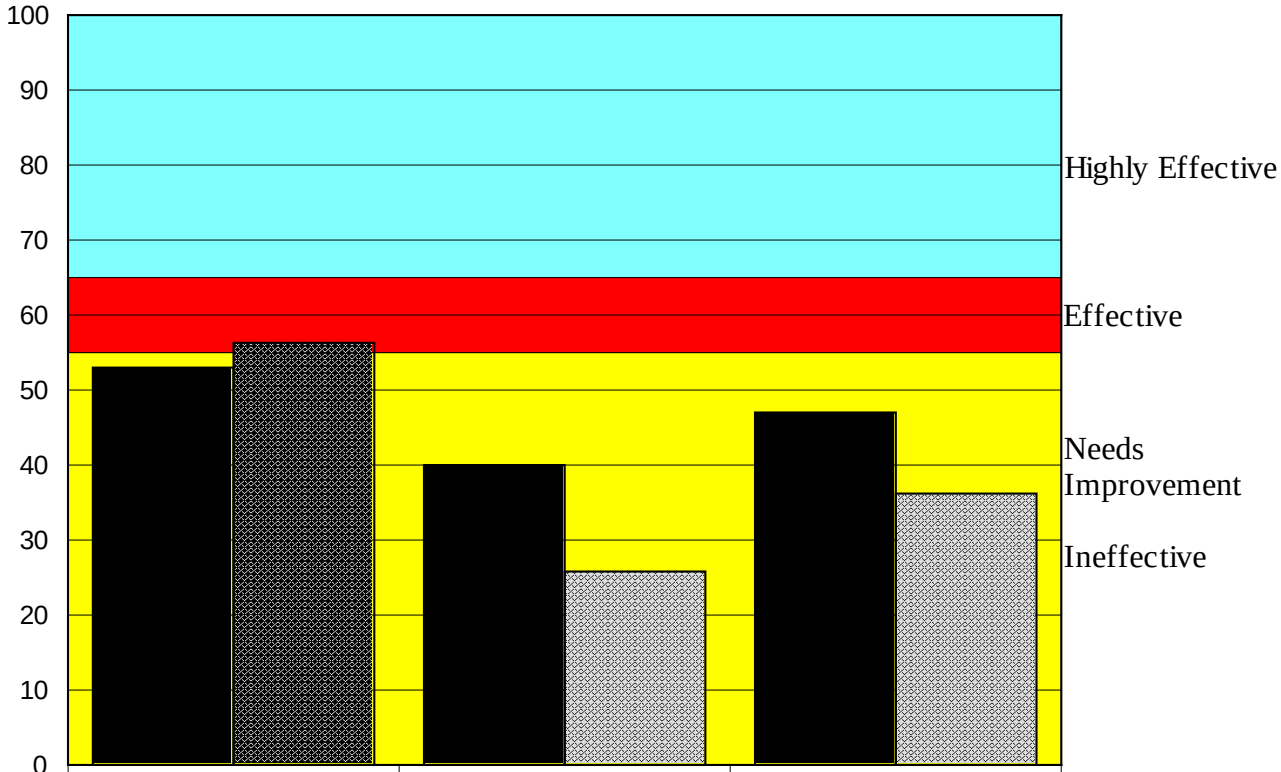
FIGURE 8:
Thompson Resources Ltd CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Thompson Resources	56.3	25.8	36.2

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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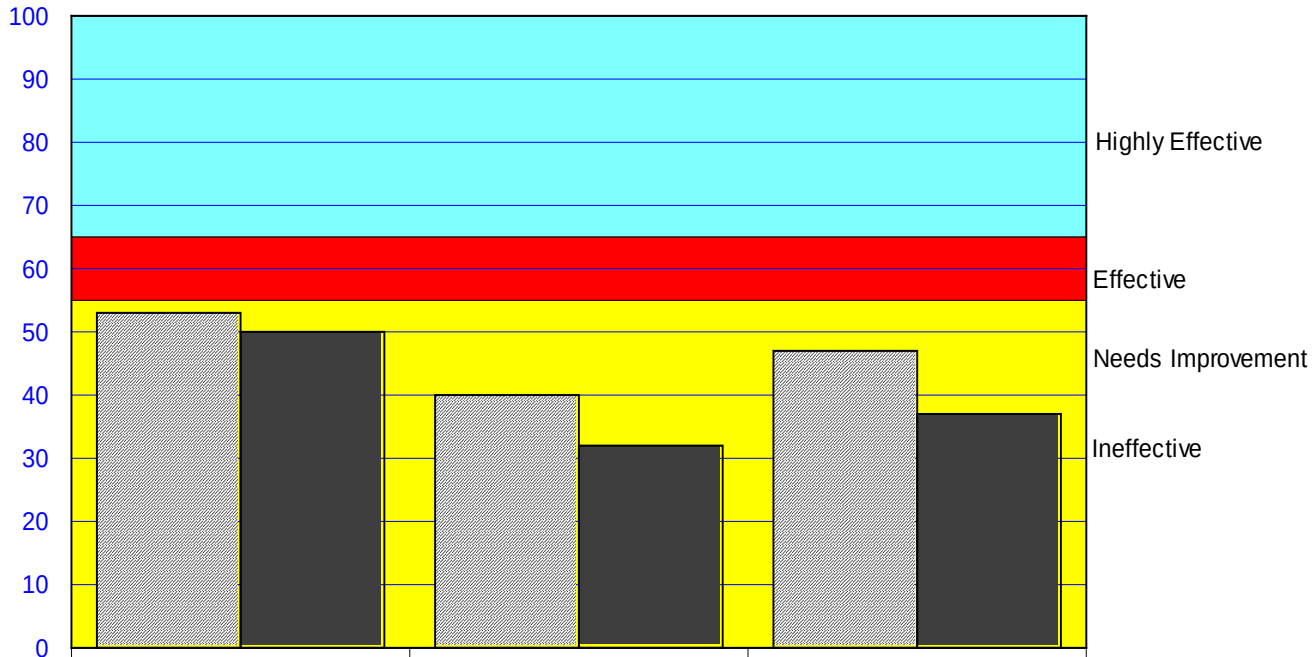
FIGURE 9:

O'Neil CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
O'Neil	50	32	37

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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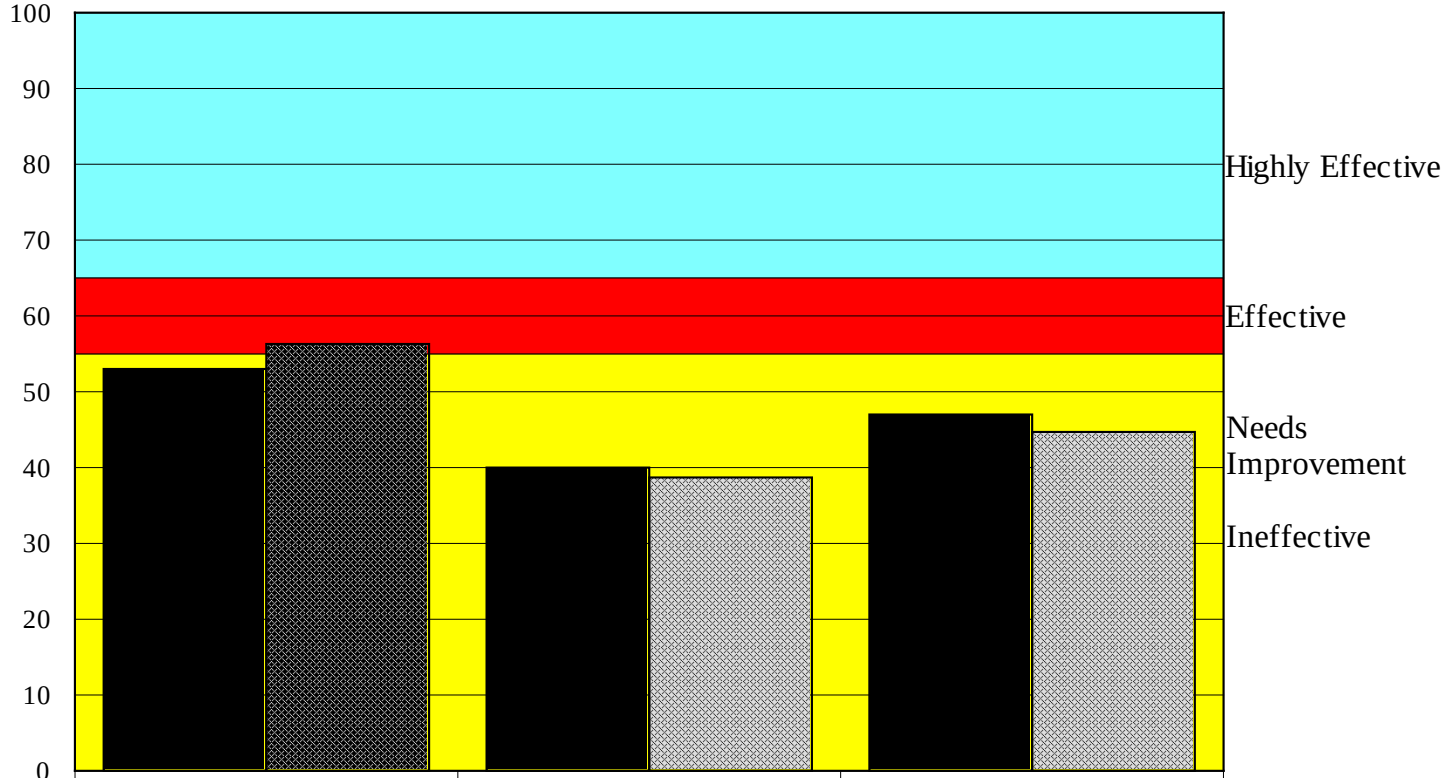
FIGURE 10:
Nicole Hebert CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Hebert	56.3	38.7	44.7

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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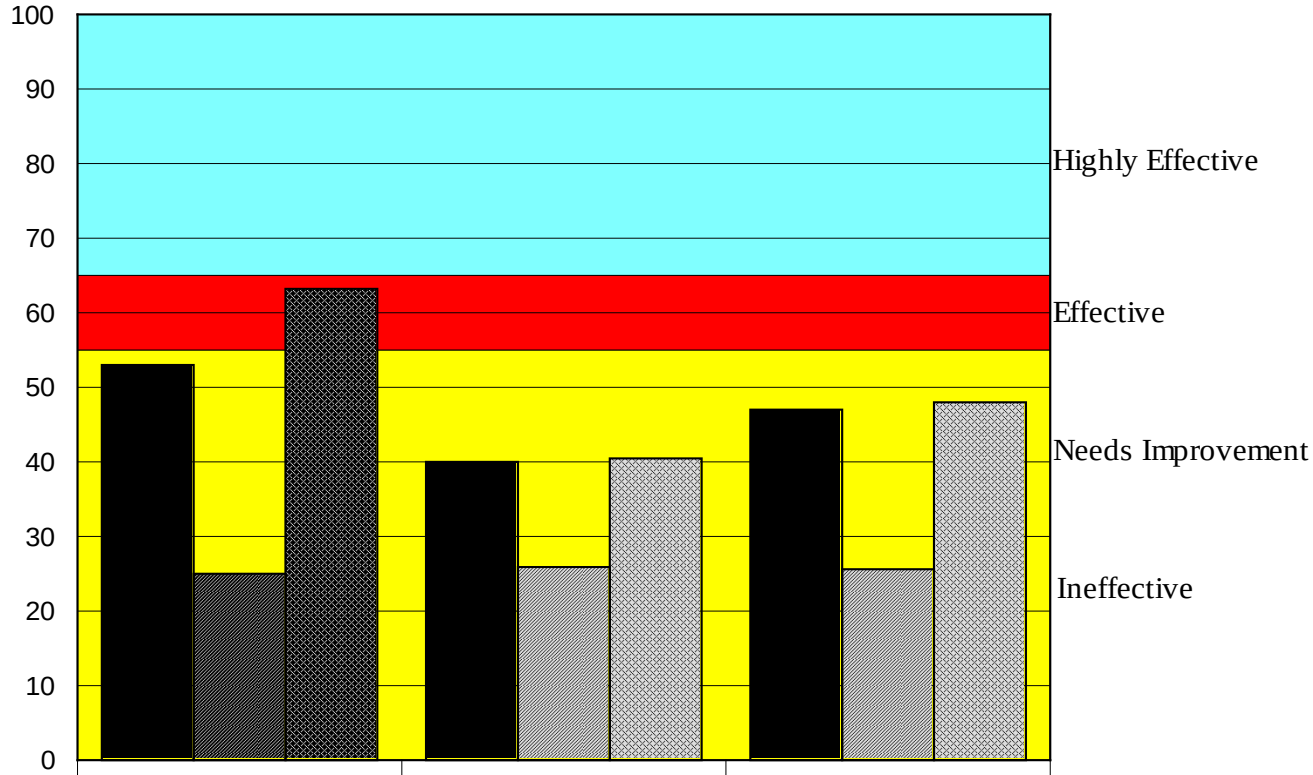
FIGURE 11:
Rhode Island County Juvenile Drug Court Overall



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Rhode Island County	25	25.9	25.6
Referral Agency Average	63.2	40.47	47.99

* The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST – DRUG COURT (CPC-DC) SYNOPSIS OF FINDINGS

Performed as part of the OJJDP study Outcome and Process Evaluation of Juvenile Drug Courts

San Diego County Juvenile Drug Court

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Final Report Submitted: April 2012

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OUTCOME AND PROCESS EVALUATION OF JUVENILE DRUG COURTS STUDY

This project is funded by a grant received from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The purpose of this study is to evaluate a national sample of juvenile drug court programs. The goals of this research are: (1) To determine if there is a reduction in recidivism and substance abuse associated with participation in a juvenile drug court program; (2) to determine if there are improvements in social functioning (e.g. school performance, employment, and family functioning) related to participating in juvenile drug court programs; (3) to identify the characteristics of successful juvenile drug court participants; (4) to determine if juvenile drug courts are operating in a manner consistent with an evidence-based approach; (5) to identify the programmatic characteristics of effective juvenile drug courts; and (6) to provide information to policymakers about the effectiveness of drug courts for juvenile offenders.

This study includes both an outcome and a process evaluation. The outcome portion of the study examines outcomes of youth participating in drug courts as compared to similar youth who are on probation. The process evaluation explores the effectiveness of the drug court and drug court programming and is the focus of this report. Ten drug courts from across the country participated in this four-year study, nine of which participated in both the process and outcome evaluation pieces. The final report for the Outcome and Process Evaluation of Juvenile Drug Courts study will offer outcome and process evaluation findings across all nine drug court sites and is expected to be submitted to OJJDP in December 2012.

CONTEXT AND SCOPE OF THIS EVALUATION

The following report is part of a larger national project centered on the effectiveness of juvenile drug court programs and provides a synopsis of findings from the process evaluation, as well as recommendations to enhance the effectiveness of the services delivered by the San Diego County Juvenile Drug Court. Programs that adhere to the principles of effective intervention are more likely to impact criminal reoffending (see Andrews & Bonta, 2003 for a review). Specifically, correctional research suggests that cognitive behavioral and social learning models of treatment are associated with considerable reductions in recidivism (Gendreau, 1996; Smith, Goggin & Gendreau, 2002). As such, the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) was used to evaluate the juvenile drug courts participating in the Outcome and Process Evaluation of Juvenile Drug Courts study. The objectives of this assessment are to conduct a detailed review of services and program materials of the juvenile drug courts and the agencies they refer youth to and to compare their current practices with the literature on "best practices" in corrections.

PROCEDURES

Description of the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC)

The Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) is a tool that the University of Cincinnati developed for assessing drug court programs. It is used to determine how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. The CPC-DC was modified from the Evidence-Based Correctional Program Checklist (CPC) [1] and includes important indicators from drug court meta-analyses (see Shaffer, 2006). The CPC

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has been validated by several recent studies conducted by the University of Cincinnati. These studies found strong correlations between outcome and both domain areas and individual items (Holsinger, 1999; Lowenkamp, 2003; Lowenkamp and Latessa, 2003, Lowenkamp & Latessa, 2005a; Lowenkamp and Latessa, 2005b; Shaffer, 2006). As part of the larger national study, the indicators on the CPC-DC will be validated using the outcome data collected on the drug court participants.

The CPC-DC consists of two instruments: one for the formal drug court (CPC-DC) and the other for the major referral agencies (CPC-DC: RA) involved in providing treatment and services to drug court clients. Each of these tools is divided into two basic areas: Content and Capacity. The capacity area is designed to measure whether the drug court and its referral agencies have the capability to deliver evidence-based interventions and services to offenders. There are two domains in the capacity area: 1) Development, Coordination, Staff and Support, and 2) Quality Assurance. The content area focuses on the substantive aspect of the drug court and its referral agencies, and also includes two areas: 1) Assessment Practices, and 2) Treatment. This area examines the extent to which the drug court and its referral agencies meet the principles of risk, need, responsivity, and treatment.

The Drug Court tool includes 41 indicators, worth 43 total points. The Referral Agency tool has 49 indicators worth a total of 51 points. Each area and all domains are scored and rated as “highly effective” (65% to 100%); “effective” (55% to 64%); “needs improvement” (46% to 54%); or “ineffective” (45% to 0%). The scores in all domains are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the domains are given equal weight. Further, some items may be considered "not applicable," in which case they are not included in the scoring. Data are collected through structured interviews with selected program staff and program participants, as well as through observation of groups and services. In some instances, surveys may be used to gather additional information. Other sources of information include policy and procedure manuals, schedules, treatment materials, curricula, case files, and other selected program materials. Once the information is gathered and reviewed, the program is scored. The following report highlights strengths, areas that need improvement, and recommendations for each of the areas for both the drug court and the referral agencies.

There are several limitations to the CPC-DC that should be noted. First, as with any research process, objectivity and reliability are an issue. Although steps are taken to ensure that the information gathered is accurate and reliable, decisions about the information gathered are invariably made by the assessors. Second, the process is time specific. That is, the assessment is based on the program at the time of the assessment. Though changes or modifications may be planned for the future, only those activities and processes that were present at the time of the review in August 2009 are considered for scoring. Third, the process does not take into account all system issues that can affect program integrity (i.e., political climate of the court). Finally, the process does not address the reasons that a problem exists within a program or why certain practices do or do not take place. Rather, the process is designed to determine the overall integrity of the program.

---

[1] The CPC is modeled after the Correctional Program Assessment Inventory developed by Gendreau and Andrews. However, only those indicators that were found to be positively correlated with outcome were retained. In addition, the CPC includes a number of items not contained in the CPAI.

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Despite these limitations, there are a number of advantages to this process. First, the criteria are based on empirically derived principles of effective programs, and all of the indicators included in the CPC-DC are correlated with reductions in recidivism. Second, it allows researchers to get inside the "black box" of a drug court and its referral agencies, something that an outcome study alone does not provide. This means researchers are able to measure the degree to which programs are meeting evidence-based standards. Third, the CPC-DC enables researchers to "quantify" the quality of a program through a scoring process. This allows for comparisons across programs, the setting of benchmarks, and for reassessment to measure progress. Fourth, it identifies both the strengths and weaknesses of a program and provides specific recommendations for program improvement.

Assessment Process

The assessment process consisted of a series of structured interviews with staff members and program participants during an on-site visit to San Diego County Juvenile Drug Court on August 17th through August 21st, 2009. Additionally, data were gathered via the examination of ten representative files (five open and five closed) as well as other relevant program materials (e.g., treatment manuals, assessments, training protocol, ethical guidelines, and staff evaluations). Finally, six treatment agencies were evaluated, including group observations: McAlister Institute (Outpatient); South Bay Community Services (Teen Recovery Center); Palavra Tree, Inc. (Teen Recovery Center); Mental Health Systems (Teen Recovery Center); San Diego Youth Services (Teen Recovery Center); and Phoenix Houses of California (Residential). Four evaluators conducted the various interviews, observations and file reviews. Data from the various sources were then combined to generate a consensus CPC-DC score and the specific recommendations in what follows.

SUMMARY OF THE DRUG COURT

The San Diego County Juvenile Drug Court has been in operation since 1998. Youth range in age from thirteen to seventeen and a half and must evidence drug abuse issues. At the time of assessment, there were three drug courts that were overseen by Judge Moring, Judge Meza and Commissioner Imhoff. Natalie Pearl was the head of the research unit, Mara Steinberg was the Supervising Probation Officer of the Juvenile Drug Court unit, and Wendy King was the drug court coordinator.

The drug court requires clients to progress through three phases of treatment designed to last nine months. However, the average time in drug court is eleven to twelve months. Throughout the drug court program, youth must attend drug treatment for up to nine hours per week. Additional components to the program follow a step-down approach. In Phase 1, youth must attend weekly court hearings, submit random drug screens at least twice per week, and have weekly contact with their probation officer. Youth must attain 90 days sobriety, and any relapse will send them back to the beginning of Phase 1. In Phase 2, youth must attend court hearings every other week, and continue the same level of drug screenings and probation officer contact. Youth must attain 180 days sobriety, and any relapse will send them back to the beginning of Phase 1. An application, interview and assessment are necessary for advancement to Phase 3. In the Phase 3, youth must attend court hearings once per month, submit random drug screens at least once per week, meet with their probation officer at least every other week, and complete aftercare. The drug court relies on the following techniques to supervise youth in the program: drug and alcohol testing, home and

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school visits, and attendance at court. The drug court utilizes several referral agencies for substance abuse counseling. The following were evaluated for this report: South Bay Community Services; Palavra Tree, Inc.; Mental Health Systems; Phoenix Houses of California; San Diego Youth Services; and McAlister Institute.

FINDINGS – DRUG COURT

CPC-DC SECTIONS	SCORE	RATING
Development, Coordination, Staff and Support	44.4%	Ineffective
Quality Assurance	42.9%	Ineffective
Offender Assessment	55.5%	Effective
Treatment	44.4%	Ineffective
Overall Capacity	**48.1%**	**Needs Improvement**
Overall Content	**43.8%**	**Ineffective**
Overall Score	**46.5%**	**Needs Improvement**

Development, Coordination, Staff and Support

Strengths:

- Staff meetings are held once a week in order to review new intakes and current clients.
- Drug court staff provide direct case management and supervision services to the youth in the drug court.
- Ethical guidelines dictate staff boundaries and interactions with youth. A copy of these guidelines is located in the drug court manual.
- Funding for the drug court is adequate to provide supervision and services as designed.

Recommendations for Improvement:

- The San Diego Juvenile Drug Court should have a specific person who is responsible for oversight and management of the referral services. This person should have sufficient education and experience to manage the drug court. He/she should also have a direct role in selecting, approving, and supervising the internal drug court staff and the external treatment providers who provide treatment to drug court youth.
- Drug court staff should be trained on drug court programming and receive at least 40 hours of on-going training a year. Staff training should relate to the theory and practice of interventions used by the program, including effective correctional practices and the cognitive-behavioral model.
- Although funding for the drug court is adequate to provide services as designed, there have been recent changes in the amount of funding. This reduction in funding required the drug court to be completely closed on the third Wednesday of every month. Additionally, they do not have enough drug court staff to sufficiently monitor all of the youth in the drug court. At the time of the assessment, the drug court was working to obtain stable funding through outside fundraising. If this was not successful, the drug court should work to obtain stable funding for the drug court.
- The drug court accepts only post-conviction/adjudication youth. Drug courts have more impact on recidivism rates when they accept only youth who are pre-conviction/adjudication

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and the youth's charges are held in abeyance (or sealed), dropped, or reduced if the youth successfully completes drug court.

Offender Assessment

Strengths:

- There are established criteria for the exclusion of certain types of offenders. The policy is written and followed, and clients were deemed appropriate for drug court by the majority of staff.
- Violent offenders are excluded from participating in the drug court.
- Youth are assessed on risk and criminogenic needs using the San Diego Risk and Resiliency Check-up, which is a validated instrument for the target population.
- Substance abuse is assessed using the Substance Abuse Subtle Screening Inventory (SASSI). The drug court began using the SASSI for a study; it is recommended that the court continue using this assessment tool for all youth.

Recommendations for Improvement:

- The drug court should assess factors that directly affect engagement in the drug court or treatment programming. Additionally, there should be evidence that clinical or staffing decisions are made based upon these responsivity factors. At least two major factors such as personality, motivational level/readiness for change, or mental illness should be assessed. Examples of appropriate responsivity instrumentation include the TCU Client Self-Rating scale, Jesness Inventory, Beck's Depression, Massachusetts Youth Screening Instrument (MAYSI), and IQ tests.
- Low risk youth should be screened out, and the drug court should target moderate and high risk youth. Currently, the drug court accepts all youth who are not ruled out based on the exclusionary criteria. It is recommended that low risk youth make up no more than 5% of drug court clients.
- Similarly, the drug court accepts all youth, regardless of their need for substance abuse treatment services as assessed by the SASSI. Only those youth in need of intensive treatment services should be accepted into the drug court.
- Assessments should be freely shared with everyone on the drug court team, including all referral agencies. This will help the agencies to not duplicate assessing for risk and need levels of referred youth.

Treatment Characteristics

Strengths:

- The San Diego County Juvenile Drug Court targets a wide range of criminogenic needs and meets criteria that at least 75% of drug court interventions should focus on criminogenic needs. The drug court targets the following criminogenic needs: antisocial peer associations; school or work; family affection/communication; and alcohol/drug abuse.
- The drug court utilizes a phase system, consisting of three phases of three months each. Staff reported that youth are required to have 270 sober days in order to graduate, and youth graduate in an average of twelve months. It is recommended that the majority of youth graduate in 12 months or less.

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- The drug court has an appropriate reward structure including phase advancement, verbal praise, and the 100% Club, which allows youth to earn "bucks" to buy items such as movie passes, gift certificates and tickets to sporting events.
- The drug court responds to noncompliance appropriately and consistently across clients. Sanctions include community service, home supervision and detention.
- The San Diego Juvenile Drug Court does not require participants to attend AA/NA. However, if one of their treatment referral agencies requires its clients to attend AA/NA, the drug court supports this requirement. Youth in drug court should not be required to attend self-help meetings. There is no evidence that these meetings are beneficial to youth and may in fact be harmful.
- The drug court completion rate varies between 70% and 75%, which meets CPC criterion.
- The drug court randomly drug tests youth on a regular basis during all three Phases.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be employed by the drug court and referral agencies. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups and/or individual treatment sessions. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Observation of groups and interviews with youth in the drug court revealed that many different approaches are utilized across the drug court and the various referral agencies. The drug court should work to ensure that internal and external staff working with drug court youth are consistently using cognitive restructuring and role play to practice skills during group and individual treatment sessions.
- Youth should spend 40% of their time in structured activities, including treatment, school and/or work on a year round basis. The drug court meets this criterion during the school year. However, drug court youth have no required summer activities to ensure their time is structured when they are not in school. The drug court should ensure that youth are required to participate in structured activities in the summer.
- Clients should be assigned to groups and services that match their style of learning and other responsivity factors. The drug court should use a responsivity instrument to assess which drug court staff, treatment agencies, treatment groups, and referral agency staff are best for which client.
- Intensity of the drug court programming should vary by risk level. High risk youth should receive higher intensity and/or duration of service than moderate risk youth. Moderate risk youth should receive higher intensity and/or duration of service than low risk youth. And, low risk youth should make up no more than 5% of the youth in drug court. While the San Diego Juvenile Drug Court varies their treatment intensity for some youth, it is not consistent. Treatment intensity should be dictated by risk level.
- The drug court should have measurable completion criteria which determine how well a youth has progressed in acquiring prosocial behaviors. While phase advancement is used, other methods should be incorporated to help determine progress. Additionally, phase advancement should not be determined based solely on sobriety. Examples of measurable completion criteria are reassessment on risk/need instrumentation, behavioral assessment

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instruments, checklists of behaviors and/or attitudes, completion of a detailed treatment plan, and the acquisition of new skills and behaviors while in the drug court.

- Staff report that they use more punishers than rewards. Studies have shown than rewarding positive behavior more than punishing negative behavior is the most conducive to offender change. It is recommended that the ratio of rewards to punishers is 4:1.
- Currently, the drug court encourages families to be involved in the drug court process, but family participation is not required. As part of drug court, the family/caregivers should be trained to provide support, including the ability to identify high risk situations for their youth and strategies for managing their environment using prosocial skills. Family groups should therefore target prosocial behavior, and participation should be mandatory. Examples of evidence-based family/caregiver curriculum include: The Parent Project, Common Sense Parenting, Strengthening Families Program, and Parenting Wisely.
- After treatment is completed, the drug court should include a high quality aftercare component. The aftercare should be a formal component in which supervision/meetings are required and an evidence-based treatment model is used.

Quality Assurance

Strengths:

- Offender reassessment is completed using the San Diego Risk and Resiliency Check-up at regular intervals (every 6-months and at termination). While this meets minimum CPC criterion, it is still recommended that the court reassess clients on the behaviors the drug court is trying to change. For example, reassessment on the SASSI would help determine the youth's progress and continued areas of need. Examples of a proper pre-post tests for criminal thinking are the Pride in Delinquency Scale (PID), TCU Criminal Thinking Scale (TCU-CTS), How I Think Questionnaire (HIT), and the Criminal Sentiments Scale – Modified (CSS-M).
- Youth re-arrest and re-conviction data is examined on an annual basis. The drug court should continue to review this information regularly.
- Several different program evaluators are available to assist with research and evaluation of the drug court. The drug court should continue to receive regular reports from these evaluators.

Recommendations for Improvement:

- The drug court should have a management audit system in place to evaluate internal and external service providers. This includes site visits, monitoring of groups, regular progress reports, and file review.
- Participant satisfaction with the drug court and treatment programming should be measured with an exit survey.
- The drug court should go through a formal evaluation every five years comparing treatment outcome with a risk-control comparison group. Effectiveness would be supported should there be some reduction in recidivism in the drug court group versus the comparison group.

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OVERALL PROGRAM RATING

San Diego County Juvenile Drug Court received an overall score of **46.5** percent on the CPC-DC. This just falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence based interventions and services for offenders, is **43.8** percent, which falls into the **Ineffective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **48.1** percent, which falls into the **Needs Improvement** category.

FINDINGS – MCALISTER INSTITUTE

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	57.1%	Effective
Quality Assurance	25.0%	Ineffective
Offender Assessment	0.0%	Ineffective
Treatment	65.5%	Highly Effective
Overall Capacity	**50.0%**	**Needs Improvement**
Overall Content	**57.6%**	**Effective**
Overall Score	**54.9%**	**Needs Improvement**

Leadership, Staff, and Support

Strengths:

- The program director has a significant role in selecting, training, and supervising staff.
- The program director is involved in direct treatment services by conducting groups, doing assessments and carrying a caseload.
- Regular meetings take place between the program director and program staff.
- Staff are evaluated yearly with regard to service delivery skills. Evaluations include peer review and quarterly file reviews.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- Program funding is adequate and stable for the task at hand.

Recommendations for Improvement:

- While the program director has the requisite experience in working with offending populations, the program director lacks formal education in a helping profession. The program director should have at least a baccalaureate degree in a helping profession.
- The program should work to ensure that qualified staff are delivering direct services. At least 75% of direct care staff should have an associate's degree or higher in one of the helping professions, as well as at least two years of experience in treatment of the offender population.
- Direct care staff should be selected for skills and values conducive to offender treatment (the belief that offenders can change, empathy, etc.).

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- Staff should receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.
- The agency should be supported by stakeholders, including the juvenile drug court. While staff report a number of referrals from the probation department, they also state that the relationship with the juvenile drug court is strained. The agency should meet with the juvenile drug court team in order to resolve any issues that are interfering with the service delivery.

Client Assessment

Strengths: None.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral that the juvenile drug court makes to the program. There should be a written policy on which clients should be excluded from the program.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, Massachusetts Youth Screening Instrument (MAYSI), or IQ tests.
- The agency uses the Youth Assessment Index (YAI) to determine the risk level of their referrals from drug court. Of the ten files reviewed, 0% are high risk, 30% are moderate risk and 70% are low risk. Only clients who are high risk and moderate risk should be receiving intensive treatment services. Also, low-risk clients should not be mixed with high risk clients in treatment groups. Additionally, since the drug court is already assessing the risk level of drug court clients using the San Diego Risk and Resiliency Check-up, the program should not use valuable resources assessing for risk. Instead, the program should access the results from the drug court.
- The need for substance abuse treatment is also assessed by the YAI. Of the ten files reviewed, 30% were high need, 40% were moderate need, and 30% were low need. The program should only serve high and moderate need youth. Similar to the risk assessment recommendation, the agency is using valuable resources assessing the need for treatment when the drug court is already doing so using the Adolescent Substance Abuse Subtle Screening Inventory (SASSI). The program should instead access these results from the drug court and only accept moderate and high need youth into the treatment program.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The groups start and end on time.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Group norms/rules are established, documented, and reviewed with the group regularly
- When there is a co-facilitator in group, both facilitators are actively participating.

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- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change. Group sessions meet four times per week for 90 minutes. Treatment lasts for approximately three months.
- The agency uses a treatment manual and follows it very closely to structure time spent in group.
- Treatment groups are always conducted and monitored by staff.
- Group size averages between six to seven clients and never exceeds 12 clients.
- Group facilitators address client difficulties in understanding the material by breaking down the concepts, explaining concepts further, and offering examples.
- The types of rewards used by the program appear appropriate; however, it would be beneficial to use a wider range of reinforcers.
- Facilitators reported verbally addressing inappropriate behavior, requiring make up groups and assigning chores. These are appropriate punishers to extinguish antisocial behavior. Additionally, facilitators offer prosocial alternatives to the negative behavior.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.
- Participants are taught to recognize and explore their underlying antisocial thoughts and values. Staff then work with youth to replace these thoughts with prosocial thoughts.
- Relapse prevention plans are developed with each youth. These plans are routinely reviewed and practiced in both group and individual sessions.

Recommendations for Improvement:

- Staff report using a twelve step model to offender treatment. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Males and females are more productive in treatment sessions when they attend treatment separately. As such, treatment groups should be gender specific.
- Homework should be a regular part of the treatment process as it provides additional practice opportunities for the youth. Homework should be assigned at the end of each group or session and be reviewed at the beginning of the next group or session.
- Although the program has an array of reinforcers, rewards should outweigh punishers by a ratio of at least 4:1. The procedure by which offenders are reinforced should meet the following criteria: rewards should be immediate; seen as valuable for shaping behavior; consistently applied; and individualized.
- While the agency uses appropriate punishers, these punishments should be appropriately applied. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. Additionally, it is important to recognize and address excessive negative emotional reactions to punishment, such as fear or anger that may interfere with learning.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse

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the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.

Quality Assurance

Strengths:

- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- The agency should have a formal quality assurance process in place. While there are visits from a quality assurance person from the corporate office, direct care staff should be assessed on more than administrative duties; direct service delivery skills should be assessed. Additionally, clients should have an opportunity to provide feedback regarding their treatment.
- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once per group cycle, and formal feedback should be provided to the facilitator.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning the target behaviors of the program. Reassessment using the SASSI would be sufficient to meet this criterion.

Overall Program Rating

McAlister Institute received an overall score of **54.9** percent on the CPC-DC. This falls into the very high end of the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence based interventions and services for offenders, is **50.0** percent, which falls into the **Needs Improvement** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **57.6** percent, which falls into the **Effective** category.

FINDINGS – SOUTH BAY COMMUNITY SERVICES

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	85.7%	Highly Effective
Quality Assurance	75.0%	Highly Effective
Offender Assessment	0.0%	Ineffective
Treatment	41.4%	Ineffective
Overall Capacity	**83.3%**	**Highly Effective**
Overall Content	**36.4%**	**Ineffective**
Overall Score	**52.9%**	**Needs Improvement**

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Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- All staff are sufficiently educated in helping professions.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Staff are evaluated yearly with regard to service delivery skills. Evaluations include team feedback forms, setting goals for the next year, and file reviews.
- Staff receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming. Additionally, staff stated they are encouraged to go to as much training as they want throughout the year, and many attend far more than 40 hours.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by stakeholders, including the juvenile drug court.
- Program funding is adequate and stable for the task at hand.

Recommendations for Improvement:

- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- The program should work to ensure that qualified staff are delivering direct services. At least 75% of direct care staff should have an associate's degree or higher in one of the helping professions, as well as at least two years of experience in treatment of the offender population. At the time of the assessment, only 63% of staff had at least two years of experience in treatment programs for offenders.

Client Assessment

Strengths: None.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral that the juvenile drug court makes to the program. There should be a written policy on how clients are deemed inappropriate for the services provided by the program.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, Massachusetts Youth Screening Instrument (MAYSI), or IQ tests.
- The agency uses the Youth Assessment Index (YAI) to determine the risk level of their referrals from drug court. Of the ten files reviewed, 13% are high risk, 53% are moderate risk and 33% are low risk. Only clients who are high risk and moderate risk should be receiving intensive treatment services. Also, low-risk clients should not be mixed with high risk clients in treatment groups. Additionally, since the drug court is already assessing the risk level of drug court clients using the San Diego Risk and Resiliency Check-up, the

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program should not use valuable resources assessing for risk. Instead, the program should access the results from the drug court.

- The need for substance abuse treatment is also assessed by the YAI. Of the ten files reviewed, 40% were high need, 40% were moderate need, and 20% were low need. The program should only serve high and moderate need youth. Similar to the risk assessment recommendation, the agency is using valuable resources assessing the need for treatment when the drug court is already doing so using the Adolescent Substance Abuse Subtle Screening Inventory (SASSI). The program should instead access these results from the drug court and only accept moderate and high need youth into the treatment program.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The groups start and end on time.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- When there is a co-facilitator in group, both facilitators are actively participating.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change. Group sessions meet two times per week for 90 minutes. Treatment lasts for three to six months, with additional optional treatment components such as a multi-family group.
- Treatment groups are always conducted and monitored by staff.
- Group size averages between ten to twenty clients, and a co-facilitator is always present.
- The types of rewards used by the program appear appropriate and are appropriately applied.
- Facilitators report verbally addressing inappropriate behavior, removing youth from group and notifying probation officers if necessary. These are appropriate punishers to extinguish antisocial behavior.
- Relapse prevention plans are developed with each youth. They are routinely reviewed and practiced in both group and individual sessions.

Recommendations for Improvement:

- Staff report using a holistic approach to offender treatment, including music and creative arts therapy. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Males and females are more productive in treatment sessions when they attend treatment separately. As such, treatment groups should be gender specific.
- Homework should be a regular part of the treatment process as it provides additional practice opportunities for the youth. Homework should be assigned at the end of each group or session and be reviewed at the beginning of the next group or session.
- While staff stated that group rules are reviewed every week and are posted on the wall, observation of group revealed that rules are not consistently followed by youth. Among the behaviors observed were cussing, ignoring the facilitators, and picking on a gay youth.

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Youth should be held accountable for following group rules. Staff should receive training on group facilitation in order to learn how to lead a productive group.

- The agency does not use a specific curriculum or manual for groups. It is recommended that a curriculum or home grown manual be used to effectively treat substance abuse be used, and the manual be followed so that group time is structured. Examples of evidence-based substance abuse curricula for youth include Pathways to Self Discovery and Change and Cannabis Youth Treatment Series **(**CYT).
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- While the agency uses appropriate punishers, these punishments should be appropriately applied. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- Group facilitators should establish a rapport with group members, while maintaining a professional boundary. Additionally, facilitators should avoid arguing with clients and roll with resistance. During group observation, the facilitators did not address any behavioral issues through redirection or extinction.
- Participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms via county and state audits. Quality assurance includes quarterly and surprise file reviews and client satisfaction surveys.
- Supervisors sit in on sessions and provide formal feedback to counselors at least once per month.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning the target behavior. Reassessment using the SASSI would be sufficient to meet this criterion.

Overall Program Rating

South Bay Community Services received an overall score of **52.9** percent on the CPC-DC. This falls into the **Needs Improvement** category.

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The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence based interventions and services for offenders, is **83.3** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **36.4** percent, which falls into the **Ineffective** category.

FINDINGS – PALAVRA TREE, INC.

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	78.6%	Highly Effective
Quality Assurance	25.0%	Ineffective
Offender Assessment	25.0%	Ineffective
Treatment	39.3%	Ineffective
Overall Capacity	**66.7%**	**Highly Effective**
Overall Content	**37.5%**	**Ineffective**
Overall Score	**48.0%**	**Needs Improvement**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by stakeholders, including the juvenile drug court.
- Program funding is adequate and stable for the task at hand.

Recommendations for Improvement:

- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- While staff receive a yearly evaluation, it is based on policies and procedures only. Staff should be regularly evaluated with regard to service delivery skills. The program director should sit in on group or individual sessions to determine the quality of interactions each staff member has with youth for the annual evaluation.
- Direct care staff are only required to complete the 30 hours of training per year required by their certifications. Staff should receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.

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Client Assessment

Strengths:

- File review revealed that out of ten files, 30% were high need, 60% were moderate need and only 10% were low need in the area of substance abuse. This indicates that the agency is targeting higher need youth for substance abuse treatment.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral that the juvenile drug court makes to the program. There should be a written policy on which clients are deemed inappropriate for the services provided by the program.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, Massachusetts Youth Screening Instrument (MAYSI), and IQ tests.
- The agency uses the Youth Assessment Index (YAI) to determine the risk level of their referrals from drug court. Of the ten files reviewed, 13% are high risk, 53% are moderate risk and 33% are low risk. Only clients who are high risk and moderate risk should be receiving intensive treatment services. Also, low-risk clients should not be mixed with high risk clients in treatment groups. Additionally, since the drug court is already assessing the risk level of drug court clients using the San Diego Risk and Resiliency Check-up, the program should not use valuable resources assessing for risk. Instead, the program should access the results from the drug court.
- The need for substance abuse treatment is also assessed by the YAI. Of the ten files reviewed, 40% were high need, 40% were moderate need, and 20% were low need. The program should only serve high and moderate need youth. Similar to the risk assessment recommendation, the agency is using valuable resources assessing the need for treatment when the drug court is already doing so using the Adolescent Substance Abuse Subtle Screening Inventory (SASSI). The program should instead access these results from the drug court and only accept moderate and high need youth into the treatment program.

Treatment

Strengths:

- Groups are gender specific.
- The groups start and end on time.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change. Group sessions meet two times per week for a total of three and a half hours. Treatment lasts for six months for drug court youth.
- Palavra Tree uses The Power Source: Taking Charge of Your Life, and the manual is followed closely to structure group time as designed by the curriculum.
- Treatment groups are always conducted and monitored by staff.

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- The types of rewards used by the program appear appropriate and include verbal praise, special privileges, and movie days.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.

Recommendations for Improvement:

- While Palavra Tree is a substance abuse treatment agency, staff also reported targeting life skills and empowerment. It is recommended that the major focus of treatment be on criminogenic needs. In addition to substance abuse, examples of criminogenic needs are antisocial attitudes, thoughts and values; antisocial peers; and relapse prevention.
- Staff report using a holistic approach to offender treatment, including drug education and The Power Source: Taking Charge of Your Life. Only those treatment modalities that have been determined effective in changing offender behavior should be utilized. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e. teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Homework should be a regular part of the treatment process as it provides additional practice opportunities for the youth. Currently, homework is used by the program as punishment. Youth should not view extra practice opportunities as negative, and homework should not used as a sanction. Homework should be assigned at the end of each group or session and be reviewed at the beginning of the next group or session.
- Group size averages over 12 clients and a co-facilitator is never used for groups. It is recommended that the average size of group members per facilitator is about 8-12.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- Although the program appears to use appropriate rewards, facilitators are not consistent in their use of reinforcers and reported that they use more punishers than rewards. The ratio of rewards to punishers should be 4:1.
- The program should use punishers to discourage negative behavior. The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should also include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations. Structured skill building is not a part of the current curriculum.
- Participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.

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- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths:

- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- The agency should have a formal quality assurance process in place. While file reviews are conducted, they are only evaluated for completeness. File review should include treatment plan progress as well. Additionally, clients should have an opportunity to provide feedback regarding their treatment.
- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once per group cycle, and formal feedback should be provided to the facilitator.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning the target behavior. Reassessment using the SASSI would be sufficient to meet this criterion.

Overall Program Rating

Palavra Tree, Inc. received an overall score of **48.0** percent on the CPC-DC. This falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence based interventions and services for offenders, is **66.7** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **37.5** percent, which falls into the **Ineffective** category.

FINDINGS – MENTAL HEALTH SYSTEMS, INC.

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	78.6%	Highly Effective
Quality Assurance	25.0%	Ineffective
Offender Assessment	0.0%	Ineffective
Treatment	31.0%	Ineffective
Overall Capacity	**66.7%**	**Highly Effective**
Overall Content	**27.3%**	**Ineffective**
Overall Score	**41.2%**	**Ineffective**

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Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by stakeholders, including the juvenile drug court.
- Program funding is adequate and stable for the task at hand.

Recommendations for Improvement:

- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments. Currently, the program director only fills in as a backup.
- Service providers should be annually evaluated with regard to service delivery skills. The program director should observe group and/or individual sessions as part of an annual evaluation.
- Staff should receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.

Client Assessment

Strengths: None.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral that the juvenile drug court makes to the program. There should be a written policy on which clients are deemed inappropriate for the services provided by the program.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, Massachusetts Youth Screening Instrument (MAYSI), or IQ tests.
- The agency uses the Youth Assessment Index (YAI) to determine the risk level of their referrals from drug court. Of the ten files reviewed, none are high risk, 50% are moderate risk, and 50% are low risk. Only clients who are high risk and moderate risk should be receiving intensive treatment services. Also, low-risk clients should not be mixed with high risk clients in treatment groups. Additionally, since the drug court is already assessing the risk level of drug court clients using the San Diego Risk and Resiliency Check-up, the program should not use valuable resources assessing for risk. Instead, the program should access the results from the drug court.

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- The need for substance abuse treatment is also assessed by the YAI. Of the ten files reviewed, none are high need, 60% are moderate need, and 40% are low need. The program should only serve high and moderate need youth. Similar to the risk assessment recommendation, the agency is using valuable resources assessing the need for treatment when the drug court is already doing so using the Adolescent Substance Abuse Subtle Screening Inventory (SASSI). The program should instead access these results from the drug court and only accept moderate and high need youth into the treatment program.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change. Group sessions meet three to four times per week. Mental Health Systems, Inc. uses a phase system, and total time in treatment is six months.
- The maximum number of youth in the program at one time is 24. Youth are split into separate groups, and a co-facilitator is always present for all groups. It is recommended that the average size of group members per facilitator is about 8-12.
- The types of rewards used by the program appear appropriate, including verbal praise, treats, and a step-down phase system.
- The agency uses a grid to determine the level of punishment youth receive for inappropriate behavior. The grid is based on the number of warnings the youth receives in groups.
- Facilitators work with clients to identify underlying thoughts and values.

Recommendations for Improvement:

- Staff reported using a 12-step or "disease" approach to offender treatment. Treatment modalities that have been determined effective in changing offender behavior should be utilized. Examples of evidence-based treatment include structured social learning and cognitive-behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e. teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Males and females are more productive in treatment sessions when they attend treatment separately. As such, treatment groups should be gender specific.
- Homework should be a regular part of the treatment process as it provides additional practice opportunities for the youth. Homework should be assigned at the end of each group or session and be reviewed at the beginning of the next group or session.
- During one of the group observations, the co-facilitator only served a policing function for disruptive behavior. If a co-facilitator is used, both facilitators should be active in the treatment process.
- While the agency uses Hazelden curricula, the manuals are not followed. Curricula and manuals should be followed closely to structure time in group and ensure consistency across groups.

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- Staff report that youth who are further along in treatment sometimes facilitate pieces of the groups. Treatment groups should always be conducted and managed by staff.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- Although reinforcers are used appropriately, rewards should outweigh punishers by a ratio of at least 4:1. The procedure by which offenders are reinforced should meet the following criteria: rewards should be immediate; seen as valuable for shaping behavior; consistently applied; and individualized.
- While the agency uses appropriate punishers, these punishments should be appropriately applied. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- Group facilitators should establish a rapport with group members, while maintaining a professional boundary. Additionally, facilitators should avoid arguing with clients and roll with resistance. During group observation, several incidents of facilitators engaging in power struggles with clients were observed.
- Participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan with their counselor. While staff indicated that relapse prevention plans are developed, only one was found in the review of ten files. Additionally, there was no indication that youth are required to practice their plan on a regular basis.

Quality Assurance

Strengths:

- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- The agency should have a formal quality assurance process in place. While file reviews are conducted, they are only evaluated for completeness. Files should include treatment plan and progress as well. Additionally, clients should have an opportunity to provide feedback regarding their treatment.
- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once per group cycle and formal feedback should be provided to the facilitator.

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- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning the target behavior. Reassessment using the SASSI would be sufficient to meet this criterion.

Overall Program Rating

Mental Health Systems, Inc. received an overall score of **41.2** percent on the CPC-DC. This falls into the **Ineffective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence based interventions and services for offenders, is **66.7** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **27.3** percent, which falls into the **Ineffective** category.

FINDINGS – SAN DIEGO YOUTH SERVICES: EAST COUNTY

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	71.4%	Highly Effective
Quality Assurance	25.0%	Ineffective
Offender Assessment	0.0%	Ineffective
Treatment	55.2%	Effective
Overall Capacity	**61.1%**	**Effective**
Overall Content	**48.5%**	**Needs Improvement**
Overall Score	**52.9%**	**Needs Improvement**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- The program director is involved in direct treatment services by conducting groups, doing assessments and carrying a caseload.
- All staff are sufficiently educated in helping professions.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by stakeholders, including the juvenile drug court.
- Program funding is adequate for the task at hand.

Recommendations for Improvement:

- In addition to having educated staff, it is important to hire staff with prior experience working with offenders. Currently, only 50% of program staff have at least two years of experience in treatment programs for offenders. It is recommended that at least 75% of all direct care staff possess this experience.

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- Although the agency utilizes a clinical supervisor, he should sit in on groups to assess the service delivery of the treatment staff as part of annual evaluations.
- Staff should receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming. Currently, only 20 hours per year of training is required by the agency; this should be increased to 40 hours annually.
- While adequate to conduct treatment programs as designed, the agency's funding has been recently cut. These cuts are affecting program administration and staff. Although the agency was able to restructure to accommodate some of the loss of funding, it still impacted the design of the program. A stable source of funding should be sought and maintained.

Client Assessment

Strengths: None.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria; the program accepts every referral that the juvenile drug court makes to the program. There should be a written policy on which clients are deemed inappropriate for the services provided by the program.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, Massachusetts Youth Screening Instrument (MAYSI), or IQ tests.
- The agency uses the Youth Assessment Index (YAI) to determine the risk level of their referrals from drug court. However, during the file review, assessors only found un-scored YAI's. Only clients who are high risk and moderate risk should be receiving intensive treatment services. Also, low-risk clients should not be mixed with high risk clients in treatment groups. Additionally, since the drug court is already assessing the risk level of drug court clients using the San Diego Risk and Resiliency Check-up, the program should not use valuable resources assessing for risk. Instead, the program should access the results from the drug court.
- The need for substance abuse treatment is also assessed by the YAI. In addition, the program uses the Adolescent Substance Abuse Subtle Screening Inventory (SASSI). However, during the file review, the SASSI's were either un-scored or youth were all low need for substance abuse treatment. The program should only serve high and moderate need youth. Similar to the risk assessment recommendation, the agency is using valuable resources assessing the need for treatment when the drug court is already doing so using the SASSI. The program should instead access these results from the drug court and only accept moderate and high need youth into the treatment program.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The groups start and end on time.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.

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- Group norms/rules are established, documented, and reviewed with the group regularly.
- When there is a co-facilitator in group, both facilitators are actively participating.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change. Intensive outpatient groups meet five times per week for three hours, and the entire program averages nine months. The less intensive group meets twice per week for two hours, and the program lasts only six months. These groups are always held separately.
- Treatment groups are always conducted and monitored by staff.
- Group size averages between 10-12 clients, and a co-facilitator is always present.
- The types of rewards used by the program appear appropriate.
- Facilitators use appropriate punishers to address antisocial behaviors. The punishers are individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and are immediately applied following the infraction.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.
- Relapse prevention plans are developed with each youth, and it is routinely reviewed and practiced in both group and individual sessions.

Recommendations for Improvement:

- The program reports using a mix of motivational interviewing and cognitive-behavioral concepts. However, group observation and interviews with youth reveal that little to no cognitive restructuring or structured skill building took place during treatment groups. Groups should be enhanced to ensure that about half of the time is devoted to cognitive restructuring and half of the time is used to supplement youth skills using structured skill building techniques.
- Males and females are more productive in treatment sessions when they attend treatment separately. As such, treatment groups should be gender specific.
- Homework should be a regular part of the treatment process, and the counselor should consistently review homework with the youth. Homework should be assigned at the end of each session and reviewed at the beginning of the next session.
- The agency does not use a specific curriculum or manual for groups. It is recommended that a curriculum or home grown manual be used to effectively treat substance abuse, and the manual should be followed so that group time is structured. Examples of evidence-bases substance abuse curricula for youth include Pathways to Self Discovery and Change and Cannabis Youth Treatment Series **(**CYT).
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- Although the program has an array of reinforcers, rewards should outweigh punishers by a ratio of at least 4:1. The procedure by which offenders are reinforced should meet the following criteria: rewards should be immediate; seen as valuable for shaping behavior; consistently applied; and individualized.
- While the agency uses appropriate punishers and applies them appropriately, it is important that a prosocial alternative to the negative behavior is taught and modeled by the facilitator as part of the disapproval process.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse

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the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.

- Participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.

Quality Assurance

Strengths:

- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- The agency should have a formal quality assurance process in place. While file reviews are conducted, they are only evaluated for completeness. Files should include treatment plan and progress as well. Additionally, clients should have an opportunity to provide feedback regarding their treatment.
- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once per group cycle and formal feedback should be provided to the facilitator.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning the target behavior. Reassessment using the SASSI would be sufficient to meet this criterion.

Overall Program Rating

San Diego Youth Services – East County received an overall score of **52.9** percent on the CPC-DC. This falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence based interventions and services for offenders, is **61.1** percent, which falls into the **Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **48.5** percent, which falls into the **Needs Improvement** category.

FINDINGS – PHOENIX HOUSES OF CALIFORNIA

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	78.6%	Highly Effective
Quality Assurance	50.0%	Needs Improvement
Offender Assessment	25.0%	Ineffective
Treatment	86.2%	Highly Effective
Overall Capacity	**66.7%**	**Highly Effective**
Overall Content	**78.8%**	**Highly Effective**
Overall Score	**74.5%**	**Highly Effective**

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Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the criminal justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Staff are evaluated yearly with regard to service delivery skills. Additionally, files are reviewed monthly.
- Staff receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by stakeholders, including the juvenile drug court.

Recommendations for Improvement:

- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- Staff consistently report that agency funding is not sufficient to facilitate the program as designed. Several sources indicated that fundraising efforts help to alleviate a $600,000 per year deficit in funding, but even with fundraising, the program remains underfunded.
- Funding has been cut 10% recently, causing the agency to lay off one counselor. It is recommended that the agency work to obtain stable and adequate funding.

Client Assessment

Strengths:

- Responsivity is assessed using the Family Assessment Measure – III (FAM III), Comprehensive Assessment Tool (CAT), Beck's Depression Scale and the Minnesota Multiphasic Personality Inventory (MMPI), among others.

Recommendations for Improvement:

- While staff report that the agency uses exclusionary criteria to screen their referrals from the drug court, the criteria itself is inconsistently followed. There should be a written policy on which clients are deemed inappropriate for the services provided by the program, and the policy should always be followed.
- Although staff reported using the Youth Assessment Index (YAI) to determine the risk level of their referrals from drug court, only one was found in the review of ten files. Only clients who are high risk and moderate risk should be receiving intensive treatment services. Also, low-risk clients should not be mixed with high risk clients in treatment groups. Additionally, since the drug court is already assessing the risk level of drug court clients using the San Diego Risk and Resiliency Check-up, the program should not use valuable

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resources assessing for risk. Instead, the program should access the results from the drug court.

- The need for substance abuse treatment is also assessed by the YAI. However, only one was found in the review of ten files. The program should only serve high and moderate need youth. Similar to the risk assessment recommendation, the agency is using valuable resources assessing the need for treatment when the drug court is already doing so using the Adolescent Substance Abuse Subtle Screening Inventory (SASSI). The program should instead access these results from the drug court and only accept moderate and high need youth into the treatment program.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The groups start and end on time.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Homework is a regular part of the treatment process and is regularly reviewed with the youth.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- When there is a co-facilitator in group, both facilitators are actively participating.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change. Group sessions meet two times per week for 90 minutes. The duration of treatment is nine months.
- There is a manual for each treatment group that is followed closely to structure the time in the group.
- Treatment groups are always conducted and monitored by staff.
- Group size averages between 10-15 clients, and a co-facilitator is always present. It is recommended that the average size of group members per facilitator is about 8-12.
- There is evidence that the group facilitators take into consideration the results of the responsivity assessments completed by the program. Therefore, responsivity is addressed by the group facilitators.
- The types of rewards used by the program appear appropriate and are appropriately applied.
- Staff use a variety of punishments and apply them appropriately. Additionally, youth are taught a prosocial alternative to their negative behavior.
- Facilitators consistently model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.
- Participants are taught to recognize and explore their underlying antisocial thoughts and values. Staff work with youth to replace these thoughts with prosocial thoughts.
- Relapse prevention plans are developed with each youth. They are routinely reviewed and practiced in both group and individual sessions.

Recommendations for Improvement:

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- While most of the treatment interventions used at Phoenix Houses of California are grounded in techniques proven to elicit offender change, not all of the programming is evidenced-based. For example, the confrontation group and family group do not use evidence-based practices. All groups need to be grounded in evidence-based practices. It is recommended that the confrontation group be eliminated and the family group incorporate methods to ensure that family members are trained to assist the youth in making long-term prosocial changes. Examples of evidence-based family/caregiver curriculum include: The Parent Project, Common Sense Parenting, Strengthening Families Program, and Parenting Wisely.
- Only the Voices and Boys Council groups are gender specific. Males and females are more productive in treatment sessions when they attend treatment separately. As such, all treatment groups should be gender specific.
- While facilitators model and role play skills with youth, they should include graduated practice of new skills in increasingly difficult situations.

Quality Assurance

Strengths:

- The program incorporates extensive internal quality review mechanisms. Quality assurance includes clinical supervision, videotaped sessions, case conferences, treatment progress review, client satisfaction surveys, and review by an outside committee.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- While sessions are videotaped and occasionally sat in on, structured feedback should be offered to the facilitators at least once per group cycle.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning the target behavior. Reassessment on the SASSI is sufficient to meet this criterion.

Overall Program Rating

Phoenix Houses of California received an overall score of **74.5** percent on the CPC-DC. This falls into the **Highly Effective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence based interventions and services for offenders, is **66.7** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **78.8** percent, which falls into the **Highly Effective** category.

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CONCLUSION

Researchers at the University of Cincinnati have assessed 512 programs nationwide and have developed a large database on correctional intervention programs.[2] Approximately 7 percent of the programs assessed have been classified as HIGHLY EFFECTIVE, 17 percent have been classified as EFFECTIVE, 31 percent have been classified as NEEDS IMPROVEMENT, and 45 percent have been classified as INEFFECTIVE.

Graphs representing the results of this assessment are provided below. The first graph or set of graphs compares the drug court or referral agency score in the capacity domain, content domain, and overall score with the average scores from all 512 programs evaluated by the University of Cincinnati. The final graph shows the drug court score and an average of the scores from all referral agencies used by the drug court compared to the average of all programs evaluated by the University of Cincinnati.

Recommendations have been made in each of the four CPC domains for the San Diego Juvenile Drug Court. These recommendations should assist the program in making necessary changes to increase program effectiveness. Certainly, care should be taken not to attempt to address all "areas needing improvement" at once. Programs that find the assessment process most useful are those that prioritize need areas and develop action plans to systematically address such needs. Previous programs have also been successful at improving the provision of services by formulating committees charged with developing strategies for delivering evidence-based programming.

This report also provides the drug court with a snapshot of the referral agencies where its youth are receiving treatment in the community. This evaluation should assist the drug court in determining what type of treatment is effective when working with juvenile drug court clients. It should also assist the referral agencies with ways they can improve the services they provide to drug court youth.

[2] Several versions of the CPAI were used prior to the development of the CPC. Scores and averages have been adjusted as needed.

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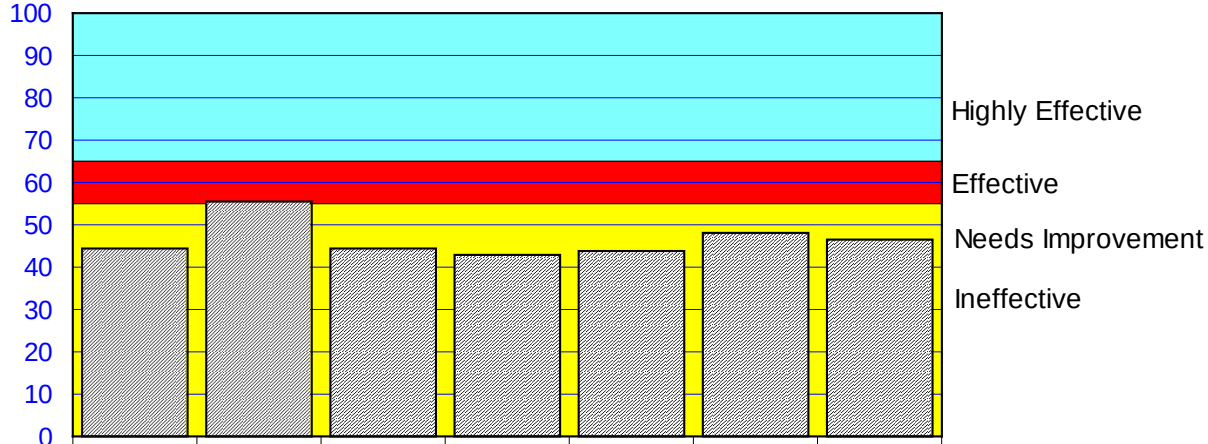
FIGURE 1:

San Diego County Juvenile Drug Court CPC-DC Scores



	Dev., Coordination, Staff, & Support	Offender Assessment	Treatment	Quality Assurance	Overall Capacity	Overall Content	Overall Score
San Diego County Juvenile Drug Court	44.4	55.5	44.4	42.9	43.8	48.1	46.5

Assessment conducted on July 7-9, 2009. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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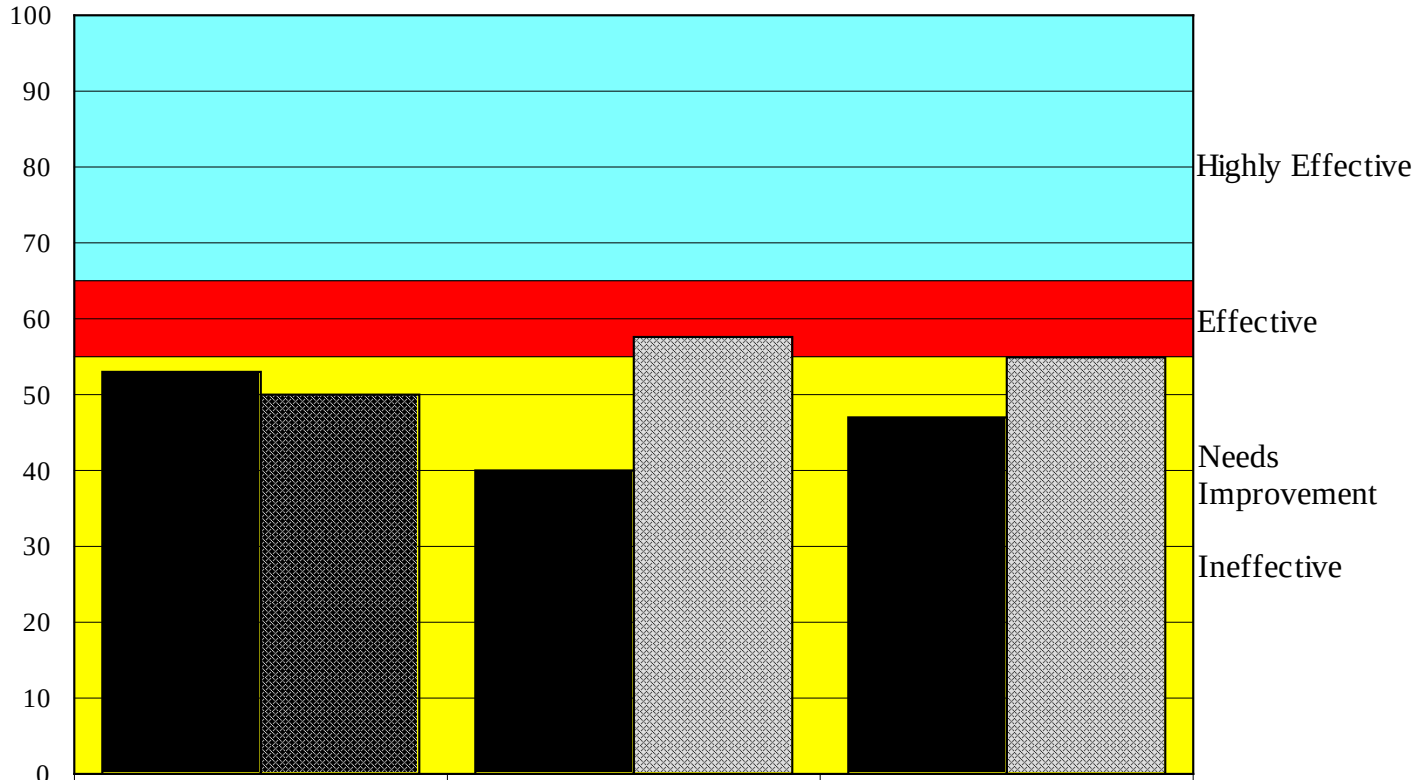
FIGURE 2:
McAllister Institute CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
McAllister	50	57.6	54.9

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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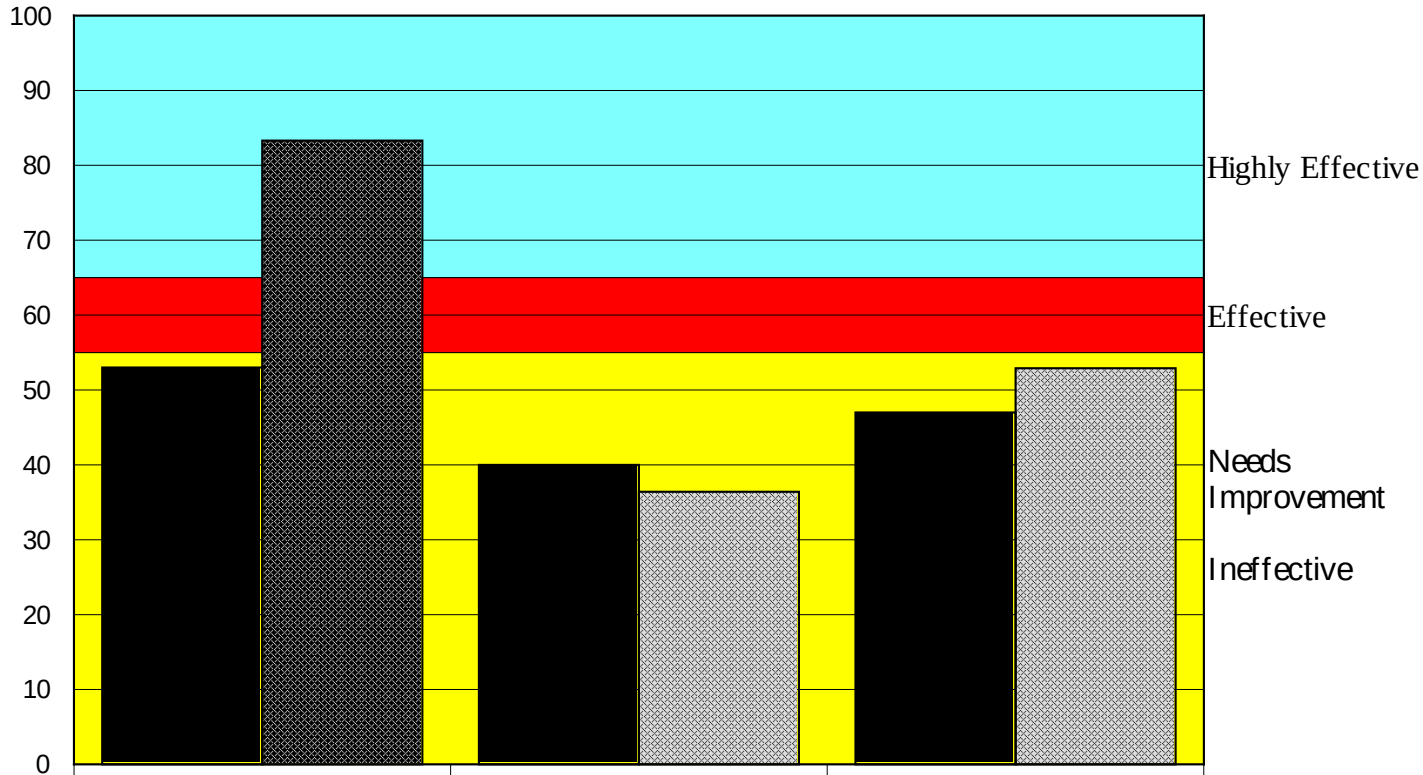
FIGURE 3:
South Bay Community Services CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
SBCS	83.3	36.4	52.9

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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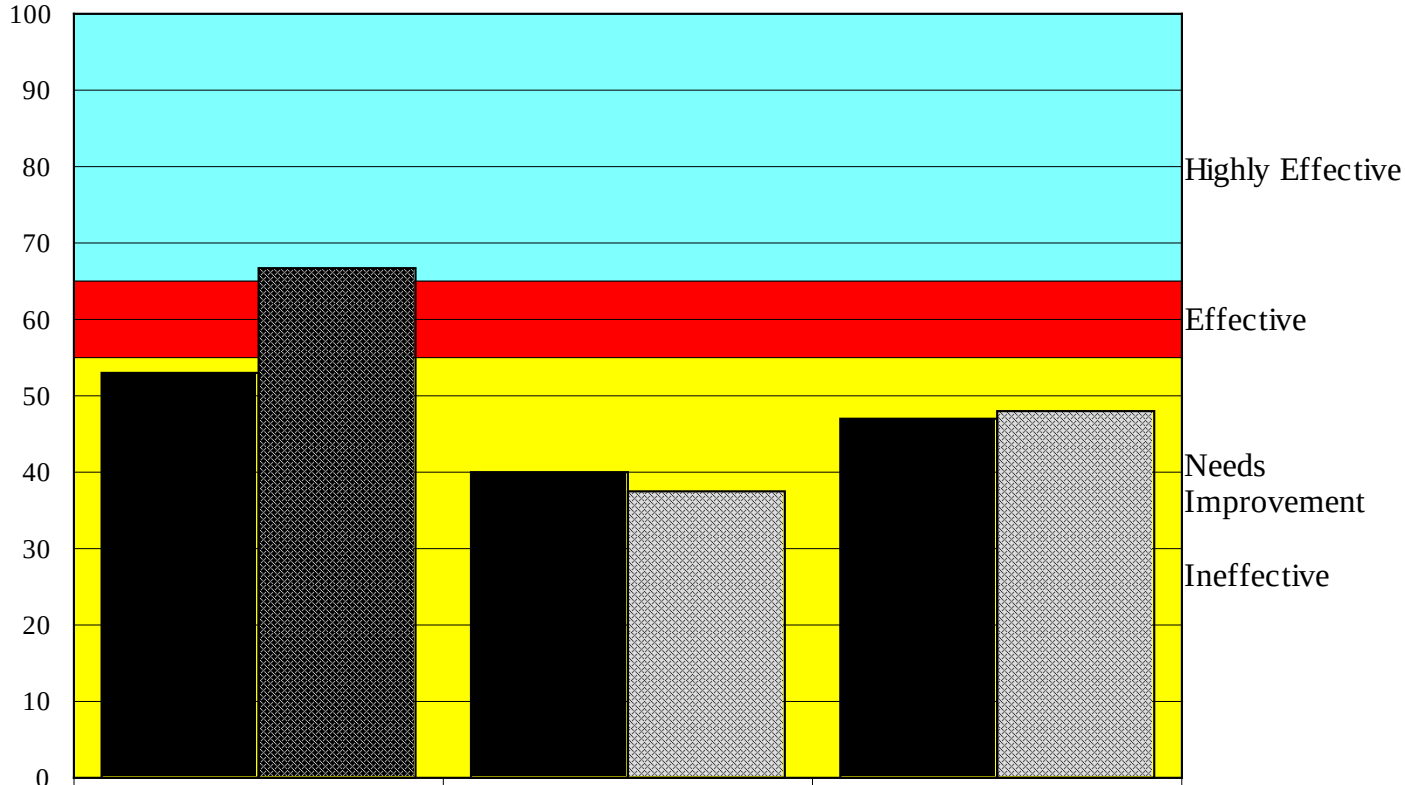
FIGURE 4:
Palavra Tree, Inc CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Palavra Tree	66.7	37.5	48

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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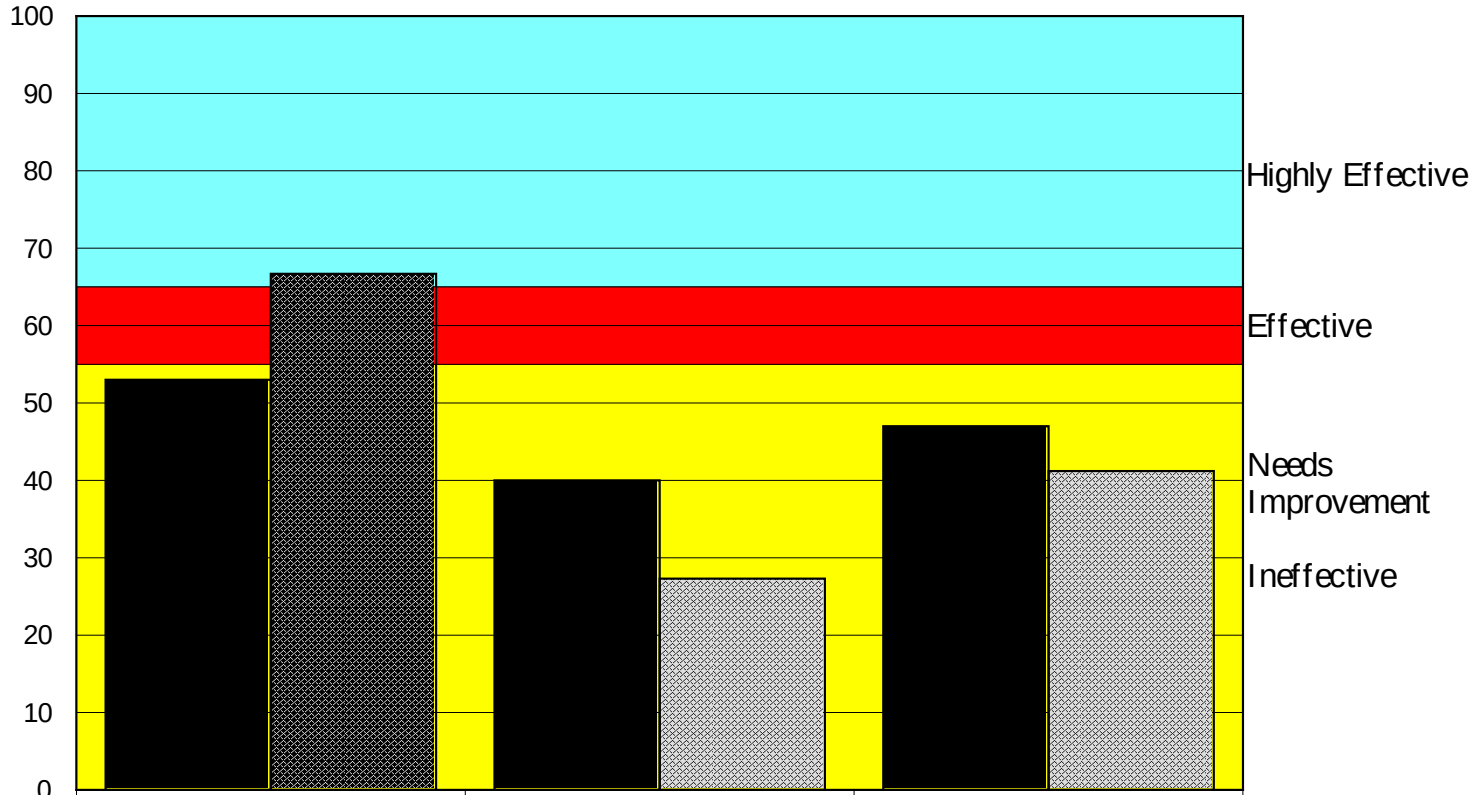
FIGURE 5:
Mental Health Systems CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
MHS	66.7	27.3	41.2

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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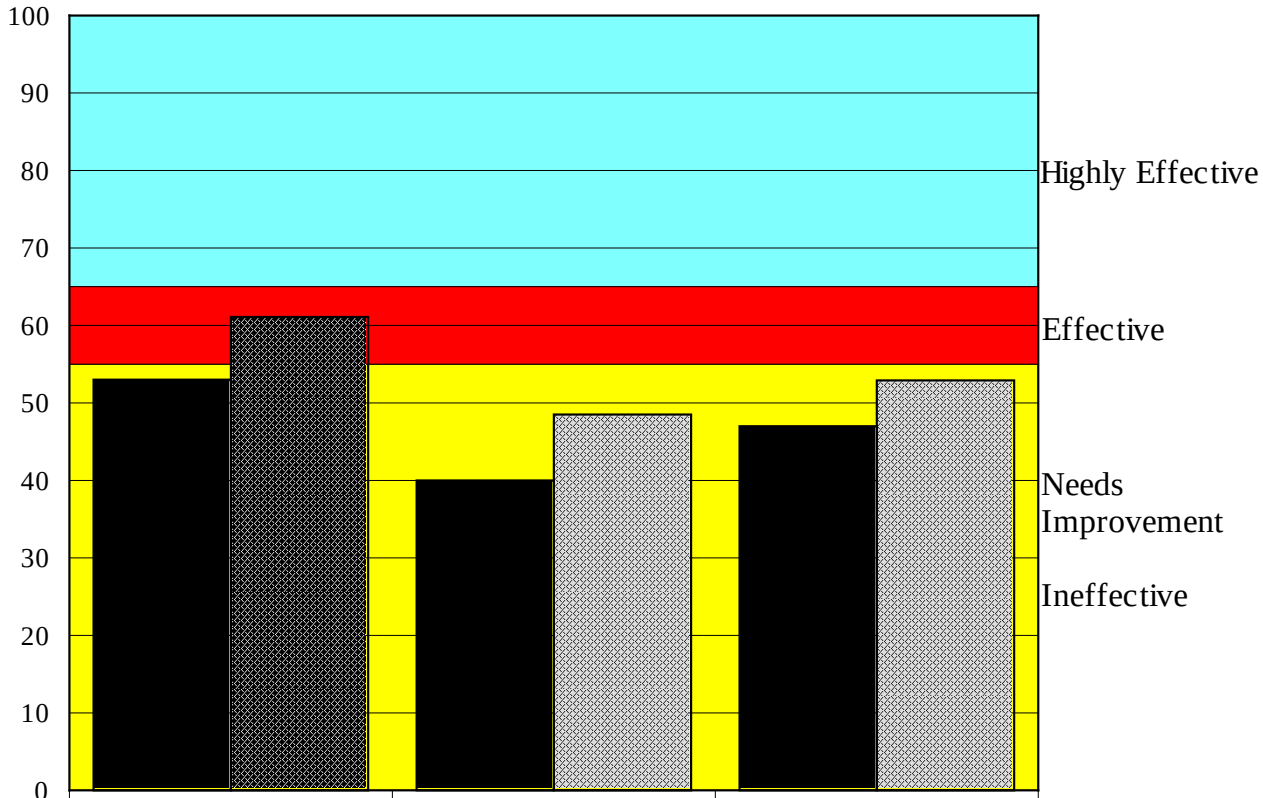
FIGURE 6:
San Diego Youth Services CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
San Diego Youth Services	61.1	48.5	52.9

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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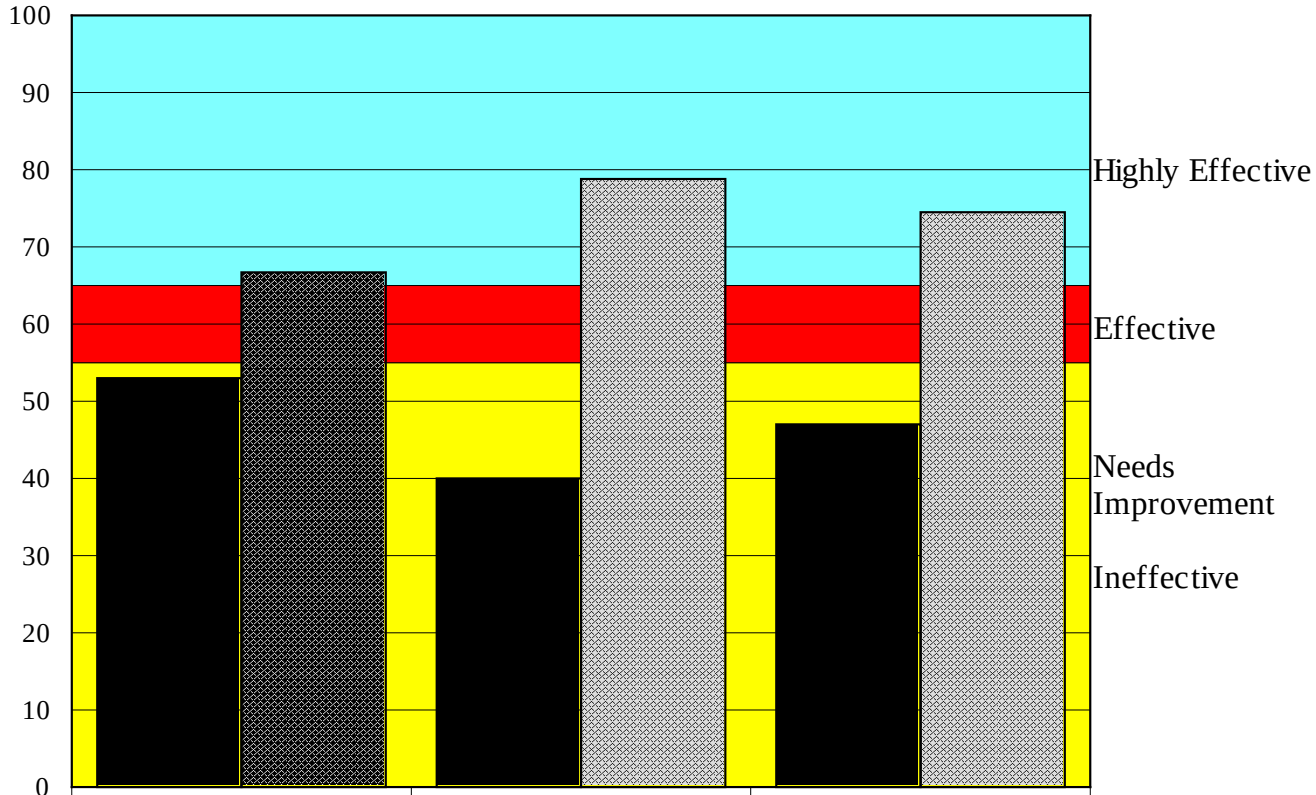
FIGURE 7:
Phoenix Houses - Residential CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Phoenix - Residential	66.7	78.8	74.5

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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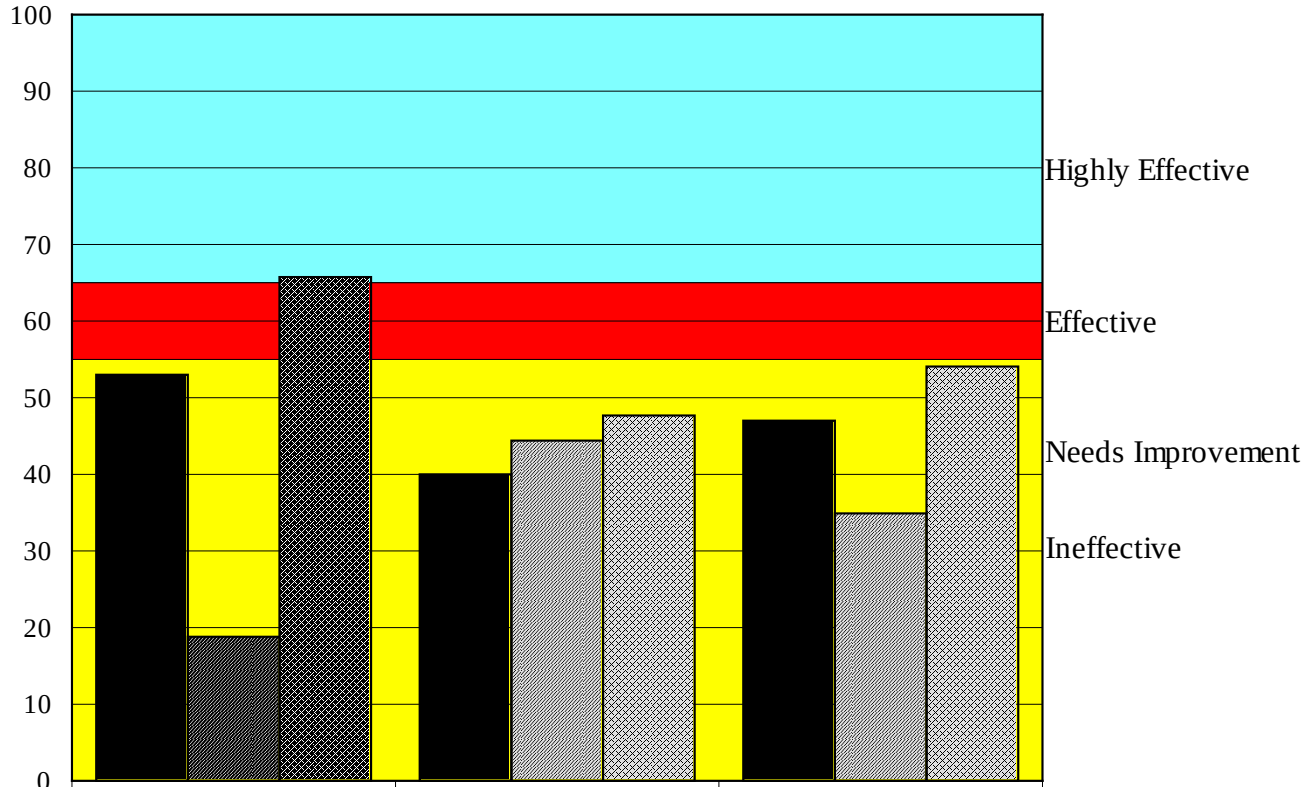
FIGURE 8:
San Diego County Juvenile Drug Court Overall



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
San Diego County	18.8	44.4	34.9
Referral Agency Average	65.75	47.68	54.07

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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EVIDENCE-BASED CORRECTIONAL PROGRAM CHECKLIST – DRUG COURT (CPC-DC) SYNOPSIS OF FINDINGS

Performed as part of the OJJDP study Outcome and Process Evaluation of Juvenile Drug Courts

Santa Clara County Juvenile Drug Court

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OUTCOME AND PROCESS EVALUATION OF JUVENILE DRUG COURTS STUDY

This project is funded by a grant received from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The purpose of this study is to evaluate a national sample of juvenile drug court programs. The goals of this research are: (1) To determine if there is a reduction in recidivism and substance abuse associated with participation in a juvenile drug court program; (2) to determine if there are improvements in social functioning (e.g. school performance, employment, and family functioning) related to participating in juvenile drug court programs; (3) to identify the characteristics of successful juvenile drug court participants; (4) to determine if juvenile drug courts are operating in a manner consistent with an evidence-based approach; (5) to identify the programmatic characteristics of effective juvenile drug courts; and (6) to provide information to policymakers about the effectiveness of drug courts for juvenile offenders.

This study includes both an outcome and a process evaluation. The outcome portion of the study examines outcomes of youth participating in drug courts as compared to similar youth who are on probation. The process evaluation explores the effectiveness of the drug court and drug court programming and is the focus of this report. Ten drug courts from across the country participated in this four-year study, nine of which participated in both the process and outcome evaluation pieces. The final report for the Outcome and Process Evaluation of Juvenile Drug Courts study will offer outcome and process evaluation findings across all nine drug court sites and is expected to be submitted to OJJDP in December 2012.

CONTEXT AND SCOPE OF THIS EVALUATION

The following report is part of a larger national project centered on the effectiveness of juvenile drug court programs and provides a synopsis of findings from the process evaluation, as well as recommendations to enhance the effectiveness of the services delivered by the Santa Clara County Juvenile Drug Court. Programs that adhere to the principles of effective intervention are more likely to impact criminal reoffending (see Andrews & Bonta, 2003 for a review). Specifically, correctional research suggests that cognitive behavioral and social learning models of treatment are associated with considerable reductions in recidivism (Gendreau, 1996; Smith, Goggin & Gendreau, 2002). As such, the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) was used to evaluate the juvenile drug courts participating in the Outcome and Process Evaluation of Juvenile Drug Courts study. The objectives of this assessment are to conduct a detailed review of services and program materials of the juvenile drug courts and the agencies they refer youth to and to compare their current practices with the literature on "best practices" in corrections.

PROCEDURES

Description of the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC)

The Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) is a tool that the University of Cincinnati developed for assessing drug court programs. It is used to determine how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. The CPC-DC was modified from the Evidence-Based Correctional Program Checklist (CPC) [1] and includes important indicators from drug court meta-analyses (see Shaffer, 2006). The CPC has been

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validated by several recent studies conducted by the University of Cincinnati. These studies found strong correlations between outcome and both domain areas and individual items (Holsinger, 1999; Lowenkamp, 2003; Lowenkamp and Latessa, 2003, Lowenkamp & Latessa, 2005a; Lowenkamp and Latessa, 2005b; Shaffer, 2006). As part of the larger national study, the indicators on the CPC-DC will be validated using the outcome data collected on the drug court participants.

The CPC-DC consists of two instruments: one for the formal drug court (CPC-DC) and the other for the major referral agencies (CPC-DC: RA) involved in providing treatment and services to drug court clients. Each of these tools is divided into two basic areas: Content and Capacity. The capacity area is designed to measure whether the drug court and its referral agencies have the capability to deliver evidence-based interventions and services to offenders. There are two domains in the capacity area: 1) Development, Coordination, Staff and Support, and 2) Quality Assurance. The content area focuses on the substantive aspect of the drug court and its referral agencies, and also includes two areas: 1) Assessment Practices, and 2) Treatment. This area examines the extent to which the drug court and its referral agencies meet the principles of risk, need, responsivity, and treatment.

The Drug Court tool includes 41 indicators, worth 43 total points. The Referral Agency tool has 49 indicators worth a total of 51 points. Each area and all domains are scored and rated as “highly effective” (65% to 100%); “effective” (55% to 64%); “needs improvement” (46% to 54%); or “ineffective” (45% to 0%). The scores in all domains are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the domains are given equal weight. Further, some items may be considered "not applicable," in which case they are not included in the scoring. Data are collected through structured interviews with selected program staff and program participants, as well as through observation of groups and services. In some instances, surveys may be used to gather additional information. Other sources of information include policy and procedure manuals, schedules, treatment materials, curricula, case files, and other selected program materials. Once the information is gathered and reviewed, the program is scored. The following report highlights strengths, areas that need improvement, and recommendations for each of the areas for both the drug court and the referral agencies.

There are several limitations to the CPC-DC that should be noted. First, as with any research process, objectivity and reliability are an issue. Although steps are taken to ensure that the information gathered is accurate and reliable, decisions about the information gathered are invariably made by the assessors. Second, the process is time specific. That is, the assessment is based on the program at the time of the assessment. Though changes or modifications may be planned for the future, only those activities and processes that were present at the time of the review in July 2009 are considered for scoring. Third, the process does not take into account all system issues that can affect program integrity (i.e., political climate of the court). Finally, the process does not address the reasons that a problem exists within a program or why certain practices do or do not take place. Rather, the process is designed to determine the overall integrity of the program.

Despite these limitations, there are a number of advantages to this process. First, the criteria are based on empirically derived principles of effective programs, and all of the indicators included in

[1] The CPC is modeled after the Correctional Program Assessment Inventory developed by Gendreau and Andrews. However, only those indicators that were found to be positively correlated with outcome were retained. In addition, the CPC includes a number of items not contained in the CPAI.

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the CPC-DC are correlated with reductions in recidivism. Second, it allows researchers to get inside the "black box" of a drug court and its referral agencies, something that an outcome study alone does not provide. This means researchers are able to measure the degree to which programs are meeting evidence-based standards. Third, the CPC-DC enables researchers to "quantify" the quality of a program through a scoring process. This allows for comparisons across programs, the setting of benchmarks, and for reassessment to measure progress. Fourth, it identifies both the strengths and weaknesses of a program and provides specific recommendations for program improvement.

Assessment Process

The assessment process consisted of a series of structured interviews with staff members and program participants during an on-site visit to Santa Clara County Juvenile Drug Court on July 27th through July 31st, 2009. Additionally, data were gathered via the examination of ten representative files (five open and five closed) as well as other relevant program materials (e.g., treatment manuals, assessments, training protocol, ethical guidelines, and staff evaluations). Finally, Juvenile Treatment Court Orientation was observed. Additionally, four treatment agencies were evaluated, including group observations: Advent Group Ministries; Asian American Recovery Services (AARS); Children, Family, and Community Services – Department of Alcohol and Drug Services (DADS); and Community Health Awareness Council (CHAC) – New Outlooks. Four evaluators conducted the various interviews, observations and file reviews. Data from the various sources were then combined to generate a consensus CPC-DC score and the specific recommendations in what follows.

SUMMARY OF THE DRUG COURT

The Santa Clara County Juvenile Drug Court has been in operation since 1996. Youth are all under eighteen years of age and must have a history of substance abuse and engaging in delinquent behavior. Youth with a history of selling drugs, possessing a firearm or felony sexual offenses are not considered for drug court (the court developed new policies shortly after the assessment which allow for consideration of some these offenses on a case-by-case basis). At the time of assessment, Margaret Johnson was the drug court judge, Michael Clarke was the probation manager, and Stephen Betts was the director of Children, Family and Community Services Division.

The drug court requires clients to progress through three phases of treatment lasting a minimum of six month, with an average of about one year. As a phase system, components of the program follow a step-down approach. In Phase 1, youth must attend a minimum of four hours of treatment per week, submit two random drug screens per week, meet with their probation officer at least twice per week, and attend court hearings once per week. In Phase 2, youth must continue the same level of treatment and urine screens, meet with their probation officer at least once per week, and attend court hearings three times per month. Additionally, parents/guardians must participate in one parent workshop. In the final Phase (3), youth must continue with a lower level of treatment, submit random urine screens at least once per week, and meet with their probation officer and attend court hearings at least twice per month. The drug court relies on the following techniques to supervise youth in the program: curfew, drug and alcohol testing, home and school visits, and attendance at court. The drug court utilizes several referral agencies for substance abuse counseling. The following were evaluated for this report: Advent Group Ministries; AARS Children, DADS; and CHAC – New Outlooks.

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FINDINGS – DRUG COURT

CPC-DC SECTIONS	SCORE	RATING
Development, Coordination, Staff, and Support	55.6%	Effective
Quality Assurance	42.9%	Ineffective
Offender Assessment	66.7%	Highly Effective
Treatment	44.4%	Ineffective
Overall Capacity	**50.0%**	**Needs Improvement**
Overall Content	**51.9%**	**Needs Improvement**
Overall Score	**51.2%**	**Needs Improvement**

Development, Coordination, Staff, and Support

Strengths:

- Regular staff meetings are held to discuss clients in the drug court.
- Drug court staff provide direct case management and supervision services to the youth in the drug court.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- Funding for the drug court is adequate, and there have been no changes in the level of funding in the past two years. However, staff noted that they would like more money to offer incentives to drug court youth.

Recommendations for Improvement:

- The Santa Clara Juvenile Drug Court should have a program coordinator or someone who is responsible for oversight and management of the drug court, the drug court team, and all of the referral services. Currently, two people serve in a program coordinator position. However, not all of the This person should also have a direct role in selecting, approving, and supervising the internal staff and external counselors hired to provide treatment.
- Drug court staff should be trained on drug court programming and receive at least 40 hours of on-going training a year. Staff training should relate to the theory and practice of interventions used by the drug court including effective correctional practices and the cognitive-behavioral model.
- The drug court accepts only post-conviction/adjudication youth. Drug courts are more likely to impact recidivism rates when they accept only youth who are pre-conviction/adjudication and the youth's charges are held in abeyance (or sealed), dropped, or reduced if the youth successfully completes drug court. As such, the drug court should adopt solely a pre-conviction/adjudication model.

Offender Assessment

Strengths:

- There are established criteria for the exclusion of certain types of offenders. The policy is written and followed, and clients are deemed appropriate for drug court by the majority of staff.
- Violent offenders are excluded from participating in the drug court.
- The drug court uses a Classification and Reclassification Tool that is an appropriate risk and need assessment to measure the risk level of the youth before they are accepted into the drug court.

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- The Santa Clara Juvenile Drug Court uses the American Society of Addiction Medicine (ASAM) and the Global Appraisal of Individual Needs (GAIN) to assess the need for substance abuse services. While the ASAM does not meet CPC criteria, the GAIN does.
- Assessments are shared with everyone on the drug court team including the referral agencies.

Recommendations for Improvement:

- The drug court assesses responsivity issues using the Massachusetts Youth Screening Instrument (MAYSI) and the Beck's Depression Inventory. While the drug court should be commended for assessing responsivity issues, the drug court should use the results of the assessments to inform clinical and staffing decisions. For example, youth should be matched to drug court staff and referral agencies based on the assessments.
- Drug courts should target moderate and high risk youth, and low risk youth should be screened out. Of the files reviewed that contained risk assessments, 13.3% were low risk, 80% were moderate risk, and only 6.7% were high risk. Low risk youth should make up no more than 5% of drug court participants.
- The drug court should target relevant higher need youth (high need for substance abuse treatment). Of the files reviewed that contained need assessments, 20% were low need, 60% were moderate need, and 20% were high need. Low need youth should make up no more than 5% of drug court participants.

Treatment Characteristics

Strengths:

- The Santa Clara County Juvenile Drug Court targets a wide range of criminogenic needs and meets criteria that at least 75% of drug court interventions should focus on criminogenic needs. The drug court targets the following criminogenic needs: antisocial peer associations; substance abuse; and family affection/communication.
- The drug court program is designed to last six months. Staff state that the average length in drug court is about one year. It is recommended that the majority of youth graduate in less than 12 months.
- Drug court participants spend an adequate amount of time in structured activities.
- The drug court has an appropriate reward structure including phase advancement, verbal praise, and occasionally gift certificates. Staff report a ratio of rewards to punishers at 4:1. This ratio is consistent with evidence-based practices.
- The drug court responds to noncompliance appropriately including community service, house arrest, increased drug screening, and detention.
- The drug court randomly drug tests youth on a regular basis during all three phases.

Recommendations for Improvement:

- The drug court uses a mix of evidence-based practices and some practices that are not evidence-based. Treatment modalities that have been determined effective in changing offender behavior should be utilized across the board. Examples of evidence-based treatment include structured social learning and cognitive behavioral models. The drug court should ensure that treatment providers are using these approaches. Groups should emphasize cognitive restructuring and structured skill building (i.e. teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.

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- Clients should be assigned to groups and services that match their style of learning and other responsivity factors. The drug court should use the results from the responsivity instruments to assess which groups are best for which client.
- The intensity of the drug court programming should vary by risk level. High risk youth should receive higher intensity and/or duration of service than moderate risk youth. Moderate risk youth should receive higher intensity and/or duration of service than low risk youth.
- The drug court should have measurable completion criteria which determine how well a youth has progressed in acquiring prosocial behaviors. These criteria should be objective and standardized. Examples of measurable completion criteria are behavioral assessment instruments, checklists of behaviors and/or attitudes, completion of a detailed treatment plan, and the acquisition of new skills and behaviors while in the drug court.
- The completion rate should be between 65% and 85%. The Santa Clara Juvenile Drug Court reports a completion rate less than 65%. The drug court should work to ensure that more youth are successful in the drug court.
- As part of drug court, the family/caregivers should be trained to provide support, including the ability to identify high risk situations for their youth and strategies for managing their environment using prosocial skills. Family groups should therefore target prosocial behavior and participation should be mandatory. While there is a required support group for family members, there is no evidence that support groups impact family functioning. Examples of evidence-based family/caregiver curriculum include: The Parent Project, Common Sense Parenting, Strengthening Families Program, and Parenting Wisely.
- After treatment is complete, the drug court should include a high quality aftercare component. The aftercare should be a formal component in which supervision/meetings are required and an evidence-based model is used.
- Although it is not required, the Santa Clara County Juvenile Drug Court recommends that youth participate in AA/NA. Youth in drug court should not be asked or required to attend self-help meetings. There is no evidence that these meetings are beneficial to youth and may in fact be harmful.

Quality Assurance

Strengths:

- Participant satisfaction with the drug court and treatment programming is measured as part of the graduation process.
- Youth are reassessed periodically via drug court staff meeting to determine if youth are progressing. This is achieved using the same Classification and Reclassification Tool used at intake.
- Youth re-arrest, re-conviction, or re-incarceration data is examined quarterly by the drug court staff.

Recommendations for Improvement:

- The drug court should have a management audit system in place to evaluate internal and external service providers. This includes site visits, monitoring of groups, regular process reports, and file review.
- The drug court should go through formal evaluation every five years comparing treatment outcome with a risk-control comparison group. Effectiveness is supported if there is some reduction in recidivism in the drug court group versus the comparison group.
- A program evaluator should be available (on staff or contract) to assist with research and evaluation of the drug court. Regular reports should be provided to the drug court.

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OVERALL PROGRAM RATING

Santa Clara County Juvenile Drug Court received an overall score of **51.2** percent on the CPC-DC. This just falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **50.0** percent, which falls into the **Needs Improvement** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **51.9** percent, which falls into the **Needs Improvement** category.

FINDINGS – ADVENT GROUP MINISTRIES

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	64.3%	Effective
Quality Assurance	50.0%	Needs Improvement
Offender Assessment	25.0%	Ineffective
Treatment	34.5%	Ineffective
Overall Capacity	**61.1%**	**Effective**
Overall Content	**33.3%**	**Ineffective**
Overall Score	**43.1%**	**Ineffective**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting and training staff. However, supervision of staff by the program director is limited and should be increased.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the criminal justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- Program funding has been stable over the past two years.

Recommendations for Improvement:

- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients on a routine basis. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- Staff should be evaluated at least once a year in regard to service delivery skills. The annual evaluation should include direct observation of groups or individual sessions.
- Staff should receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.

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- It is important that the agency be supported by stakeholders, particularly the juvenile drug court. Interviews with staff reveal that Santa Clara Juvenile Drug Court does not involve the agency in decision making concerning drug court clients. Advent should work with the drug court to address this lack of support.
- Although funding appears to be stable, staff consistently reported that the agency lacks the funds to implement the program as designed. The agency should seek additional funding sources to ensure that services can be delivered as intended.

Client Assessment

Strengths:

- The agency follows appropriate exclusionary criteria to ensure clients are appropriate for the treatment provided to them.

Recommendations for Improvement:

- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, Massachusetts Youth Screening Instrument (MAYSI), or IQ tests.
- Only clients who are high risk and moderate risk should be receiving intensive treatment services. Also, low-risk clients should not be mixed with high risk clients in treatment groups. The agency should utilize the risk assessment used by the court, or conduct their own risk assessment, to determine the risk level of the referrals prior to program acceptance.
- The program should serve high and moderate need youth; based upon file review it was unclear if the group targeted higher need youth. Only those youth who are in clear need of substance abuse treatment services should be accepted into the program.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change. Group sessions are one and a half hours long. The dosage of treatment varies based on the drug court phase of the youth. Phase one lasts for eight weeks, and youth attend five groups per week. Phase two lasts for twelve weeks, and youth attend three groups per week. Phase three lasts for four weeks, and youth attend two groups per week.
- Treatment groups are always conducted and monitored by staff.
- Group size averages eight clients with two facilitators.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.
- Facilitators work with clients to identify underlying thoughts and values.

Recommendations for Improvement:

- Treatment modalities that have been determined effective in changing offender behavior should be utilized. Examples of evidence-based treatment include structured social learning and cognitive behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e. teaching offenders prosocial skills to replace antisocial skills), including the use of

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modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. While the agency says they have Hazelden curricula, there is no evidence that it is used in treatment. Treatment groups mostly use talk therapy.

- Treatment groups should start on time and end on time, breaks should be limited to five to ten minutes, and the check-in process should not take up the majority of the treatment session or be the focus of the treatment session.
- Homework should be regularly assigned to participants to provide additional practice opportunities. Homework should be assigned at the end of each group and reviewed by the facilitator at the beginning of each group. Constructive feedback should be provided to the participants concerning their homework.
- Norms/rules should be established and followed with each group. Expectations should be reviewed and understood by all participants. When participants do not follow the rules, facilitators should address the noncompliance.
- When a co-facilitator is present in a group session, both facilitators should be equally active in the treatment process.
- Groups should have a set curriculum or manual that is consistently followed.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- While facilitators use a lot of encouragement and praise, facilitators indicate that they try not to use rewards as youth begin to expect them. Rewards should be used to reinforce positive behavior. In order for rewards to be effective, there should be a range of rewards and rewards should outweigh punishers by a ratio of at least 4:1. Rewards should be immediate, seen as valuable for shaping behavior, consistently applied, and individualized.
- The program should use punishers to discourage negative behavior. Staff are inconsistent in their use of punishers. Shaming techniques, which have been empirically shown to be ineffective in facilitating offender change, were used by staff. The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should also include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- While underlying thoughts and values are identified with participants, participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan with their counselor.

Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms via on-going certification supervision and consultation groups. Quality assurance includes quarterly file review and client satisfaction surveys.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

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Recommendations for Improvement:

- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once per group cycle, and formal feedback should be provided to the facilitator.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning substance abuse. Since the drug court uses the Global Appraisal of Individual Needs (GAIN), the program can reassess for progress using the GAIN.

Overall Program Rating

Advent Group Ministries received an overall score of **43.1** percent on the CPC-DC. This falls into the **Ineffective** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **61.1** percent, which falls into the **Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **33.3** percent, which falls into the **Ineffective** category.

FINDINGS – ASIAN AMERICAN RECOVERY SERVICES

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	78.6%	Highly Effective
Quality Assurance	50.0%	Needs Improvement
Offender Assessment	0.0%	Ineffective
Treatment	39.3%	Ineffective
Overall Capacity	**72.2%**	**Highly Effective**
Overall Content	**34.4%**	**Ineffective**
Overall Score	**48.0%**	**Needs Improvement**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the criminal justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Staff receive one month of initial training, and two hours of training are offered every Friday afternoon. This meets criterion that staff receive at least 40 hours of on-going training each year related to effective service delivery.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by stakeholders, including the juvenile drug court.

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- Program funding has been stable for the last two years.

Recommendations for Improvement:

- To help understand the needs of the clients and the challenges that staff face, the program director should be providing direct service to clients on a routine basis. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- Staff should be evaluated at least once a year in regard to service delivery skills. The annual evaluation should include direct observation of groups or individual sessions. While staff are not currently assessed on service delivery skills at as part of their annual evaluation, plans are in place to begin formal observation of groups with feedback to facilitators. This will be accomplished by the installation of a two-way mirror and audio recordings for observation purposes.
- Although funding appears to be stable, staff consistently reported that the agency lacks the funds to implement the program as designed. The agency should seek additional funding sources to ensure that services can be delivered as intended.

Client Assessment

Strengths: None.

Recommendations for Improvement:

- The program does not have identified exclusionary criteria. There should be a written policy on which clients are deemed inappropriate for the services provided by the program.
- Responsivity is not measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, Massachusetts Youth Screening Instrument (MAYSI), or IQ tests.
- While staff indicate that clients are mostly high risk, none of the files reviewed for this evaluation were higher than moderate risk. Out of the thirty files reviewed, 80% were low risk and 20% were moderate risk. Only clients who are high risk and moderate risk should be receiving intensive treatment services. Also, low-risk clients should not be mixed with high risk clients in treatment groups. The agency should utilize the risk assessment used by the court, or conduct their own risk assessment, to determine the risk level of their referrals from drug court.
- The program should serve high and moderate need youth. Only two substance abuse inventories were found in the thirty files that were reviewed. The agency should be using a needs assessment with every client and ensure that only those youth in need of substance abuse treatment services are accepted into treatment.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change. Drug court participants receive between one to five hours of treatment for up to six months.
- Treatment groups are always conducted and monitored by staff.
- Group size averages between five to eight clients, which meets CPC criterion.

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- The types of rewards used by the program appear appropriate and wide-ranging, including verbal praise and pizza for good behavior.
- Facilitators avoid arguments with participants and roll with resistance.
- Facilitators work with clients to identify underlying thoughts and values.
- Relapse prevention plans are developed with each youth. They are routinely reviewed and practiced.

Recommendations for Improvement:

- Currently, the program is not using evidence-based treatment modalities. Treatment modalities that have been determined effective in changing offender behavior should be utilized. Examples of evidence-based treatment include structured social learning and cognitive behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e. teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Males and females are more productive in treatment sessions when they attend treatment separately. As such, treatment groups should be gender specific.
- One group that was observed started twenty minutes late and ended twenty minutes early, and client interviews indicated this happens regularly. Treatment groups should start on time and end on time, breaks should be limited to five to ten minutes, and the check-in process should not take up the majority of the treatment session or be the focus of the treatment session.
- Homework should be regularly assigned to participants, and the homework should be reviewed by the facilitator and constructive feedback should be provided to the participants.
- Groups should have a set curriculum or manual that is consistently followed. The agency has developed a curriculum based on activities that have been done over the years, but this is not followed closely and does not dictate specific treatment topics for each session. Examples of evidence-bases substance abuse curricula for youth include Pathways to Self Discovery and Change and Cannabis Youth Treatment Series **(**CYT).
- Although the agency has an array of appropriate rewards, they need to be appropriately applied. Rewards should be used to reinforce positive behavior. In order for rewards to be effective, there should be a range of rewards and rewards should outweigh punishers by a ratio of at least 4:1. Rewards should be immediate, seen as valuable for shaping behavior, consistently applied, and individualized.
- The program should use punishers to discourage negative behavior. Currently, the program relies on the probation officers to implement punishers, and inappropriate behavior in groups is largely ignored. The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- Group facilitators should establish rapport with group members, while maintaining a professional boundary.
- While participants are taught to recognize antisocial thinking, participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.

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Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms. The clinical supervisor reviews treatment plans, assessments, and Outcome Rating Scales (ORS) and Session Rating Scales (SRS) for each client and session. Quality assurance also includes quarterly file review and client satisfaction surveys.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once per group cycle, and formal feedback should be provided to the facilitator.
- A pre-post test should be used to measure client progress on target behaviors. The pre-post test should measure changes in attitudes and behaviors concerning substance abuse. Since the drug court uses the Global Appraisal of Individual Needs (GAIN), the program can reassess for progress using the GAIN.

Overall Program Rating

Asian American Recovery Services received an overall score of **48.0** percent on the CPC-DC. This falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **72.2** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **34.4** percent, which falls into the **Ineffective** category.

FINDINGS - CHILDREN, FAMILY AND COMMUNITY SERVICES DEPARTMENT OF ALCOHOL AND DRUG SERVICES (DADS)

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	50.0%	Needs Improvement
Quality Assurance	50.0%	Needs Improvement
Offender Assessment	50.0%	Needs Improvement
Treatment	42.3%	Ineffective
Overall Capacity	**50.0%**	**Needs Improvement**
Overall Content	**43.8%**	**Ineffective**
Overall Score	**46.0%**	**Needs Improvement**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.

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- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- The agency reports being supported by stakeholders, including the juvenile drug court.

Recommendations for Improvement:

- The program director should have a significant role in selecting, training, and supervising staff.
- To help understand the needs of the clients and the challenges that staff face, the program director should provide direct service to clients on a routine basis. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments.
- While the service delivery skills of staff are assessed via review of charts and case notes and weekly supervision meetings, the program director should sit in on groups as part of an annual evaluation. Formal feedback should be given to help facilitators improve their service delivery at least annually.
- Staff should receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.
- While the agency has ethical guidelines in place, these guidelines should specifically dictate appropriate boundaries and interactions with youth.
- Program staff consistently state that program funding is lacking both in adequacy and stability. The agency should work to ensure that program funding is sufficient and stable to run the program as designed.

Client Assessment

Strengths:

- The agency follows appropriate exclusionary criteria to ensure clients are appropriate for the treatment provided to them.
- Responsivity, specifically motivation and cognitive functioning, are assessed via the ASAM.

Recommendations for Improvement:

- Only clients who are high risk and moderate risk should be receiving intensive treatment services. Also, low-risk clients should not be mixed with high risk clients in treatment groups. The agency should utilize the risk assessment used by the court, or conduct their own risk assessment, to determine the risk level of the referrals prior to program acceptance.
- The program should serve high and moderate need youth; based upon file review it was unclear if the group targets higher need youth. Only those youth who are in clear need of substance abuse treatment services should be accepted into the program.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The treatment groups are gender specific.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- Treatment groups are always conducted and monitored by staff.
- Group size averages between four to six clients, which meets CPC-DC criterion.

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- The program uses the results of the responsivity assessment to address and respond to the different learning styles and barriers of the participants in the group.
- The types of rewards used by the program appear appropriate, including verbal praise.
- The facilitators have good rapport with group participants.
- Facilitators avoid arguments with participants and roll with resistance.
- Relapse prevention plans are developed with each youth. They are routinely reviewed and practiced with counselors.

Recommendations for Improvement:

- Currently, the program is not using evidence-based treatment modalities. Treatment modalities that have been determined effective in changing offender behavior should be utilized. Examples of evidence-based treatment include structured social learning and cognitive behavioral models. There should be an emphasis on cognitive restructuring and structured skill building (i.e. teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Based on observation, group sessions routinely begin late and/or end early, and client interviews indicate this happens regularly. Treatment groups should start on time and end on time, breaks should be limited to five to ten minutes, and the check-in process should not take up the majority of the treatment session or be the focus of the treatment session.
- Homework should be regularly assigned to participants. Homework should be reviewed by the facilitator, and constructive feedback should be provided to the participants.
- Currently, treatment length is based on what insurance will allow. Treatment length and intensity should be based on the risk and need level of the client. Set treatment lengths should be established based on how long it should take youth to progress through the treatment.
- Groups should have a set curriculum or manual that is consistently followed. Examples of evidence-bases substance abuse curricula for youth include Pathways to Self Discovery and Change and Cannabis Youth Treatment Series **(**CYT).
- Although the agency has an array of appropriate rewards, they need to be appropriately applied. Rewards should be used to reinforce positive behavior. In order for rewards to be effective, there should be a range of rewards, and rewards should outweigh punishers by a ratio of at least 4:1. Rewards should be immediate, seen as valuable for shaping behavior, consistently applied, and individualized.
- The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should also include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- Participants should be taught how to recognize antisocial thinking and how to replace those thoughts with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.

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Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms; a quality assurance staff member was starting soon after this evaluation. Quality assurance also includes file review and client satisfaction surveys.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).

Recommendations for Improvement:

- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once per group cycle, and formal feedback should be provided to the facilitator.
- A pre-post test should be used to measure client progress on target behaviors. Since the drug court uses the Global Appraisal of Individual Needs (GAIN), the program can reassess for progress using the GAIN.

Overall Program Rating

Children, Family and Community Services – Department of Alcohol and Drug Services received an overall score of **46.0** percent on the CPC-DC. This falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **50.0** percent, which falls into the **Needs Improvement** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **43.8** percent, which falls into the **Ineffective** category.

FINDINGS – COMMUNITY HEALTH AWARENESS COUNCIL (CHAC) NEW OUTLOOKS

CPC-DC: RA SECTIONS	SCORE	RATING
Leadership, Staff, and Support	85.7%	Highly Effective
Quality Assurance	75.0%	Highly Effective
Offender Assessment	25.0%	Ineffective
Treatment	34.5%	Ineffective
Overall Capacity	**83.3%**	**Highly Effective**
Overall Content	**33.3%**	**Ineffective**
Overall Score	**51.0%**	**Needs Improvement**

Leadership, Staff, and Support

Strengths:

- The program director is professionally trained and has requisite experience to run this agency.
- The program director has a significant role in selecting, training, and supervising staff.

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- The program director is involved in providing direct services via assessments, group treatment, or individual treatment to youth in the program.
- All staff are sufficiently educated in helping professions and have adequate experience in treatment programs with youth involved in the juvenile justice system.
- Direct care staff are selected for skills and values conducive to offender treatment.
- Regular meetings take place between the program director and program staff.
- Ethical guidelines dictate staff boundaries and interactions with youth.
- The agency reports being supported by stakeholders, including the juvenile drug court.
- Program funding is adequate and stable for the task at hand.

Recommendations for Improvement:

- Staff should be evaluated annually with regard to service delivery skills. Formal feedback should be given to help facilitators improve their service delivery at least annually.
- Staff should receive formal training on the curriculum being used and at least 40 hours of on-going training per year, with the majority of the on-going training related to clinical skills used to deliver effective programming.

Client Assessment

Strengths:

- The agency follows appropriate exclusionary criteria to ensure clients are appropriate for the treatment provided to them.

Recommendations for Improvement:

- While the agency uses a bio-psycho-social assessment, responsivity is not formally measured by the program. Factors that affect engagement in treatment should be measured using validated tools. Examples include TCU Client Self-Rating Scale, Jesness Inventory, Beck's Depression, Massachusetts Youth Screening Instrument (MAYSI), or IQ tests.
- While the agency uses a bio-psycho-social assessment, a formal risk assessment is not used by the agency. Only clients who are high risk and moderate risk should be receiving intensive treatment services. Also, low-risk clients should not be mixed with high risk clients in treatment groups. The agency should utilize the risk assessment used by the court, or conduct their own risk assessment, to determine the risk level of their referrals from drug court.
- The program should serve high and moderate need youth. The bio-psycho-social assessment used by the agency is not appropriate to determine need for substance abuse services. The agency should be using a needs assessment with every client to ensure that only those youth in need of substance abuse treatment services are accepted into treatment. The agency should access the Global Appraisal of Individual Needs (GAIN) used by the drug court or conduct their own needs assessment.

Treatment

Strengths:

- The majority of interventions focus on criminogenic needs.
- The groups start and end on time.
- The group facilitators are knowledgeable about the materials discussed in group.
- The group facilitators encourage participation in the group.
- Group norms/rules are established, documented, and reviewed with the group regularly.
- When there is a co-facilitator in group, both facilitators are actively participating.

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- The duration of the program is sufficient to affect the target behavior and allows youth enough time to learn needed skills for long-term behavioral change. Group sessions meet for two hours twice per week for approximately three months.
- Treatment groups are always conducted and monitored by staff.
- Group size averages between six to eight clients, and a co-facilitator is always present. This meets CPC-DC criterion that groups contain no more than 12 youth per facilitator.
- Facilitators avoid arguments with participants and roll with resistance.

Recommendations for Improvement:

- Currently, the program is not using evidence-based treatment interventions. Treatment modalities that have been determined effective in changing offender behavior should be utilized. Examples of evidence-based treatment include structured social learning and cognitive behavioral models. There should be an emphasis on structured skill building (i.e. teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play in all of the groups. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- Males and females are more productive in treatment sessions when they attend treatment separately. Treatment groups should be gender specific.
- Homework should be regularly assigned to participants as part of treatment groups, and the homework should be reviewed by the facilitator and constructive feedback should be provided to the participants.
- While the agency has a treatment manual, it is not consistently used by all facilitators. The manual should be routinely followed by all facilitators to ensure consistency and fidelity of treatment.
- The program should address and respond to the different learning styles and barriers of the participants in the group. Responsivity assessments will aid in this process.
- Service providers should utilize a range of rewards to reinforce offender behavior. Rewards should outweigh punishers by a ratio of at least 4:1. The procedure by which offenders are reinforced should meet the following criteria: rewards should be immediate; seen as valuable for shaping behavior; consistently applied; and individualized.
- The program should have some punishers to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. The process for punishing should include the following components: punishers should be individualized; considered undesirable by the offenders; varied; match the intensity of the infraction; and be immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator/counselor.
- Facilitators should consistently (almost every group and individual session) model prosocial skills, explain to the clients the importance of learning the new skill, practice and rehearse the new skills with the client and provide feedback. Finally, they should include graduated practice of new skills in increasingly difficult situations.
- An effort should be made to establish rapport with group members to encourage learning and behavior change.
- Participants should be taught how to recognize antisocial thinking and how to replace those thoughts with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost-benefit analysis should be used to assist the participants in recognizing antisocial/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be developed, and clients should have to regularly practice the coping skills listed on the plan with their counselor.

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Quality Assurance

Strengths:

- The program incorporates sufficient internal quality review mechanisms. Quality assurance includes file review and client satisfaction surveys.
- The program completes a discharge summary for all clients and provides the summary to the court (or referral agency).
- Pre/post tests are given to youth to assess changes in their behavior.

Recommendations for Improvement:

- Internal quality assurance should include observation of direct service with feedback to staff. Observation should occur once per group cycle, and formal feedback should be provided to the facilitator.

Overall Program Rating

CHAC – New Outlooks received an overall score of **51.0** percent on the CPC-DC. This falls into the **Needs Improvement** category.

The overall CAPACITY score, designed to measure whether the program has the *capability* to deliver evidence-based interventions and services for offenders, is **83.3** percent, which falls into the **Highly Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **33.3** percent, which falls into the **Ineffective** category.

CONCLUSION

Researchers at the University of Cincinnati have assessed 512 programs nationwide and have developed a large database on correctional intervention programs.[2] Approximately 7 percent of the programs assessed have been classified as HIGHLY EFFECTIVE, 17 percent have been classified as EFFECTIVE, 31 percent have been classified as NEEDS IMPROVEMENT, and 45 percent have been classified as INEFFECTIVE.

Graphs representing the results of this assessment are provided below. The first graph or set of graphs compares the drug court or referral agency score in the capacity domain, content domain, and overall score with the average scores from all 512 programs evaluated by the University of Cincinnati. The final graph shows the drug court score and an average of the scores from all referral agencies used by the drug court compared to the average of all programs evaluated by the University of Cincinnati.

Recommendations have been made in each of the four CPC domains for the Santa Clara County Juvenile Drug Court. These recommendations should assist the program in making necessary changes to increase program effectiveness. Certainly, care should be taken not to attempt to address all "areas needing improvement" at once. Programs that find the assessment process most useful are those that prioritize need

[2] Several versions of the CPAI were used prior to the development of the CPC. Scores and averages have been adjusted as needed.

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areas and develop action plans to systematically address such needs. Previous programs have also been successful at improving the provision of services by formulating committees charged with developing strategies for delivering evidence-based programming.

This report also provides the drug court with a snapshot of the referral agencies where its youth are receiving treatment in the community. This evaluation should assist the drug court in determining what type of treatment is effective when working with juvenile drug court clients. It should also assist the referral agencies with ways they can improve the services they provide to drug court youth.

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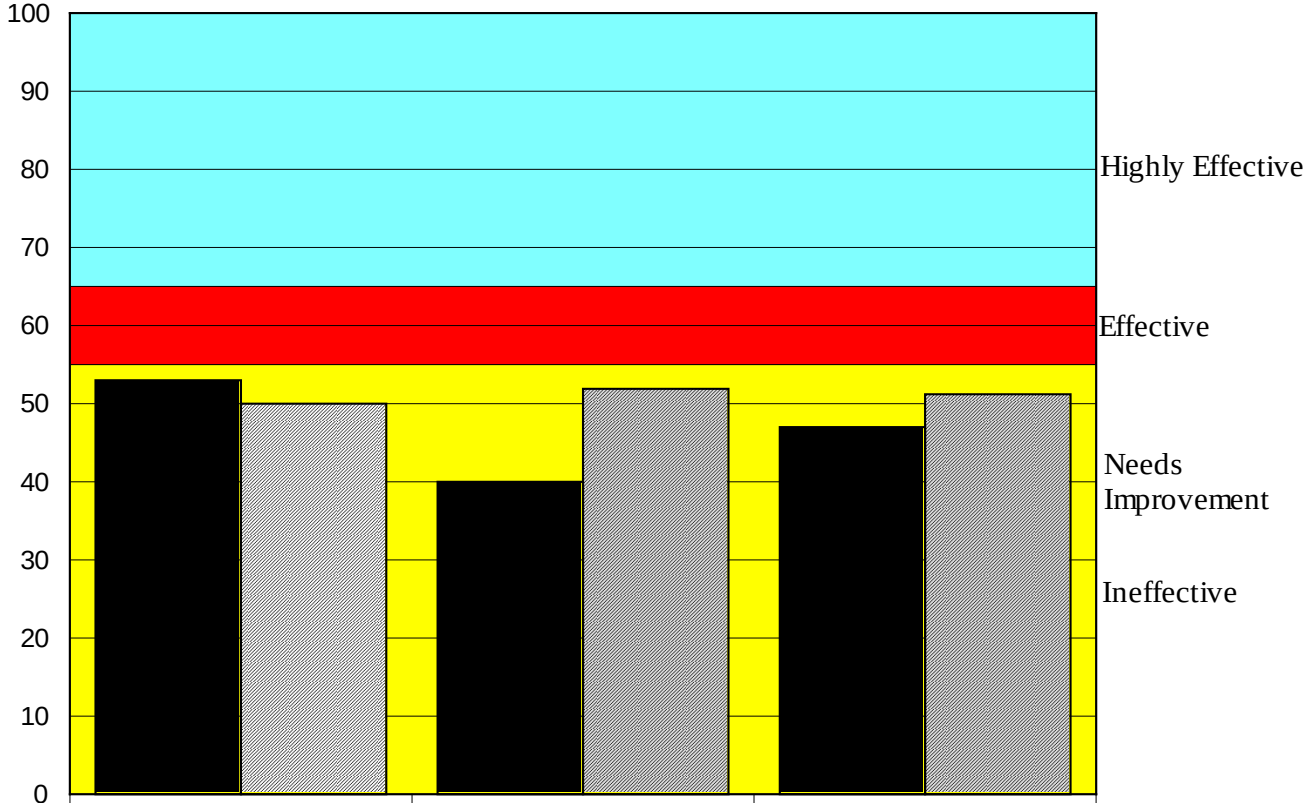
FIGURE 1:

Santa Clara County Juvenile Drug Court CPC-DC Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Santa Clara County	50	51.9	51.2

* The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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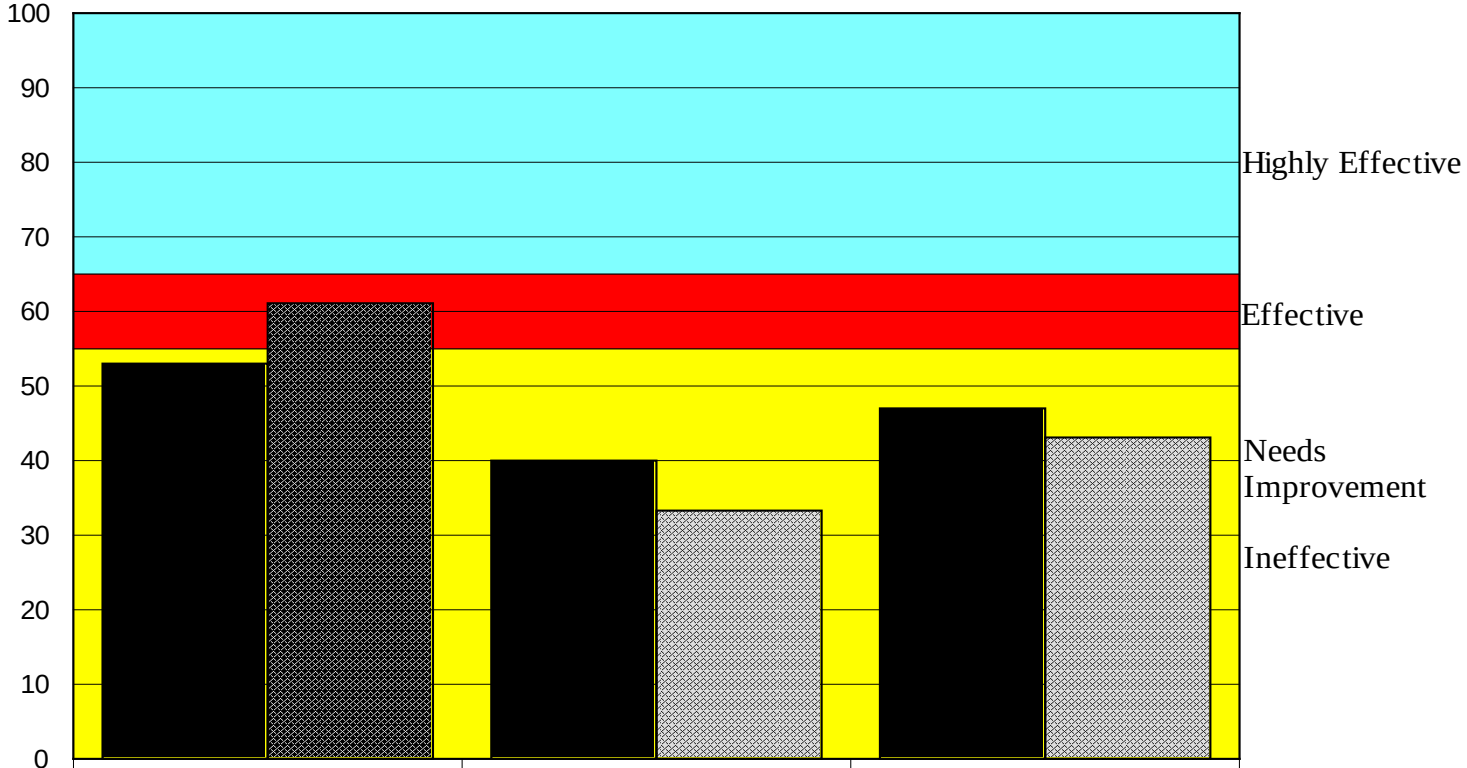
FIGURE 2:
Advent Ministries CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Advent	61.1	33.3	43.1

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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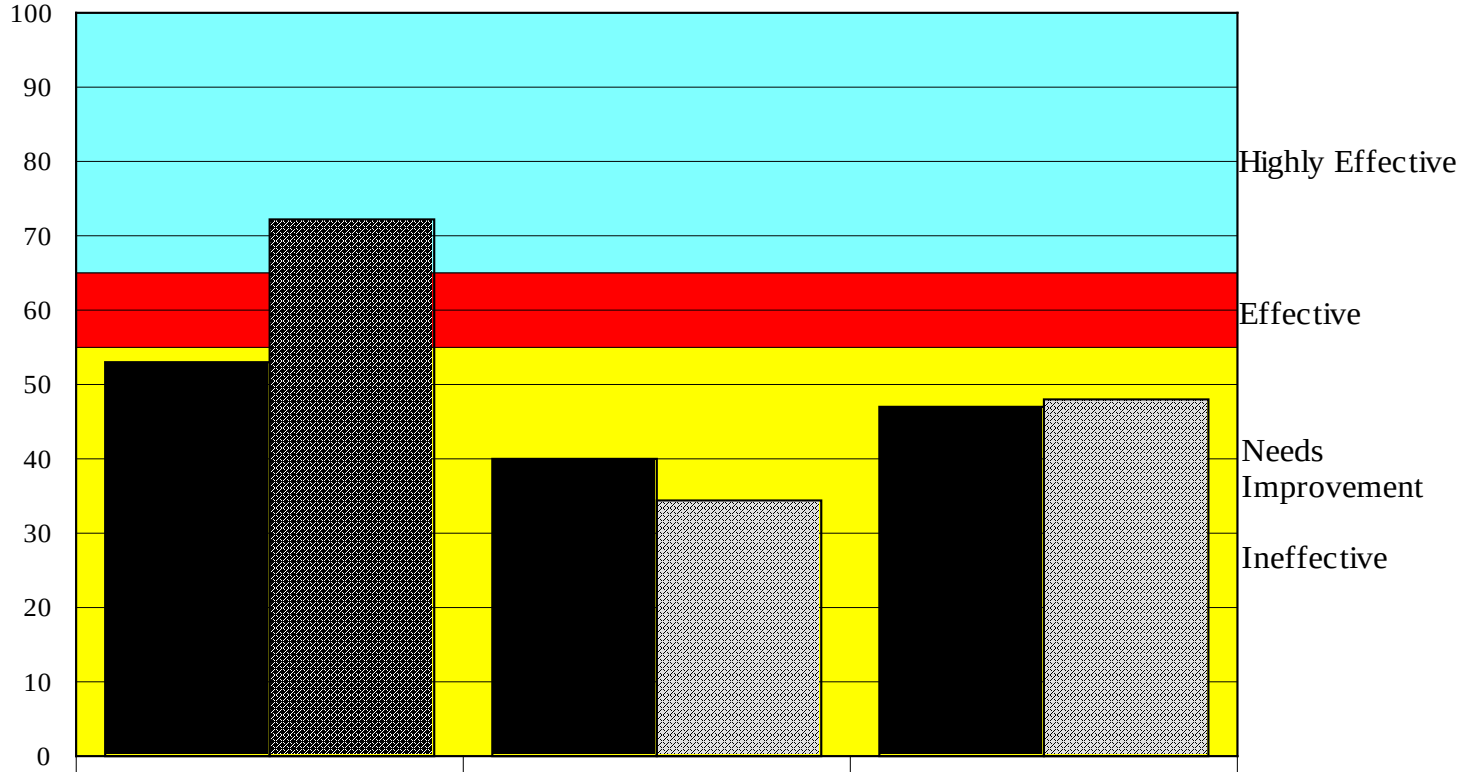
FIGURE 3:

Asian American Recovery Services CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
AARS	72.2	34.4	48

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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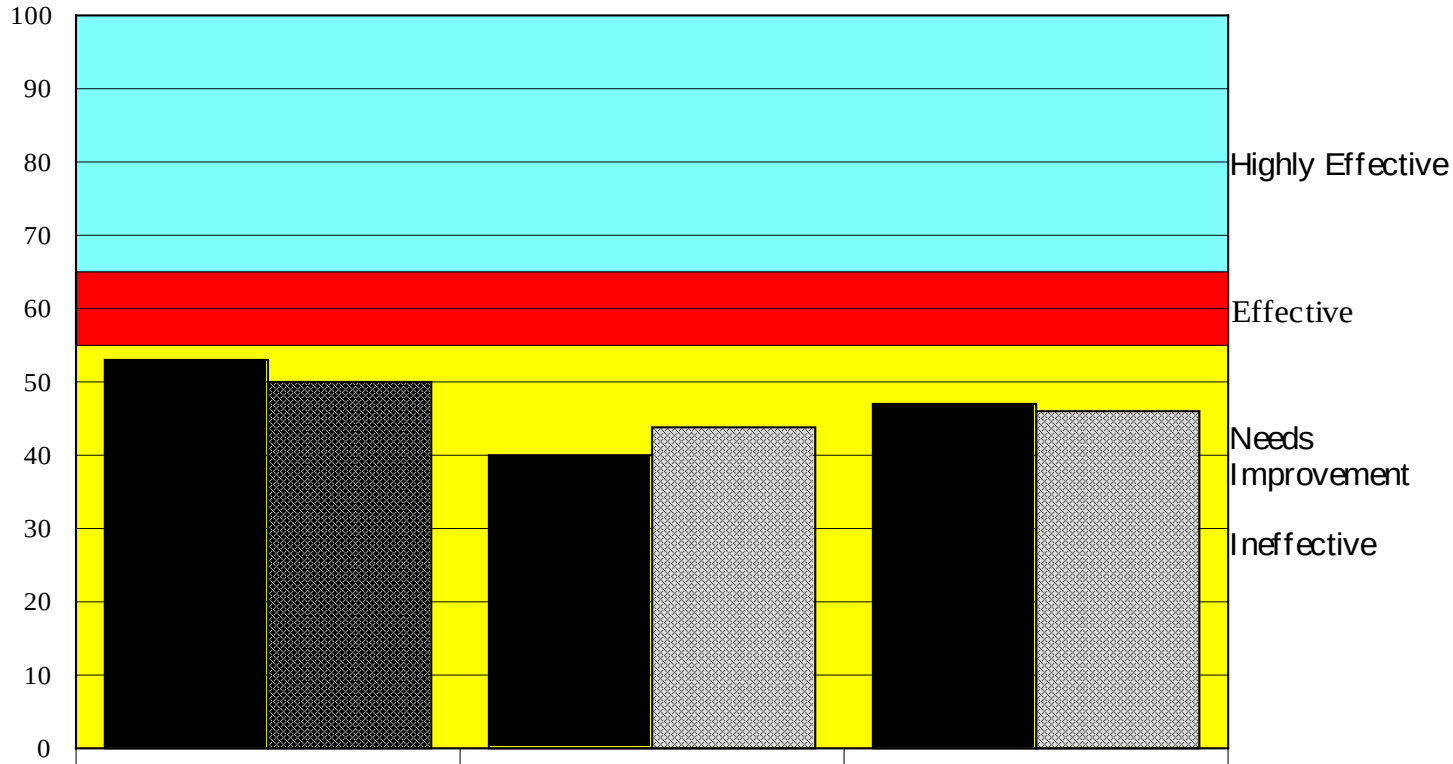
FIGURE 4:
Department of Alcohol & Drug Services CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
DADS	50	43.8	46

* The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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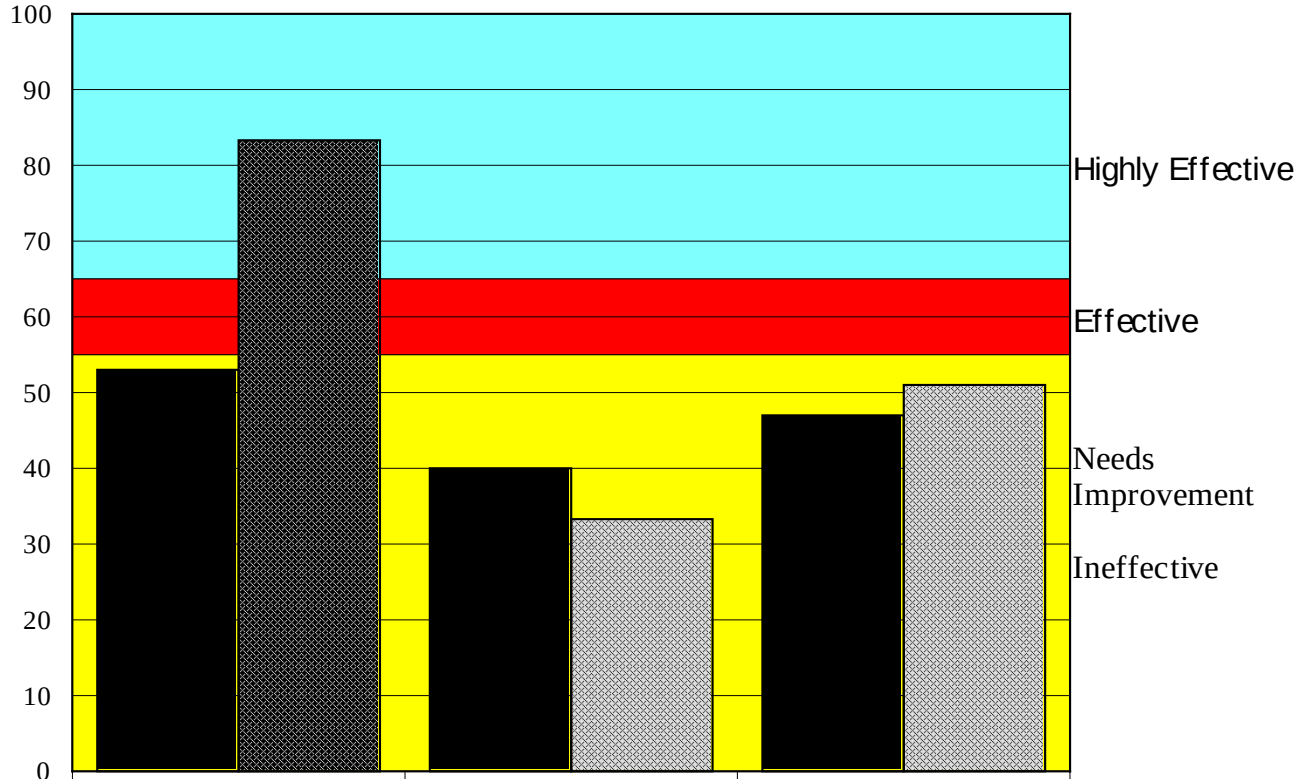
FIGURE 5:
CHAC - New Outlooks CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
CHAC - New Outlooks	83.3	33.3	51

*The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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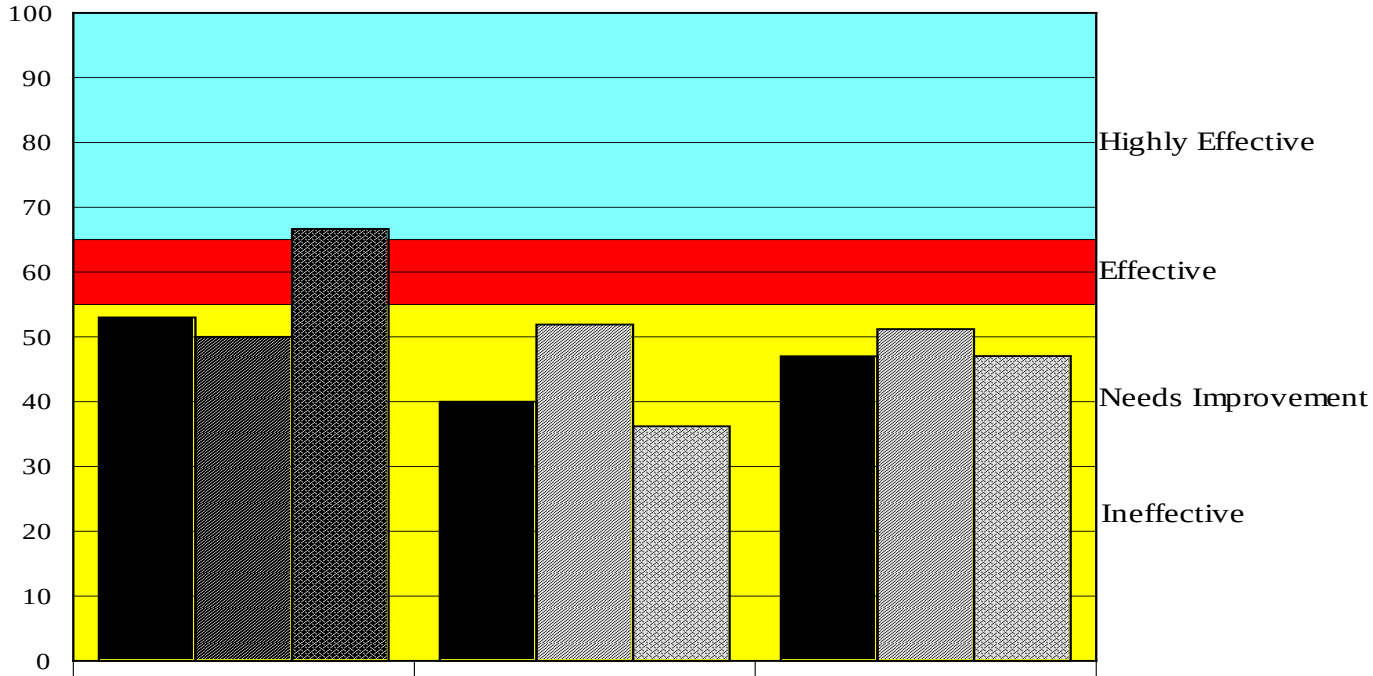
FIGURE 6:

Santa Clara County Juvenile Drug Court Overall



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Santa Clara County	50	51.9	51.2
Referral Agency Average	66.65	36.2	47.025

* The average scores are based on 512 results across a wide range of programs. Highly Effective=65% or higher; Effective=55-64%; Needs Improvement=46-54%; Ineffective=45% or less.

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Appendix F: Statistical Models

Table 1. Multivariate Logistic Regression Models with Recidivism

	Supervised		**Follow Up**		**Any**	
	Referral b (se) Odds Ratio	Adjudication b (se) Odds Ratio	Referral b (se) Odds Ratio	Adjudication b (se) Odds Ratio	Referral b (se) Odds Ratio	Adjudication b (se) Odds Ratio
Drug Court vs. Comparison	0.66 (0.12)* 1.95	0.53 (0.13)* 1.70	0.46 (0.12)* 1.59	0.58 (0.14)* 1.78	0.56 (0.12)* 1.75	0.58 (0.12) 1.78
Risk Level	0.31 (0.09)* 1.36	0.22 (0.10)* 1.25	0.22 (0.10)* 1.24	0.41 (0.11)* 1.51	0.41 (0.09)* 1.51	0.41 (0.09) 1.50
Time at Risk (Months)	0.01 (0.01) 1.01	-0.01 (0.01) 0.99	0.02 (0.01)* 1.02	0.03 (0.01)* 1.03	0.01 (0.01)* 1.03	0.01 (0.01) 1.01
Age at Intake	-0.21 (0.05)* 0.81	-0.23 (0.05)* 0.79	-0.11 (0.05)* 0.90	0.04 (0.06) 1.04	-0.27 (0.05)* 0.77	-0.16 (0.05)* 0.85
Sex (1=Female)	-0.30 (0.14)* 0.74	-0.24 (0.16) 0.79	-0.38 (0.15)* 0.68	-0.37 (0.17)* 0.69	-0.43 (0.14)* 0.65	-0.30 (0.14)* 0.74
Race (1=White)	-0.37 (0.12)* 0.69	-0.35 (0.14)* 0.71	-0.64 (0.13)* 0.53	-0.55 (0.14)* 0.58	-0.42 (0.12) 0.66	-0.41 (0.12)* 0.66
Constant	2.01 (0.92)	2.60 (1.01)	0.31 (0.94)	-3.54 (1.11)	3.57 (0.93)	1.11 (0.92)
Model x^2 (df)	92.80 (6)*	53.45 (6)*	93.92 (6)*	94.05 (6)*	129.61 (6)*	95.49 (6)*
Nagelkerke R^2	0.09	0.06	0.10	0.11	0.12	0.10
N	1320	1292	1316	1316	1316	1300

* $p < .05$

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Table A2. Hierarchical logit models assessing individual and program effects on youth recidivism (Referral)

	Unconditional Model b (se)	*Level 1 Model* b (se)	*Random Slope Model* b (se)	*Full Model* b (se)
Intercept, γ_{00}	0.24 (0.21)	5.13 (0.93)	5.67 (0.97)	5.67 (0.97)
Fixed Effects				
Individual Level (n =1345)				
Drug Court vs. Comparison	--	0.48 (0.12)*	0.43 (0.30)	0.41 (.30)
Risk Score	--	0.05 (0.04)	0.04 (0.04)	0.04 (0.04)
Time at Risk (Months)	--	0.02 (0.01)*	0.013 (0.01)*	0.013 (0.01)*
Age at Intake	--	-0.31 (0.05)*	-0.33 (0.05)*	-0.34 (0.05)*
Sex (1=Female)	--	-0.46 (0.14)*	-0.46 (0.14)*	-0.47 (0.14)*
Race (1=White)	--	-0.24 (0.10)	-0.23 (0.10)*	-0.23 (0.10)*
Program Level (n = 9)				
CPC Score	--	--	--	0.002 (0.02)
Interaction DC/Comparison, CPC	--	--	--	0.02 (0.03)
Random Effects				
Recidivism Mean,u_{0j} Variance	0.35 (0.18)	0.33 (0.17)	0.42 (0.23)	0.42 (0.23)
Drug Court/Comparison, u_{1j} Variance	--	--	0.64 (0.37)	0.61 (0.36)
Model x^2 (df)	--	83.16 (6)*	66.70 (6)*	67.11 (8)*

* p < .05;

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Table A2. Hierarchical logit models assessing individual and program effects on youth recidivism (Adjudication)

	Unconditional Model b (se)	*Level 1 Model* b (se)	*Random Slope Model* b (se)	*Full Model* b (se)
Intercept, γ_{00}	-0.46 (0.26)	2.22 (0.96)	2.95 (1.00)*	2.94 (0.99)*
Fixed Effects				
Individual Level (n =1345)				
Drug Court vs. Comparison	--	0.53 (0.12)*	0.50 (0.32)	0.46 (0.31)
Risk Score	--	0.07 (0.04)	0.06 (0.04)	0.06 (0.04)
Time at Risk (Months)	--	0.014 (0.01)*	0.01 (0.01)	0.01 (0.01)
Age at Intake	--	-0.19 (0.05)*	-0.22 (0.05)*	-0.22 (0.05)*
Sex (1=Female)	--	-0.39 (0.15)*	-0.41 (0.15)*	-0.41 (0.15)*
Race (1=White)	--	-0.17 (0.08)*	-0.15 (0.09)	-0.15 (0.09)
Program Level (n = 9)				
CPC-DC Score	--	--	--	0.02 (0.03)
Interaction DC/Comparison, CPC-DC	--	--	--	0.03 (0.03)
Random Effects				
Recidivism Mean,u_{0j} Variance	0.56 (0.28)*	0.52 (0.26)*	0.64 (0.35)	0.69 (0.39)
Drug Court/Comparison, u_{1j} Variance	--	--	0.77 (0.43)	0.58 (0.32)
Model x^2 (df)	--	54.14 (6)*	35.97 (6)*	37.57 (8)*

* p < .05 based on z test;

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