ModelsforChange
Systems Reform in Juvenile Justice

Innovation Brief

Implementing Evidence-based Practices in a Louisiana Juvenile Drug Court

Operating since 2005, the 4th Judicial District's juvenile drug court made a decision in 2009 to modify their screening, assessment, and treatment offerings based on newly emerging practice guidelines for adolescent substance abuse interventions. Significant effort went into identifying and adopting standardized screening and assessment measures and implementing evidence-based treatments in order to create and pilot a model for juvenile drug court. Families, as program partners and collaborators, were prioritized in program design as they are integral to a youth's success.

The Issue

The 4th Judicial District (including Morehouse and Ouachita Parishes [i.e. counties]) examined the available statistics in 2004 and found that nearly 3000 youth were arrested annually. Of those, 25% were thought to be alcohol or drug-related offences. Recognizing that incarceration was an inadequate response to their youths' cycle of drug use and delinquent activity, a decision was made, in 2005, to implement a juvenile drug court program.

Quality-of-care and cost were priority issues in developing the treatment side of the drug court. The solution was found when the University of Louisiana at Monroe was asked to offer services through its marriage and family therapy program. This program offered student interns eager to apply their clinical training, faculty supervisors, and a location accessible to public transportation.

As the program was initiated, developers recognized that youth were commonly presenting with co-occurring behavioral, mental health and substance abuse disorders.

This posed a challenge and demanded an examination of research-supported treatment options specifically designed for adolescent clients. In 2009, the 4th JDC began a collaboration with the MacArthur Foundation through its *Models for Change* initiative with a goal to implement and refine a model treatment program utilizing evidence-based practices to better address the complex problems seen in the youth participating in the juvenile drug court program. The innovative processes and products of this effort are

highlighted in this document and the more detailed tools are referenced for more in-depth exploration of this model juvenile drug court treatment.

Innovations

To initiate this model, program developers started by refining their thinking about the target population as they created mission and vision statements endorsed by core stakeholders. Through the mission statement, court team members described their goal of reducing youth and family alcohol/drug use and delinquency through intensive supervision, therapeutic intervention, and education, in order to strengthen individuals, families, and the community. To achieve this outcome, specific goals and objectives were established in the initial phase of program development. These goals included 1) reducing the number of non-violent juvenile offenders in detention or custody, 2) reducing the recidivism rates of non-violent juvenile offenders, 3) assisting program participants in becoming drug free, 4) achieving a high graduation rate, 5) enhancing academic and/or vocational achievements, and 6) positively influencing the recreational and social activities and the family functioning of program participants.

In an effort to achieve these goals, there was a priority to base efforts on research-driven programming and specifically increase access to evidence-based practices. Program developers decided to focus on implementing several research-driven elements in their admissions and treatment processes. These program elements are described below.

Application of Evidence-based Principles in Screening and Assessment. Youth are referred to the JDC from several points of contact with the juvenile justice system (detention, FINS, probation, the district attorney, and juvenile court). Use of the MAYSI-2 (Massachusetts Youth Screening Instrument-2) and the SAVRY (Structured Assessment of Violence in Youth) by referral sites helps to determine whether a youth may be eligible for further assessment and possible referral to the JDC Program. Both measures have been developed and standardized for populations of youth in the juvenile justice system.

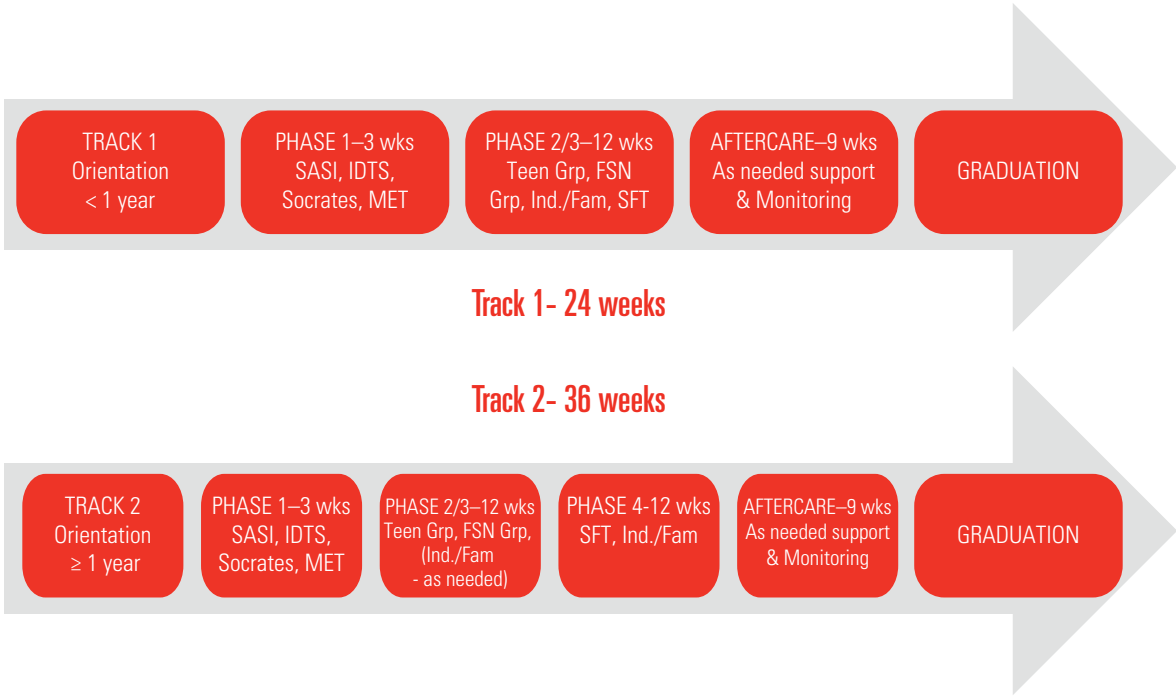
Youth who have indications of problems with drugs or alcohol that are relevant to their charges are referred for evaluation of their legal charges by the Assistant DA. Once the legal exclusions are applied and a youth is deemed eligible, a JDC Case Manager conducts a 'clinical eligibility screening'. This involves administering additional standardized measures including the SASSI-A2 (Substance Abuse Subtle Screening Inventory) and the CRAFFT.

Processes and Decisions Related to Screening and Assessment. Once the clinical and legal eligibility screenings are complete and the youth and their family member(s) have been oriented to the court program, the JDC team will meet to discuss and evaluate each admission. Members of the 'core' team — including a juvenile judge, prosecuting attorney, indigent defender board attorney, the juvenile drug court coordinator/case manager, probation officer and treatment provider representative — make the final decision regarding admission.

Emphasis on Comprehensive Assessment. Following program admission, a more comprehensive assessment is completed to evaluate treatment history, current patterns of alcohol/drug use, mental health issues, and family strengths and challenges. To inform planning, the following measures are routinely administered:

- Comprehensive Adolescent Severity Inventory (CASI – selected modules)
- Inventory of Drug Taking Situations (IDTS)
- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES).

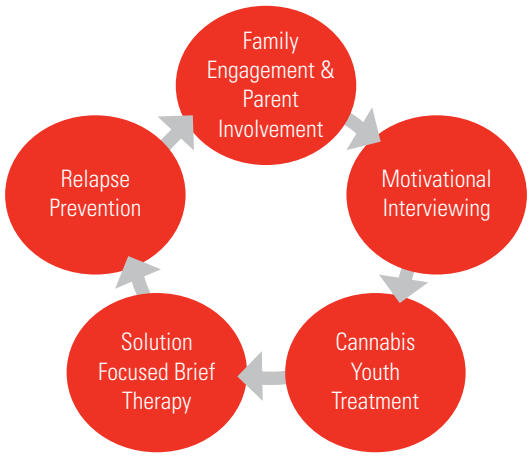
Using information gathered from this assessment, an



individualized treatment plan is formulated. The JDC team's goal is to achieve treatment enrollment within fourteen days (of a youth's arrest).

Determining the Presence of Co-occurring Disorders. Consistent with national findings, a significant percentage of youth presenting to the JDC have co-occurring mental health disorders. Youth admitted to the JDC program have been diagnosed with major depression, dysthymia, various anxiety disorders, oppositional defiant disorder, and conduct disorder. To accommodate the range and severity of their presentations, JDC program developers recognized the need to offer different treatment 'tracks' (*Track 1 & 2*) that could offer a longer length of treatment contact for those with greater symptom intensity. In this design, *Track 2* offers an additional phase of care during which continuing group, individual, and family interventions can take place. A graphical representation of the treatment tracks can be found in the Program Guidelines document; the link to this document can be found in the Resource section.

Application of Evidence-based Practice. To address the range of symptoms and skill challenges experienced by youth in the JDC, two evidence-based practices were identified and implemented: *Cannabis Youth Treatment* (CYT aka-MET/CBT) delivered as a group intervention, and *Solution-Focused Brief Therapy* (SFT) providing the framework for individual and family therapy. Both are described on the National Registry of Effective Programs and Practices website. CYT is focused on anger management, problem solving, coping with craving & urges, managing depression, and preventing relapse. Made up of several components, CYT combines motivational interviewing and cognitive-behavioral interventions in multiple treatment formats. Youth attend 'teen' groups,



and parents participate in the 'family support network' group. Group supervision is provided on an ongoing basis and a lead clinician regularly observes group delivery to measure fidelity.

SFBT uses the client's strengths and resources to help them address challenges in their life and to assist them in identifying and moving toward achievable goals. The intervention teaches a skill for problem resolution that can be replicated after treatment ends.

Engagement and Collaboration with Families. Each youth in the program has an identified family member (or legal guardian or other court-identified adult) who is expected to be highly engaged in the juvenile drug court process to encourage and support success in the program. Family members are called upon to educate the team as to the family's cultural / religious beliefs and their unique strengths and resources. Family members sign contracts related to their involvement that clearly identifies the court's expectations. Collaborative elements include attendance and participation in all court proceedings, creating a supportive and appropriate environment outside of court that encourages change, truthfully and promptly communicating with program staff regarding progress, imposing program-mandated curfews, and attending all required treatment elements.

Establishing an Outcomes Monitoring Process. The JDC team established an ongoing outcomes monitoring process that could be easily analyzed to inform them if the program was drifting from their mission and overarching goals were not being realized. In mid-2011, the Drug Court Case Management (DCCM) monitoring program, used in multiple states nationally, was implemented to assist the team in gathering a range of variables that allows them to more accurately analyze outcomes and make needed program adjustments. Adoption of this program allowed them to collect and enter data on the number and type of treatment sessions attended, the results of drug screens, the sanctions applied and incentives received during program participation, any medications prescribed during care, and the broader clinical history of each youth in the program. These data are used to take an in-depth look at program impact and inform necessary program modifications.

Results and Lessons

The 4th JDC's initial review of their juvenile drug court program data revealed a more complicated range of presenting problems than was initially anticipated. Program developers observed that youth referred to their program had more severe presentations of substance abuse and frequently presented with co-occurring mental health disorders. These complicated clinical and life history presentations contributed to the decision to implement comprehensive screening and assessment processes and to adopt evidence-based treatment programs, as described above. Their awareness of the increased complexity of the youth being admitted also led to their decision to implement the DCCM monitoring system so that more sophisticated statistical analyses could be run to better identify program impacts.

Preliminary findings, using the new data reporting format and reflecting the modified treatment offerings, have recently been generated. Outcome analyses focused on six goals established at the time of program initiation: 1) reducing rates of detention/custody, during and after program involvement; 2) reducing re-arrest rates during the same periods; 3) reducing alcohol/ drug use relapse; 4) achieving high rates of program graduation; 5) enhancing academic/vocational achievements; and, 6) positively influencing recreational, social, and family functioning.

Data analysis revealed that the 100% of participants were not remanded to custody during their involvement in the program, surpassing the program's goal of 50%. Seventy-one percent (71%) served no time in detention or custody in the 12 months following program involvement (goal was 60%) and 93% had no similar or more severe charges in the 12 months following graduation (goal was 60%).

The program's goal of having 75% of participants become drug free during their final treatment phase was also achieved (76%). Ninety-four percent (94%) had no drug charges while in the program (goal was 70%). Though normative for an adolescent population yet not as desirable

as drug free, 43% reported that they had not used alcohol or drugs in the 12 months following program graduation (goal was 70%).

Eighty-four percent (84%) of those attending school were able to increase their performance and/or attendance (goal was 80%); the same percentage (84%) achieved the goal of not having greater than 10 unexcused absences during program involvement (goal was 75%). Of those ineligible for school enrollment, 100% were engaged in job-skill programs or had secured employment at the time of their program graduation (goal was 75%).

Data available on program participants related to improvements in recreational, social, and family functioning showed that 51% reported that their recreational and social activities were positively influenced through program involvement (goal was 75%). Sixty-seven percent (67%) reported improved family functioning (goal was 75%) and 85% reported improvements in family relationships (goal was 75%). Overall, the majority of program goals were met or significantly surpassed – including those related to recidivism and return to custody. Job skills and academic achievement goals were also met or surpassed. Further reducing alcohol / drug use following program graduation remains an aspirational goal, but one cannot underestimate the impact of several months of drug-free time in the course of an adolescent's development (i.e. lowering overall juvenile and criminal justice penetration risk). Findings from these analyses will inform continued model development.

The Broader Impact

In April 2012, in collaboration with the John D. and Catherine T. MacArthur Foundation and the Louisiana *Models for Change* lead entity—the Louisiana State University Health Sciences Center Institute for Public Health and Justice—a conference was held in New Orleans to promote awareness and disseminate program information related to the 4th JDC's development and implementation of an evidence-based, research-informed juvenile drug court. As demonstrated to drug court stakeholders, administrators, and leaders from around Louisiana, the 4th JDC has created a model program site, where jurisdictions throughout the state can come to receive consultation and training on juvenile drug court model development. This program brief and online access to operational guidelines, legal forms, and treatment-related forms are a part of this dissemination effort. The Program Guidelines document also contains 'Questions to Consider' for jurisdictions implementing or reviewing their juvenile drug court operations.

Resources

Evidence-Based Practice Recommendations for Juvenile Drug Courts—A guide to screening, assessment, treatment, and outcome monitoring of a "model" juvenile drug court. Available at http://www.modelsforchange.net/publications/235

Louisiana Fourth Judicial District Court Juvenile Drug Court—Policies, procedures, implementation guidelines, and questions to consider when implementing. Available at http://sph.lsuhsc.edu/evidence-based-treatment-and-services

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This brief is one in a series describing new knowledge and innovations emerging from *Models for Change*, a multi-state juvenile justice reform initiative. *Models for Change* is accelerating movement toward a more effective, fair, and developmentally sound juvenile justice system by creating replicable models that protect community safety, use resources wisely, and improve outcomes for youths. The briefs are intended to inform professionals in juvenile justice and related fields, and to contribute to a new national wave of juvenile justice reform.