Continuum of Care Initiative Evaluation

Annual Report

Fiscal Year 2008-09

July 1, 2008 – June 30, 2009

Colorado Department of Human Services

Children, Youth and Families
Division of Youth Corrections (DYC)

TRIWEST GROUP

Continuum of Care Initiative Evaluation

Annual Report

Submitted to:

Colorado Department of Human Services

Children, Youth and Families

Division of Youth Corrections

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Contents

List of Tables and Figures

Executive Summary

The Colorado Division of Youth Corrections is in the fourth year of a comprehensive systems improvement effort. This initiative has brought significant attention and improvements to the Division's continuum of services from initial (assessment) services through commitment and parole. The flexible funding authorization contained in Footnote 41 of House Bill 08-1375 was the necessary first step in the overall Continuum of Care Initiative. The Division of Youth Corrections is using this funding flexibility to support the implementation of a set of integrated system improvements based on research-based principles of effective practice.

> The Continuum of Care Initiative is an integrated set of strategies involving state-of-the-art assessment, enhanced treatment services within residential facilities, and improved transitions to appropriate community-based services.

The initiative is based on principles of effective juvenile justice strategies that have been proven through research and practice to work. The integrated set of strategies making up the Continuum of Care Initiative are based primarily on available research and the current national research base regarding "what works" in juvenile justice. Over the past four years, the Division has examined and realigned internal operational practices to be more consistent with the principles of evidence-based practice (EBP) in order to offer the most effective programs possible to reduce recidivism and re-victimization by juvenile offenders. A body of research in this area has shown that this approach, when appropriately implemented, can result in significant systems cost savings[1]. As part of this strategy, the Continuum of Care Initiative seeks to provide the optimal length of service in each stage of the continuum as youth move from secure residential to community-based services on parole.

Five Key Strategies

The Continuum of Care Initiative is implemented within the broader umbrella of the Division of Youth Correction's Mission and serves to operationalize the Five Key Strategies through which the Division's Mission is accomplished. The Five Key Strategies provide clear guidance that:

> *The Division will provide the **right services at the right time** (strategy 1), delivered by **quality staff** (strategy 2), using **proven practices** (strategy 3), in **safe environments** (strategy 4) embracing **restorative justice principles** (strategy 5).*

Throughout the Division of Youth Corrections, starting with the executive Leadership Team, these five strategies are used as a filter to weigh the pursuit and adoption of new initiatives or modifications and improvements to existing efforts. The Continuum of Care Initiative is structured to compliment the Division's Five Key Strategies. As illustrated by the figure on the next page, the Continuum of Care Initiative is built around five primary principles of Evidence Based Practice. While the figure shows the

[1] See, for example, Drake, E.K., Aos, S. & Miller, M.G. (2009). Evidence Based Public Policy Options to Reduce Crime and Criminal Justice Costs. Olympia, WA: Washington Institute for Public Policy.

principles as distinct and linear, they are inter-related and must be implemented together in order to yield the full benefits of the Continuum of Care Initiative. These principles are described and linked to the Five Key Strategies of DYC's mission in the body of this report.

Principles of the Continuum of Care Initiative

The Continuum of Care Initiative – An Integrated Best Practice Model

As the Continuum of Care Initiative develops, it is emerging as an integrated set of strategies involving state-of-the-art assessment, individualized case management, enhanced treatment services within residential facilities, and improved transitions to appropriate community-based services. For example, one of the most important areas discussed in the research literature relates to assessment and case planning. First, there is a call for more reliance on actuarial methods of screening and assessment. Colorado's statewide implementation of the Colorado Juvenile Risk Assessment (CJRA) exemplifies this recommendation. Second, the use of consistent, structured decision making by client managers is identified as a prerequisite for fair and valid placements and responsive treatments. The Division's

approach to developing the Discrete Case Plan (DCP) for each youth based on integrated risk and needs data along with expert judgment is in keeping with this recommendation. Finally, the literature increasingly recognizes the importance of structured data systems to chart the progress of youth in placement in order to support oversight of service providers. The integration of the CJRA and DCP into the statewide data system (Trails) is aligned with this national recommendation.

Data Sources

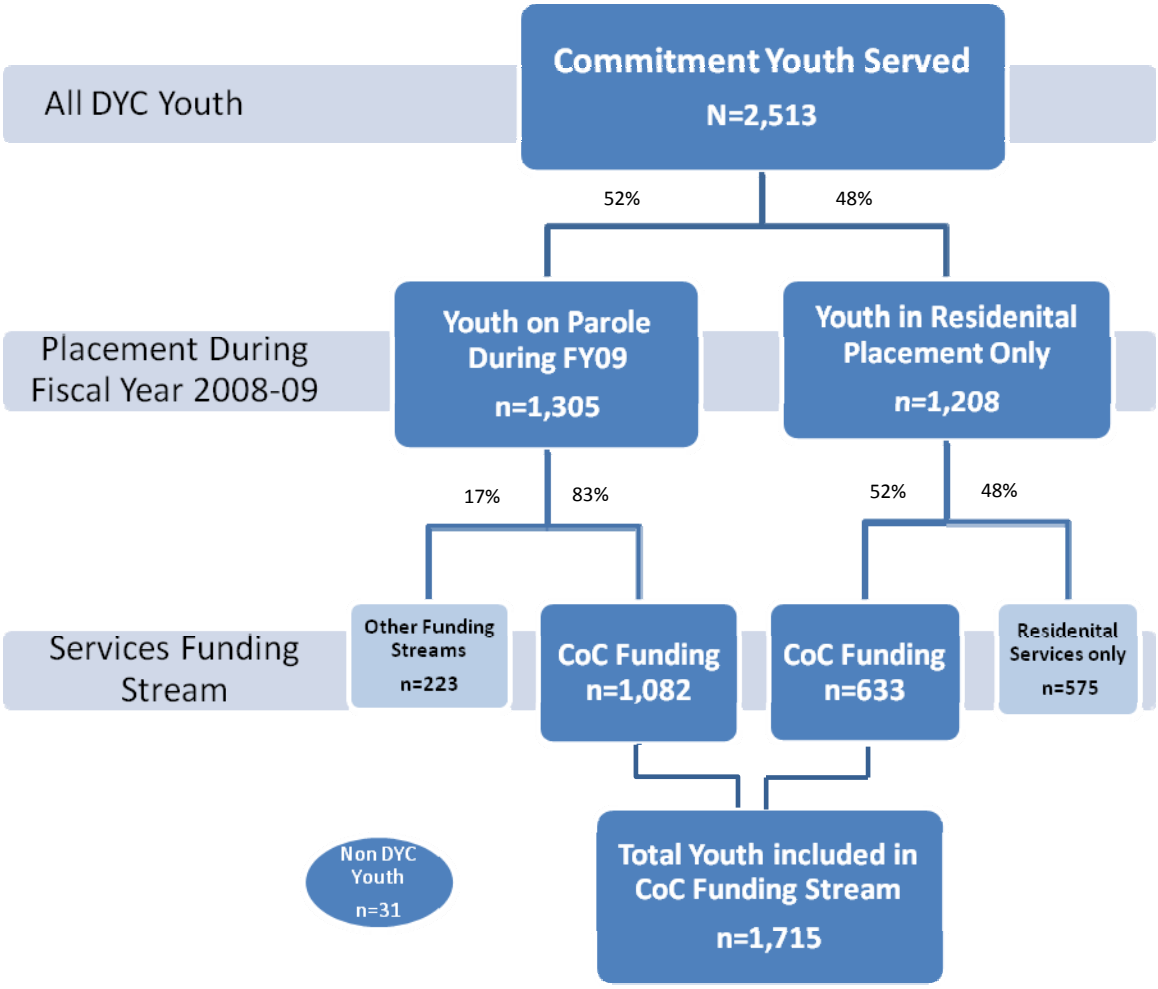
Data for this report comes from five primary sources, described in detail in the body of this report. These data sources are:

1. **Continuum of Care Initiative tracking forms,** developed by the Division, were completed by Client Managers to document each service purchased through the Continuum of Care Initiative.
2. **Colorado Trails Data System**
3. **DYC Risk Assessment Data (CJRA)**
4. **Recidivism data** for youth committed during Fiscal Year 2008-09, only pre-discharge recidivism data was available.
5. **Case examples** were provided by each of the four management regions.

Implementation of the Continuum of Care Initiative

While all committed youth are impacted by the Initiative, different paths are followed, based on individual need and circumstance. As a result, not all committed youth during this fiscal year received direct services funded by the flexible funding authorization. Some youth received residential services only, while others received non-residential services through other case management and funding streams. The graphic below illustrates the distribution of committed youth across different funding and placement types.

FY 2008-09 Committed Youth

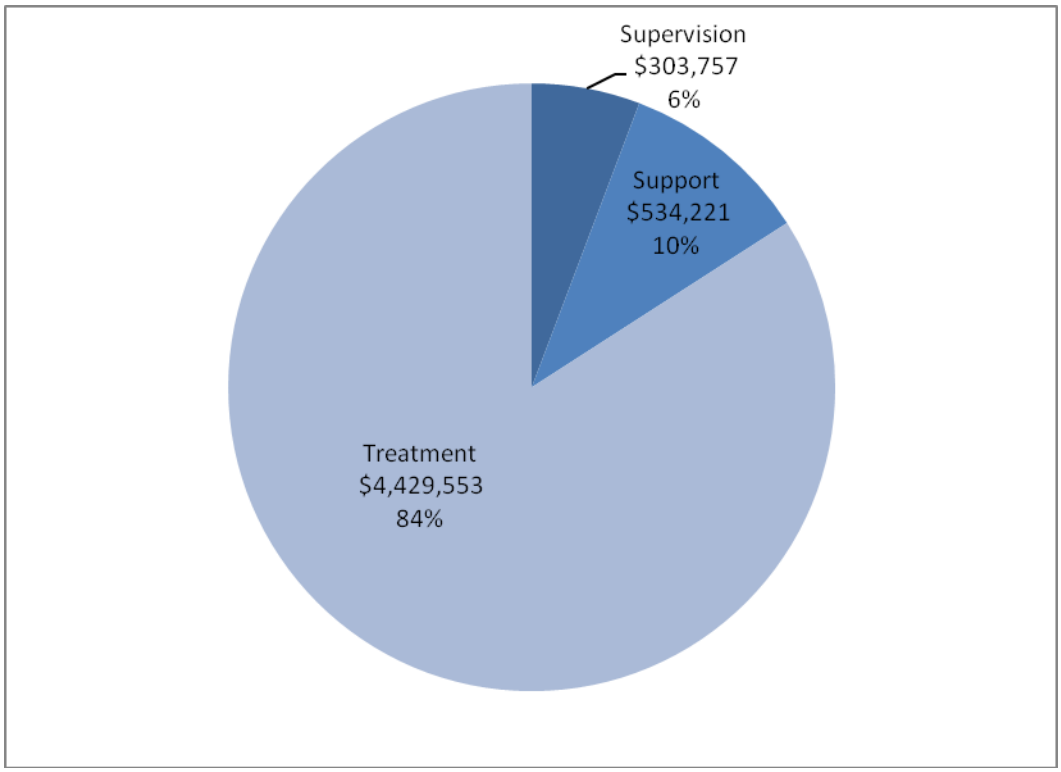


A total of 2,513 committed youth were served during Fiscal Year 2008-09. Of these youth 1,305 were served on parole status at some point during the year, while the remaining 1,208 youth were in residential placement during the entire fiscal year. As seen in the figure above, the vast majority of parole youth (83%, n=1,082) received direct non-residential services paid through the Continuum of Care flexible funding stream. The remaining 17% of paroled youth either received services through the Continuum of Care Initiative via indirect spending (e.g. blocks of services purchased on behalf of multiple youth), received services through other funding streams, or did not receive services because their client manager determined there was no clinical indication of need. For more detail regarding the characteristics of youth served, please refer to the full report.

Flexible Fund Expenditures

Information regarding the types of services purchased under the Continuum of Care Initiative was tracked by the Division's management regions for FY 2008-09. Tracking data showed expenditures of $5,267,532. This is an $804,979 (18%) increase over last year's spending and represents the 20% flexible spending provision in the Division's Contract Placements Line Item. The line item increased from an initial 10% in FY 2005-06 to 15% in FY 2006-07 and to 20% in FY 2007-08.

FY 2008-09 Continuum of Care Initiative Expenditures by General Category



The vast majority (84%) of expenditures was dedicated to treatment and treatment-related services (see below for details on treatment expenditures). This proportion was consistent across each of the management regions. Another 10 percent of expenditures were for support-related services, while the remaining six percent went to the purchase of supervision services.

Treatment Expenditures

The total of $4,429,553 in treatment expenditures includes all services targeted to change behavior(s) that will improve or enhance an individual youth's ability to function in the community. This includes an array of skill building and therapeutic services, described in detail below.

The highest proportion of treatment expenditures (40.9%) were spent on community living and social skill development. This includes social and life skills training programs that target the development,

modeling, and application of critical life skills for community living discussed below. Given that the average age of youth at the time of their commitment is 16.5 years and the average length of commitment, including parole, is 25.5 months, most youth committed to the Division are minors at the time of their commitment, but are adults at the time they discharge. As a result, a crucial part of transition services provided to youth being discharged includes providing youth with the needed skills to live independently for the first time. During the time youth spend on parole, they have the opportunity to learn general skills needed for pro-social community functioning.

The table below shows the distribution of treatment expenditures.

FY 2008-09 Treatment Expenditures by Type of Service		
Service Type	**Expenditures**	**Percent of Total**
Community Living & Social Skill Development	$ 1,810,370	40.9%
Family Therapy	$ 559,054	12.6%
Job/Skills Training	$ 528,108	11.9%
Provider Network Maintenance	$ 367,409	8.3%
Case Management and Planning	$ 367,282	8.3%
Offense Specific Treatment	$ 234,434	5.3%
Individual Therapy	$ 132,488	3.0%
Youth Mentoring	$ 85,221	1.9%
Day Treatment	$ 84,732	1.9%
Art or Recreational Therapy	$ 74,617	1.7%
Restorative Community Justice	$ 66,933	1.5%
Evidence Based Behavior Training[2]	$ 40,977	0.9%
Substance Abuse	$ 34,366	0.8%
Group Therapy	$ 28,976	0.7%
Assessment	$ 14,586	0.3%
Total	**$ 4,429,553**	**100%**

[2] Includes Cognitive Behavior Training (CBT); Dialectic Behavior Training (DBT) and Motivation Enhancement Therapy (MET).

Assessing Youth Risk and Needs

A comprehensive, empirically validated risk assessment allows the Division to identify and respond to the factors directly contributing to youth offending behavior. Anchored by the Colorado Juvenile Risk Assessment (CJRA), findings from five assessment disciplines are integrated in a Clinical Evaluation Report. The report offers targeted treatment recommendations encompassing overall criminogenic factors, alcohol and drug use, mental health, medical and educational needs. Assessment Specialists, working collaboratively with community partners, create a comprehensive, individualized and interdisciplinary assessment plan for all newly committed juvenile offenders. In the 2007-08 Fiscal Year, the statewide Trails information management system was enhanced to support the Continuum of Care Initiative through integration of the CJRA. Assessment Specialists and Client Managers can now complete the CJRA on the Trails system. Trails highlights the elevated risk domains from the CJRA so that they can be integrated into the Clinical Evaluation Report and the Discrete Case Plan.

Implementation of the CJRA throughout the Division is a cornerstone of the Continuum of Care Initiative. Since 2006, the Division has continued to enhance procedures to ensure that all committed youth have CJRAs completed at specified points in time along the commitment continuum. These assessments help to enhance the decision making process throughout a youth's commitment, from initial residential placement to parole.

Fiscal Year 2008-09 CJRA Implementation

All youth committed during Fiscal Year 2008-09 had a CJRA completed both at the time of initial assessment and, in cases where a youth had been discharged, again at the time of discharge. All but 40 youth who were paroled during the fiscal year had a CJRA completed at the time they moved onto parole.

FY 2008-09 CJRA Completion Rates			
Time Period	**Initial CJRA[3] n=2,158**	**Parole CJRA[4] n=993**	**Discharge CJRA[5] n=651**
CJRA Completion Rate	100%	96.0%	100%

[3] Only includes youth who were committed after the CJRA initial implementation date of July 1, 2006 and excludes one youth for whom no assessment was completed due to a commitment of only 129 days with credit for 94 days already served.
[4] Only includes youth who were committed after the CJRA was implemented and were paroled as of June 30, 2009.
[5] Only includes youth who were committed after the CJRA was implemented and were discharged as of June 30, 2009.

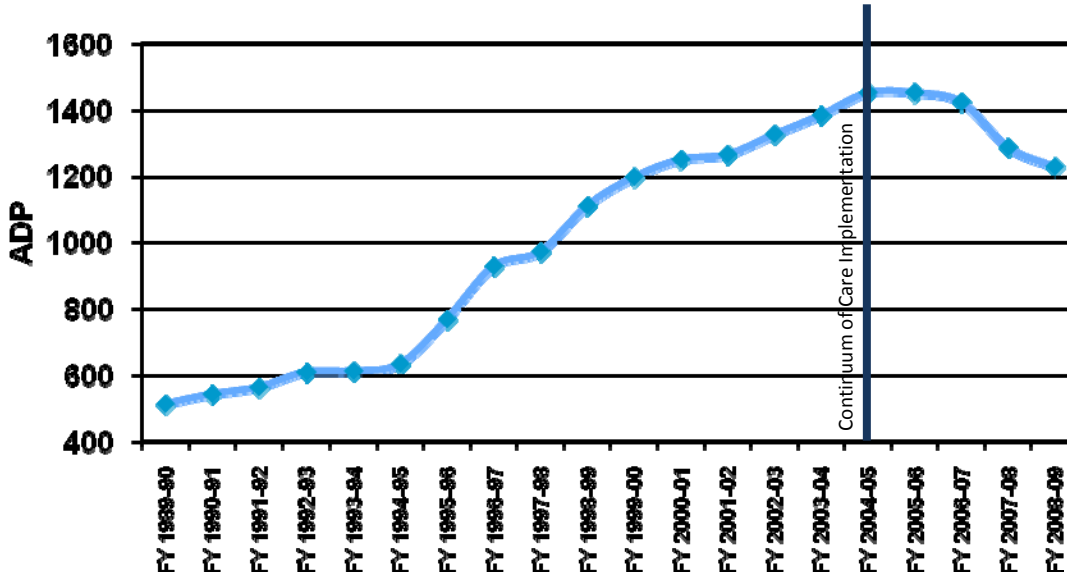
Based on original assessment validation studies in Washington State, each domain of the CJRA has three ranges of scores: low risk (bottom 33.3% of all scores), moderate risk (the middle 33.3% of scores), and high risk (the top 33.3% of scores). More than half of committed youth fall into the highest third of possible scores in the criminal history, relationships, family, substance abuse, attitudes, aggression, and skills domains. Moreover, risk levels appear to be increasing over the past three years. This increase in levels of risk in all but three domains indicates that, on average, youth committed to the Division during this fiscal year have higher risk for re-offending (as well as an elevated and more complex treatment need) than youth served in commitment two years ago.

Continuum of Care Initiative Outcomes

Two of the primary features of the Continuum of Care Initiative, using assessment to appropriately target services and using flexibility in residential funding to optimally manage youth time in residential placement and create effective transitions to non-residential services, potentially allow for a more efficient use of Division resources.

As seen in the figure below, since the implementation of the Continuum of Care Initiative during Fiscal Year 2004-05, a significant increasing trend has been reversed. Average daily population (ADP) in commitment has declined for the past three years. This year's Commitment ADP of 1229.9 represents a 5 percent decline over the past fiscal year.

20 Year Commitment ADP Trends



Mitigating Risk for Re-Offending

Committed youth tended to score in the high risk range of risk scores, based on original "norms" established in the validation of the risk assessment instrument in Washington State. Clearly this indicates that, as a whole, committed youth tend to present a high risk for re-offending, when compared to the probation population in Washington State used for the tool validation.

In examining whether or not risk was mitigated specifically for youth committed to the Division, new score ranges were determined based on the overall distributions of scores across the committed population. Because the purpose of the CJRA is to determine the areas of greatest risk and need for targeting services, successful mitigation of risk should show decreases in risk scores for youth where the initial assessment score was elevated enough to warrant a need for treatment in that area.

Dynamic risk scores measure risk factors that can be changed through intervention. Results point to significant decreases in dynamic risk for Continuum of Care youth.

Analysis of change between initial assessment and discharge re-assessment demonstrated significant improvement for most risk areas. Similar improvements were demonstrated for related protective factors. Please refer to the body of the full report for a detail presentation of these findings.

Cost Efficiency – The Link Between Assessment, Case Planning, Treatment and Risk Reduction

While currently available data do not allow a true analysis of cost-benefit or return on investment for the Continuum of Care, several observations can be made pointing to the Initiative as a cost effective set of strategies. There is a substantial research base (e.g., Aos, Phipps, Barnoski & Lieb 2001) in comparative economics that examines whether, or how much, a program's benefits are likely to outweigh its costs. The general model followed in these studies involves searching for research-based evidence about what works and what doesn't to lower offending behavior, and then estimating the comparative economics that these programs could have for taxpayers. In order to conduct such an analysis for the Continuum of Care Initiative, we would need detailed information regarding the exact programs youth receive along with information about the quality of implementation of those programs and the recidivism experiences of youth who participated in them.

However, the data available at the time of this report does offer encouragement for the efficiency and cost effectiveness of the Initiative. Available data depicts a pathway that begins with the purchase of interventions in specific areas using Continuum of Care funds and leads to the provision of services in those areas and to the reduction of related criminogenic risk. By following this pathway, we can demonstrate that Initiative funds are being deployed in a way that is supported by available local data and national research, and that these funds are yielding decreases in targeted criminogenic risk areas for the DYC population. This cost efficiency pathway is exemplified by the Initiative's expenditures for family therapies. Last year's Continuum of Care Annual Evaluation Report noted that family risk scores were

not improving significantly for youth served. DYC leadership addressed this finding by making family treatments a priority, directing Client Managers to attend to this risk area in case planning and making funds available for family interventions for youth whose risk scores warranted such intervention. In the current year, the $559,054 spent on family interventions represented 12.6% of the total treatment related dollars and yielded an almost twenty-five percent reduction in family-related risk between initial assessment and discharge. The national research base has demonstrated that high quality family interventions such as Multisystemic Therapy and Functional Family Therapy can yield very large returns on investment (in the range of $28-$45 for every dollar spent) because of their success in reducing future offending.

Pre-Discharge Recidivism and Recommitment Rates

As shown below, while pre-discharge recidivism was lower during this fiscal year than in the baseline year prior to Continuum of Care Initiative implementation, it was slightly higher than the rate has been in the past three years. This difference, however, was not statistically significant.

Pre-Discharge Recidivism Rates

	Fiscal Year						
Pre-Discharge Recidivism	**03-04**	**04-05**	**CoC Implemented**	**05-06**	**06-07**	**07-08**	**08-09**
Yes	33.0%	39.1%		32.4%	33.5%	33.3%	34.7%
No	77.0%	61.8%		67.6%	66.5%	66.7%	65.3%

Rates of recommitment have declined in the past two years, compared to the years directly before and after the implementation of the Continuum of Care Initiative. While the decline was not statistically significant, it points to the ability of the Continuum of Care strategies to efficiently move youth from residential placement to the community while maintaining positive youth behavior outside the context of a restrictive residential placement.

Available data suggest that the Continuum of Care Initiative is being implemented as intended and in keeping with national best practice.

Observations and Recommendations

Most notably, the Division of Youth Corrections continues to prioritize and move forward with an evidence-based approach to management and implementation. Leadership utilizes the Division's Five Key Strategies (discussed on page 1 of this report) in concert with the five principles of the Continuum of Care Initiative (page 2) to evaluate new efforts and measure the success of ongoing programs.

An Effective Approach – The current juvenile justice literature base clearly points to the strategies authorized through the footnote as the most appropriate and effective approach to managing services for juvenile offenders (e.g., Barnoski & Aos, 2005; NCJFCJ 2009). In fact, a consistent finding across research and program evaluations has been the centrality of targeting treatment for juvenile offenders based on individualized assessment of criminogenic risk and need factors. The Continuum of Care Initiative is built on effective juvenile justice strategies that have been proven through research and practice to be effective.

- Following assessment, the Initiative emphasizes a coordinated continuum of care with a broad array of program and service options that are sequenced and combined to create a range of intervention options that ensure the appropriate treatment, education, training, and care compatible with the youth's specific needs.

- Second, it emphasizes community-based options when appropriate. Instead of removing youth from their home environment, community-based services impact the youth's total environment by addressing problems in the community where they develop, and by establishing the long-term support necessary to sustain progress.

- Third, the Continuum of Care Initiative features individualized programming that is sufficiently intensive and comprehensive to accommodate the individual needs and potentials of the youth and their families.

- Fourth, the Initiative attends to aftercare and re-integration so that youth continue receiving the support of treatment services following their treatment in a residential facility.

Successes in the Continuum of Care Initiative

The Colorado Juvenile Risk Assessment (CJRA) is fully implemented across the system. As completion rates for the CJRA approach 100%, all youth served through the Division are receiving case management that is based on empirically supported risk assessment at multiple points in their commitment.

The Continuum of Care Initiative continues to identify and serve youth who enter the system as a high risk for re-offending. CJRA risk and needs data demonstrate that youth served through the initiative enter services at a high level of risk to re-offend, most across multiple risk domains. This indicates that the Division continues to target resources to those youth who represent the highest delinquency costs in terms of the social cost of re-offense as well as costs stemming from returns to the juvenile justice system.

> As a whole, the CJRA is driving significant system improvements – and youth risk for re-offending is decreasing.

Case planning targets criminogenic risk factors for each youth. Through integration of the CJRA into the Trails data system and coordination with the Discrete Case Plan that drives care planning for committed youth, services for youth are linked closely to each youth's criminogenic risks and needs. Both at the

time of initial assessment (by Assessment Services) and during development of the Discrete Case Plan (by Client Managers), empirical, actuarial data is combined with clinical judgment and knowledge of individual youth factors to build targeted placements and services.

While we recognize that significant training and ongoing quality assurance is necessary to ensure this practice is realized throughout the system, case examples reviewed for this report yielded promising samples of youth whose Client Managers used all available data to match services to their individual risks and needs, and who received services from residential placement through community transition that allowed them to succeed in the community.

Criminogenic risk decreases for youth receiving Continuum of Care Initiative services. CJRA data demonstrates that dynamic risk scores decreased significantly for youth receiving services. The proportion of youth with high-range risk scores decreased from assessment to discharge across all of the dynamic risk domains. Similarly, the proportion scoring in the high protective factor score range increased across most domains. This suggests that the Continuum of Care Initiative is appropriately identifying and targeting treatment to areas of criminogenic risk.

Recidivism and recommitment rates remain flat. While this year's rate of pre-discharge recidivism (34.7%) is marginally higher than the past two years, it remains lower than the baseline year's rate of 39.1 percent. This year's rate of recommitment (22.2%) is unchanged from last year and remains slightly lower than past years. In the context of a population that appears to bring greater complexity and multiple risk areas requiring intervention, this stability in recidivism and recommitment may represent a meaningful success for the Continuum of Care.

Data-driven ongoing quality assurance. Last year's evaluation report noted that, while CJRA data revealed improvements for several dynamic risk areas, there was no improvement in the important family risk domain. Leadership in the Division took note of this finding and worked to increase attention to the family domain and ensure youth and families with risk in this area were identified and served. While available data do not allow us to explore in detail how this area was enhanced, risk assessment data for this report demonstrates a significant reduction in family-related dynamic risk.

Introduction and Background

The Colorado Division of Youth Corrections is in the fourth year of a sweeping, comprehensive systems improvement effort – the Continuum of Care Initiative. This initiative has brought significant attention and improvements to the Division's continuum of services from initial (assessment) services through commitment and parole. The flexible funding authorization contained in Footnote 41 of House Bill 08-1375, described below, was the vital first step of the overall Continuum of Care Initiative. The Division of Youth Corrections is using this funding flexibility to support the implementation of a set of integrated system improvements based on research-based principles of effective practice.

The Division of Youth Corrections (DYC) sought authorization from the General Assembly to flexibly deploy funds from the Division's Purchase of Contract Placements funding line item in order to optimize the availability of the most effective services in the most appropriate settings to meet the rehabilitation needs of juvenile offenders in DYC's custody. In Fiscal Years (FY) 2005-06 through 2008-09, the General Assembly authorized the Division to engage in a demonstration of enhanced flexibility in treating and transitioning youth from residential to non-residential settings:

Footnote 41 of House Bill 08-1375:

> *It is the intent of the General Assembly that up to 20.0 percent of the General Fund appropriation to this line may be used to provide treatment, transition, and wrap-around services to youths in the Division of Youth Correction's system in residential and non-residential settings.*

The Continuum of Care Initiative is an integrated set of strategies involving state-of-the-art assessment, enhanced treatment services within residential facilities, and improved transitions to appropriate community-based services.

The Division of Youth Corrections, as part of its ongoing endeavor to systematically pursue and utilize the most advanced strategies available for juvenile rehabilitation, has implemented the Continuum of Care Initiative. The initiative is based on principles of effective juvenile justice strategies that have been proven through research and practice to work. The integrated set of strategies making up the Continuum of Care Initiative are based primarily on available research and the current national research base regarding "what works" in juvenile justice.

Over the past four years, the Division has examined and realigned internal operational practices to be more consistent with the principles of evidence-based practice (EBP) in order to offer the most effective programs possible to reduce recidivism and re-victimization by juvenile offenders. A body of research in this area has shown that this approach, when appropriately implemented, can result in significant systems cost savings[6]. As part of this strategy, the Continuum of Care Initiative seeks to provide the

[6] See, for example, Drake, E.K., Aos, S. & Miller, M.G. (2009). Evidence Based Public Policy Options to Reduce Crime and Criminal Justice Costs. Olympia, WA: Washington Institute for Public Policy.

optimal length of service in each stage of the continuum as youth move from secure residential to community-based services on parole.

Five Key Strategies

The Continuum of Care Initiative is implemented within the broader umbrella of the Division of Youth Correction's Mission and serves to operationalize the Five Key Strategies through which the Division's Mission is accomplished. The Five Key Strategies provide clear guidance that:

> *The Division will provide the **right services at the right time** (strategy 1), delivered by **quality staff** (strategy 2), using **proven practices** (strategy 3), in **safe environments** (strategy 4) embracing **restorative justice principles** (strategy 5).*

Throughout the Division of Youth Corrections, starting with the executive Leadership Team, these five strategies are used as a filter to weigh the pursuit and adoption of new initiatives or modifications and improvements to existing efforts.

While the Continuum of Care Initiative is linked to all five strategies, the strongest ties are to strategies one and three. Strategy one states that the Division will provide the **right services at the right time**. The Continuum of Care Initiative responds directly to this strategy through a combination of responsive ongoing assessment, case planning and service provision tied directly to the unique needs of each youth served at the time the youth needs each service.

Strategy three emphasizes **proven practices**. The Continuum of Care is built around state of the art assessment and individualized case planning practices that link to evidence based interventions, delivered in the community or, when appropriate, in facilities.

The Mission of the Division of Youth Corrections is to protect, restore, and improve public safety through a continuum of services and programs that:

- effectively supervise juvenile offenders,
- promote offender accountability to victims and communities, and
- build skills and competencies of youth to become responsible citizens.

On the next page, Figure 1 illustrates the Continuum of Care Initiative, structured to compliment the Division's Five Key Strategies. The Continuum of Care Initiative is built around five primary principles of Evidence Based Practice. While the figure shows the principles as distinct and linear, they are inter-related and must be implemented together in order to yield the full benefits of the Continuum of Care Initiative. Each principle is described and linked to the Five Key Strategies of DYC's mission.

Figure 1: Principles of the Continuum of Care Initiative

Principle 1: Assess Risk – Identify and respond to high-risk juvenile offenders.

The Continuum of Care Initiative is driven by high quality, actionable information. Assessment helps identify specific categories of criminogenic risk, reveal roadblocks to treatment, provide enough variability to show change before and after treatment in targeted areas, and provide direction for transition and aftercare services.

The Division's Assessment Services is the front line for the Continuum. The assessment of risk is linked to the Five Key Strategies in that high quality assessment allows DYC to understand the youth's risks and needs in order to ensure that each youth receives **the right**

> The Continuum of Care Assessment Services model reflects the most current best practices, combining actuarial risk assessment with expert-driven individualized clinical assessment.

services at the right time. The assessment process applies evidence-based evaluation tools (**proven practices** – Strategy 3) to measure and communicate critical criminogenic aspects of functioning for juvenile offenders committed to the Division of Youth Corrections. Comprehensive assessment also allows youth to be placed in the most appropriate environment (**safe environments** – Strategy 4) to meet his or her needs while maintaining community safety.

The Colorado Juvenile Risk Assessment (CJRA) is state-of-the-art in that it provides an overall score related to risk for re-offending and also provides a detailed analysis of the specific risk and protective factors that may contribute to a youth's success or failure under Division of Youth Corrections supervision. The CJRA was selected after a careful vetting process based on its widespread adoption and acceptance as state-of-the-art. State-specific versions of the instrument are in use in over a dozen states. The instrument has been validated in other sites as highly predictive of future offending. Its effectiveness has been proven through research and practice and it has become one of the leading juvenile risk assessment tools in the country. Implementation of the CJRA places Colorado among a relatively small group of states at the forefront of juvenile justice risk assessment.

The CJRA was piloted, all Client Managers were trained, and full-scale implementation took place during the last two months of FY2005-06, with follow up training in 2007-08. Training emphasized strategies for individualized case management that matches youth to appropriate supervision and treatment services.

In keeping with its commitment to employing proven practices, risk assessment is accomplished using Motivational Interviewing techniques that have been widely demonstrated to yield honest, accurate responses from youth while helping youth identify meaningful goals for change during their time under DYC commitment and parole. Following up on the system-wide roll out of the CJRA, the Division provided comprehensive training in Motivational Interviewing. This combination reflects the most current research-based understanding of effective assessment.

Anchored by the CJRA, findings from a variety of assessment disciplines are integrated in a Clinical Evaluation Report. This approach reflects national best practices as it combines the advantages of actuarial risk and needs assessment with an individualized, expert-driven clinical assessment. The report offers targeted treatment recommendations encompassing criminogenic factors relating to alcohol and drug use, mental health, medical and educational needs. Assessment Specialists, working collaboratively with community partners, create a comprehensive, individualized and interdisciplinary assessment plan for all newly committed juvenile offenders.

As noted, assessment is organized around the CJRA. Through this tool, each youth's unique criminogenic needs are identified by a series of questions that probe the areas of a youth's life that have been proven to predict pro- or anti-social behavior: family, relationships, use of free time, attitudes and behaviors, alcohol and drugs, education, employment, mental health, aggression, and social skills. Each area is analyzed in terms of both risk factors that make it more likely a youth will re-offend and protective factors that buffer youth from risks and make it less likely they will re-offend.

Beginning last year (2007-08), the statewide Trails information management system was enhanced to support the Continuum of Care through integration of the CJRA. Assessment Specialists and Client Managers complete the CJRA on the Trails system. Trails then highlights the elevated risk domains from the CJRA for the Client Manager to incorporate into the Clinical Evaluation Report and the Discrete Case Plan, described directly below.

Principle 2: Target Needs – Identify and treat risk factors that contribute to offending behavior.

This principle reflects a strong response to Key Strategy One – **the right services at the right time**. Using recommendations from the Clinical Evaluation Report and CJRA results, the Continuum of Care directs that Client Managers next build a Discrete Case Plan (DCP) for each youth. Based on their unique pattern of risk and protective factors, the DCP is designed to link each committed youth to the most appropriate set of services and placements and helps client mangers to tailor the intensity and duration of supervision and treatment for each youth. In turn, the DCP supports team-based treatment and transition planning and helps treatment providers recognize and target youth-specific criminogenic needs, thus avoiding broad-spectrum services with undefined goals and lengths of stay. As noted above, this individualized approach making use of an empirically-supported actuarial tool in the context of expert clinical judgment represents current best practice

Principle 3: Evidence Based Treatment – Provide treatment that is proven to work.

The Division's third Key Strategy specifies use of **proven practices**. Principle 3 of the Continuum of Care recognizes that, in order for the risk assessment data and case management to positively impact youth outcomes, youth must have access to a comprehensive continuum of services based on proven, evidence-based strategies. This continuum is designed to ensure that youth receive the most appropriate placements based on his or her criminogenic risks, needs and protective factors as assessed through the CJRA. Moreover, access to a full array of services supports an efficient utilization of funds and resources by allowing youth to move to lower levels of restrictiveness (and cost) as their risk profile and treatment progress allows. Use of evidence-based programming can also result in significant cost avoidance. The Washington State Institute for Public Policy, for example, has demonstrated that evidence-based treatments such as Functional Family Therapy, Multisystemic Therapy, and Aggression Replacement Training result in overall societal returns of $2 to $12 in benefits and avoidance of the costs associated with future crime for every $1 spent (Aos, et al., 2004).

In light of clear and consistent evidence that targeted treatments matched to youth-specific criminogenic needs show the most benefit (Andrews & Zingler, 1990) and that residential treatment has demonstrated inconclusive results (Lyons, et al., 1998), the Division continues to move towards a more effective and efficient balance between residential and community-based intervention strategies. After enhancing targeted treatment capacity in State-operated commitment programs in FY 2006-07 by constructing the State's new Sol Vista Youth Services Center and adding 29 newly funded positions dedicated to the treatment of juveniles who have committed sexual offenses, as well as those having

mental health and substance abuse treatment needs, the Continuum of Care Initiative has been focusing on building capacity to link youth to appropriate evidence based community and family-based services.

Through an Evidence Based Practices (EBP) Committee made up of DYC leaders and provider representatives, the Continuum of Care Initiative is moving forward with the complex process of identifying the most effective evidence based modalities for serving committed youth and enhancing the capacity of the service array in both state and contracted facilities.

In FY 2008-09, the EBP Committee successfully piloted a model for surveying and promoting evidence-based interventions. After working with both state and contracted providers to develop the protocol, the pilot began with state facilities to survey the available service array for evidence based treatment strategies that respond to the criminogenic risks and needs of the youth committed to DYC care.

The EBP Survey Process is built around the following framework, linking the survey to the Division's priorities for evidence based practice. Survey domains are listed in bold along with corresponding evidence base principles.

Assessment/Case Management:

- DYC Evidence Based Principles: Assess Actuarial Risk and Needs; Enhance Intrinsic Motivation (CJRA in case planning); Target Interventions

Treatment Planning:

- DYC Evidence Based Principles: Enhance Intrinsic Motivation; Target Interventions

Treatment Program Model:

- DYC Evidence Based Principles: Use of Cognitive-Behavioral Treatment Models; Increase Positive Reinforcement; Engage Ongoing Support in Natural Communities; Measure Relevant Processes and Practices (Fidelity)

Supervision Strategies:

- DYC Evidence Based Principles: Target Interventions, Enhance Intrinsic Motivation, Increase Positive Reinforcement, Engage Ongoing Support in Natural Communities

Treatment Milieu:

- DYC Evidence Based Principles: Enhance Intrinsic Motivation, Increase Positive Enforcement; Measure Relevant Processes and Practices (Fidelity)

Transitions:

- DYC Evidence Based Principles: Engage Ongoing Support in Natural Communities

Data-Driven QA:

- DYC Evidence Based Principles: Measure Relevant Processes and Practices (Fidelity)

Principle 4: Individualized Case Management – Match youth to the most effective placement and treatment.

Linking to Key Strategy One, **the right service at the right time**, information-driven case management is at the crux of the Continuum of Care strategy. Without effective case management, the information made available through Assessment Services and the CJRA is of limited value. Similarly, the continuum of treatment options available through the service array is only useful to the extent that options are matched to the needs of individual youth. The Division's Continuum of Care Initiative strategy includes protocols to match youth to services based on criminogenic risks and needs as well as individual characteristics and situational factors that may constitute barriers to treatment, such as a lack of motivation, anxiety, reading levels and learning styles. With clear protocols in place, the Division is working to develop useful data sets and tracking protocols to support ongoing quality assurance, reporting and training to ensure that all youth benefit from the most appropriate set of placements and services.

Placements and services may have a positive effect, no effect, or even result in increased rates of re-offending. The Continuum of Care Initiative requires Client Managers to use criminogenic assessment information to target youth according to their risk level and ensure that treatment addresses factors that contribute to offending behavior. This requires intense focus to tailor the intensity and duration of supervision and treatment for each youth. This approach, in turn, will allow the Division to utilize resources more efficiently by ensuring that youth receive supervision and treatment that matches their criminogenic risks and needs, and takes into account individual responsivity issues, such as personality and learning characteristics, and other factors that constitute barriers to treatment, such as a lack of motivation, anxiety, and reading levels.

> Individualized case management allows youth to be matched to the most effective placement and treatment – yielding better outcomes for youth and efficient use of State resources.

The impact of this approach is illustrated through the example of David (not real name), a DYC youth whose CJRA revealed risk elevations in the areas of attitudes, skills and aggression. His Client Manager targeted these areas for treatment and tracked progress. By the time David transitioned to the community he was prepared to return to school and begin part time employment – now with an understanding of the skills and behaviors necessary to succeed.

Principle 5: Data-driven quality assurance (fidelity) – Maintain high quality treatment.

The prioritization of high quality data is central to the Five Key Strategies and forms the foundation for the Continuum of Care. The Division is an increasingly data-driven organization. Division leaders understand the necessity of using data to monitor and promote the highest quality services possible. To this end, The Division's Research Unit has partnered with DYC leadership to develop and implement protocols for ongoing review of the assessment process, case plan development, their link to the actual services youth receive and ultimately to youth outcomes.

The Current Report

Building on the work of the past years' evaluation efforts, the FY 2008-09 Annual Report looks more deeply into the ways that DYC realizes its Five Key Strategies. Specifically, the report describes the implementation of the Colorado Juvenile Risk Assessment (CJRA) and how individual youth risk and needs information drives case planning and service delivery across the system. The report also makes use of CJRA data to describe the youth served by DYC in terms of their risk and needs profiles.

Reflecting the Division's mission to reduce the risk posed by youth to community safety, and to themselves, CJRA data is also used to describe reductions in risk for youth served through the Continuum of Care. Other related outcomes explored in this report include changes in pre-discharge recidivism, re-commitments, lengths of stay in DYC commitment, parole discharge types and parole adjustment at time of discharge. In order to illustrate some of the experiences, successes and challenges of serving youth, several case examples are incorporated into the report.

Finally, the current report includes a discussion of how the Continuum of Care and related system improvement efforts represents best practice in the context of national juvenile justice reform efforts.

The Continuum of Care Initiative – An Integrated Best Practice Model

When the Division of Youth Corrections set out to implement the Continuum of Care Initiative five years ago, its vision was to systematically pursue and utilize the most advanced strategies available for juvenile rehabilitation. As the Initiative develops, it is emerging as an integrated set of strategies involving state-of-the-art assessment, individualized case management, enhanced treatment services within residential facilities, and improved transitions to appropriate community-based services. After surveying the current research and policy literature for this report, Colorado's Continuum of Care Initiative, along with the Division's Five Key Strategies, sits at the forefront of national best practice.

Dialogue regarding juvenile justice best practice is found across a wide range of forums and publications. However, the large-scale investments in juvenile justice reform made by the John D. and Catherine T. MacArthur Foundation through its Models for Change project and by the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative have been instrumental in shaping the consensus regarding best practices. In addition, the National Juvenile Justice Network and federal Office of Juvenile Justice and Delinquency Prevention (OJJDP), among others, have published numerous position papers and national surveys of state practices.

Across this national discussion, the resulting set of best practice principles, themes and emphases largely reflect the Division of Youth Corrections Continuum of Care Initiative and Five Key Strategies. A few examples are briefly presented below.

Assessment and Case Planning – The best practice literature consistently points to three elements of best practice in the area of assessment and case planning.

- First, there is a call for more reliance on actuarial methods of screening and assessment. Colorado's statewide implementation of the CJRA exemplifies this recommendation.
- Second, the use of consistent, structured decision making by client managers is identified as a prerequisite for fair and valid placements and responsive treatments. The Division's approach to developing the Discrete Case Plan (DCP) for each youth based on integrated risk and needs data along with expert judgment is in keeping with this recommendation.
- Finally, the literature increasingly recognizes the importance of structured data systems to chart the progress of youth in placement in order to support oversight of service providers. The integration of the CJRA and DCP into Trails is aligned with this national recommendation.

More specifically, the national literature has identified risk assessment models that combine risks and needs and go beyond calculating a single score of how likely a juvenile might be to re-offend. The Division's use of the CJRA incorporates risks along with protective factors and treatment needs. Rather than treating risk as a stable characteristic of the youth, the dynamic risk-and-needs approach understands that risk can be mitigated by matched interventions and that, for example, a youth with a

drug or alcohol problem may be at higher risk for re-offending but may also be a good candidate for successful community transition if that problem can be addressed effectively in the community. Importantly, the risk-and-need assessment strategy goes beyond simply sorting adolescents into lower or higher risk groups by providing information about how to select interventions to reduce risk.

Evidence-Based Services – Colorado has made a strong commitment to evidence based approaches, both to assessment and treatment. The Evidence Based Practices (EBP) Committee, EBP Survey and growing set of evidence-based services in the DYC service array represent a leadership position in the national discussion of best practice in juvenile justice. Along with states such as Oregon, Washington, Tennessee, Pennsylvania and North Carolina that are moving towards interventions proven to be effective, Colorado has identified this priority and is actively partnering with treatment providers across the state to transform the service array.

Transition from Large Residential Facilities to Community-Based Treatment – The Continuum of Care, in keeping with the Five Key Strategies, seeks to provide the right service at the right time and to serve youth in the least restrictive, most community-based options possible. This emphasis is reflected in national priorities that have seen many states move from exclusive reliance on large youth centers to more integrated systems that combine such facilities with smaller, geographically distributed treatment-focused facilities and community resources.

Mental and Behavioral Health – The Continuum of Care's investment in mental and behavioral health treatment is strongly supported by the national best practice literature. While the co-occurrence of behavioral health problems and juvenile offending has long been recognized, Colorado is among the first states to respond by making treatment more available. States including Minnesota and Pennsylvania have recently mirrored Colorado's efforts by putting mental health services in place for youth with identified mental health needs.

Throughout the body of this report we will refer to evidence-based principles and practices and point out how the components of the Continuum of Care reflect these practices.

Case Illustrations: Putting the Strategies into Action

In order to illustrate the Continuum of Care Principles in action, two case illustrations are briefly presented. The following examples of David and Marie (not their real names) are consistent with many other youth receiving support through the Continuum of Care Initiative.

David[7]

David began receiving support through the Continuum of Care Initiative after a six-month residential placement followed by a community transition to parole. He was defiant at home and truant during summer school. David's criminogenic risks and needs were assessed using the CJRA and the results indicated high risk factors and needs in the areas of relationships, attitudes and aggression.

Principle 1: Assess Risk

David's Client Manager created a discrete case plan with David and his parents and an Aunt from out of state, who supported David's mother during his involvement with the Division. The plan included placement at a structured residential facility offering supports that matched the needs and risks revealed by the CJRA. During the case planning process, the family suggested that David might have underlying mental health needs. Referring back to the results of the CJRA, David's Client Manager was able to explain that, while David may have mental health needs, they were not contributing to his criminal behavior that was the focus of the case plan. The Client Manager made the decision to concentrate treatment on David's specific criminogenic needs and risks. At the same time, he supported the family's decision to pursue further mental health assessment and services.

Principle 2: Target Needs (Discrete Case Plan)

Initially, David was successful in his placement and progress was being made particularly in his relationship with his father. However, as with many youth, his progress stalled. When his family became concerned and questioned the appropriateness of the placement, David's Client Manager and the staff at his placement returned to David's assessed needs and risks and while maintaining focus on his criminogenic factors they were able to slightly modify their approach based on what they had learned about David, his skills, challenges and motivators. David was able to address barriers to treatment and again made progress.

Principle 4: Matching – Individualized Case Management

David's transition plan, established early in the case planning process, was for him to return to his public high school and find and maintain employment. Job skills training and support in finding employment were provided and by the time he entered parole he was successfully employed at a grocery store.

[7] Case illustrations do not use client's real name.

Transitions from a structured residential setting to parole and back to family and community are challenging. Without the right levels and types of support youth can fail, making this is a critical time for prevention of recidivism. For David, much work had been completed prior to his transition to set him up for success, including the job training and work on his relationship with his father, with whom he was planning to live. David's Client Manager used Continuum of Care funding to support David's transition by providing for continued work with the therapist David had connected with during his placement. David was able to transition successfully back to school, home and community. He was able to find and maintain employment and pay his restitution in full. He graduated from high school with a 4.0 GPA his last two semesters and was accepted to several schools in Colorado including the Colorado School of Mines.

Principle 4: Matching – Individualized Case Management

While David's academic success may not be typical, the pattern of assessment, case planning, intervention and successful transition is found in many stories across the Division.

Marie

Marie offers another example of the Continuum of Care principles in action. Her successful transition was driven by her ability to apply new skills gained through the Continuum of Care in order to support her goals for change and to provide for her child.

Marie's criminogenic needs and risks were assessed using the CJRA and other diagnostic instruments. Results indicated high dynamic risk in relationships, family, substance use, attitudes, aggression and skills.

Principle 1: Assess Risk

Marie's Client Manager constructed her Discrete Case Plan on her criminogenic needs and risks and worked with her family to identify an intensive drug and alcohol treatment program as the best initial placement option. In many states, youth who use substances are automatically placed in a substance abuse treatment program based upon the assumption that decreased substance use would decrease criminal behavior. However, research has demonstrated that substance use does not reliably predict delinquent behavior. The CJRA provides a reliable tool for the Colorado Division of Youth Corrections to determine when substance use is a factor in criminal behavior. In Marie's case, results of the CJRA pointed to a high level of risk in the substance use domain meaning that her substance use was related to her criminal behavior. Therefore, placement in an intensive drug and alcohol program represented a good match for Marie's individual needs.

Principle 2: Target Needs (Discrete Case Plan)

For Marie, the challenges inherent in transitioning from placement to the community were increased because she was pregnant with her first child and her parents were not able to support her. Following best practice approaches,

Principle 3: Evidence Based Treatment

the Client Manager identified other family members to support Marie's transition. Grandmothers joined Marie's team and offered needed support. Marie's case plan addressed these challenges and helped her gain the skills she needed for a successful transition.

Marie is a determined young woman who used her commitment to the Division of Youth Corrections to set her sights on taking care of her child and breaking free of the lifestyle she had grown up with. She was able to apply the skills she learned during her commitment to seek out and take advantage of several community services for young mothers. Part of her case plan included job skills training and as a result she was able to find and maintain employment in the food service industry. She worked consistently and saved enough money before her child was born to move into an apartment and take a 2-month maternity leave. She has continued along this successful path since becoming a mother.

Principle 4: Matching – Individualized Case Management

Marie's Client Manager observed Marie's ability to succeed without intensive services during transition. A reassessment of Marie's risks and needs using the CJRA confirmed the Client Manager's observations and supported the decision that additional services were not needed. The reassessment showed marked decreases in the dynamic risk domains previously identified as high (family, substance use, attitudes and skills). The Client Manager monitored Marie carefully and, due to the flexibility of the Continuum of Care Initiative Funding, she would have been able to step in with services if needed. In this situation, additional services were not needed. At times, it is a challenge for Client Managers to opt not to provide services. Being able to support these decisions with an empirical, actuarially developed tool is a cornerstone of the Continuum of Care.

Principle 4: Matching - Individualized Case Management

While David's and Marie's experiences in the Division of Youth Corrections Continuum of Care Initiative are unique to them, they are representative of the principles and strategies of the Initiative. The data and analyses presented throughout the following pages of this report represent objective measures of the successes of the Division's strategies and challenges facing the Initiative. We hope that these brief case illustrations anchor these empirical measures with a glimpse into how the Initiative impacts the lives of the youth served.

Data Sources

Data for this report comes from five primary sources.

1. **Continuum of Care Initiative tracking forms,** developed by the Division, were completed by Client Managers to document each service purchased through the Continuum of Care Initiative. For each youth receiving services, these forms track the amount of funds expended (costs), the types of service purchased, and the service provider. Tracking forms also include a Trails ID for linking youth receiving services to corresponding information in the Trails system.

2. **Colorado Trails Data System –** Extracts from the Trails data system provide information regarding the characteristics of committed youth, commitment length of service (LOS) for each youth, and overall monthly ADP over the course of the fiscal year.

3. **DYC Risk Assessment Data** is available for the first three years of implementation of the Colorado Juvenile Risk Assessment (CJRA). The CJRA has been integrated into the Trails Data System; extracts from that system are used to provide information on youth risks and treatment needs as well as targeted areas in the youth's Discrete Case Plan (DCP). The CJRA measures risk and protective factors linked to re-offending across 12 different domains: criminal history, demographics, school, use of free time, employment, relationships, family, substance use, mental health, attitudes, aggression and skills. Scores are separated into static factors (historical events that cannot be changed) and dynamic factors (current issues that can be improved to either reduce the risk for re-offending or increase the protection against existing risk). Please see Appendix A for a copy of the full CJRA.

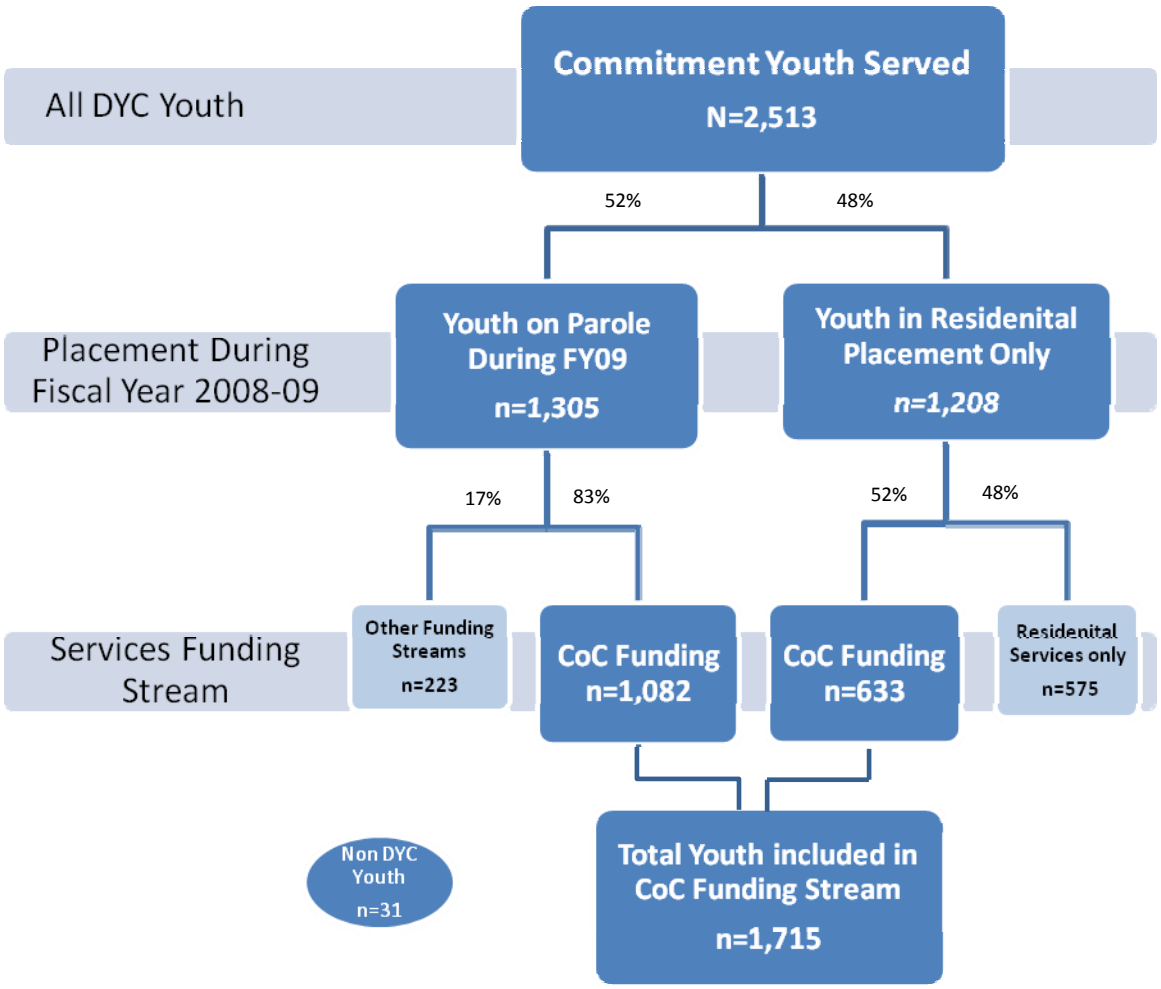
4. **Recidivism data** was provided for each served youth by the Division's Research and Evaluation Unit. For youth committed during Fiscal Year 2008-09, only pre-discharge recidivism data was available. Pre-discharge recidivism is defined by the Division as a filing for a new offense that occurs before a youth is discharged. This can include a new offense occurring while a youth is in placement or during time on parole. Post-discharge recidivism is defined by the Division as a filing for a new offense occurring in the 12 months after discharge. This information was not available for youth committed during Fiscal Year 2008-09 because the necessary 12 months (plus additional time for records to be entered and analyzed) has not yet elapsed.

5. **Case examples** were provided by each of the four management regions. Each Client Manager supervisor submitted information for one youth considered to be a successful example of the Continuum of Care process and one youth with negative outcomes during commitment. Additional treatment plan and placement data for these youth was located in Trails and included as examples of certain components of the Continuum of Care.

Implementation of the Continuum of Care Initiative

As previously discussed, the Continuum of Care Initiative represents a comprehensive systems improvement effort across the entire DYC commitment population. The flexible funding authorized in Footnote 41 of HB 08-1375 represents an important component of this effort. While all committed youth are impacted by the Initiative, different paths are followed, based on individual need and circumstance. As a result, not all committed youth during this fiscal year received direct services funded by the flexible funding authorization. Some youth received residential services only, while others received non-residential services through other case management and funding streams. The graphic below illustrates the distribution of committed youth across different funding and placement types.

Figure 2: FY 2008-09 Committed Youth



A total of 2,513 committed youth were served during Fiscal Year 2008-09. Of these youth 1,305 were served on parole status at some point during the year, while the remaining 1,208 youth were in residential placement during the entire fiscal year. As seen in Figure 2, the vast majority of parole youth (83%, n=1,082) received direct non-residential services paid through the Continuum of Care flexible funding stream. The remaining 17% of paroled youth either received services through the Continuum of Care Initiative via indirect spending (e.g. blocks of services purchased on behalf of multiple youth), received services through other funding streams, or did not receive services because their client manager determined there was no clinical indication of need.

More than half (n=633) of the youth that received residential services also received transitional services through the Continuum of Care funding stream. This "backing in" of services practice that lays the foundation for optimally moving youth from residential placement to the community (by starting transition services well before a youth leaves residential placement) is vital to managing the residential population. This will likely become more important as state facilities move to 120% of capacity in the future and the need for optimally moving youth out of state facility placement becomes greater.

Additionally, 31 youth not committed to the Division received some services through the Continuum of Care funding stream. For example, some youth were being supervised in Colorado through the Interstate Compact on Juveniles (ICJ), and therefore were not officially committed to the Division, but services were provided based on an agreement among the states to assist in supervising paroled youth moving from another jurisdiction. A total of 1,715 committed youth[8] received direct services through the Continuum of Care flexible funding stream. No funds were expended to provide services for detained youth.

Characteristics of Committed Youth

The following tables show the demographic distributions of committed youth. There were no statistically significant differences between youth who received direct services from the Continuum of Care Initiative versus those who received services via other mechanisms[9], including both residential services only and non-residential services through other funding streams.

[8] The Division does not have additional information regarding the 31 "other" youth served through with Continuum of Care funding.

[9] For gender, χ^2=2.24; p=.135. For Ethnicity, χ^2=.87; p=.99. Differences in average age where statistically significant (t=5.05; p=.00), but the difference of .2 years was not clinically meaningful.

Table 1: FY 2008-09 Demographic Distribution of Committed Youth Including Residential and Non-Residential Services				
	Continuum of Care Funding		Other Case Management	
	Number	Percent	Number	Percent
Gender				
Female	237	13.8%	93	11.7%
Male	1478	86.2%	705	88.3%
Total	1,715	100%	798[10]	100%
Race/Ethnicity				
American Indian/Alaskan Native	37	2.2%	18	2.3%
Asian	11	0.6%	7	0.9%
Black or African American	322	18.8%	152	19.0%
Hispanic	620	36.2%	287	36.0%
Native Hawaiian/Pacific Islander	4	0.2%	2	0.3%
White	714	41.6%	330	41.4%
Unable to Determine	7	0.4%	2	0.3%
Total	1,715	100%	798	100%
Average Age at Commitment	16.5 years		16.7 years	

Youth that received direct services through Continuum of Care funding were comparable, demographically, to the much smaller group of committed youth who received services via other means (listed under "Other Case Management" in the table above). Together, these two groups make up the entire residential and non-residential (parole) commitment population. The majority of youth served was male. Just over one-third (36%) were Hispanic, less than half were White (42%), and 19 percent were African American. The average age at commitment was 16.5 years.

[10] This group includes the 223 youth on parole and 575 youth in residential placement whose have services delivered by other means.

Regional Distribution of Committed Youth

There were some statistically significant differences[11] across the Division's four management regions. In the Western region, 88.4 percent of all committed youth received services directly funded by the Continuum of Care Initiative. In the Southern region 75.4 percent of all committed youth received services directly funded by the Continuum of Care. These proportions are higher than the Central and Northeast regions.

Table 2: FY 2008-09 Regional Distribution of Committed Youth

	Central	Northeast	Southern	Western	Total
Number Receiving Direct Services via Continuum of Care Funding	699	421	381	214	1,715
Percent of Overall Committed Youth Population	64.7%	61.4%	75.4%	88.4%	68.2%

Offense and Commitment Characteristics

There were no significant differences between youth receiving direct Continuum of Care Initiative funded services and youth with other case management profiles in either the original commitment offense type or sentence type.

Table 3: Original Commitment and Offense Type for Youth Served (FY 2008-09)

	Continuum of Care Funding		Other Case Management	
	Number	Percent	Number	Percent
Original Commitment Type				
Non-Mandatory	1202	70.1%	574	72.2%
Mandatory	376	21.9%	170	21.4%
Repeat	105	6.1%	40	5.0%
Violent	7	0.4%	3	0.4%
Aggravated	24	1.4%	8	1.0%
Total[12]	1,714	100%	795	100%

[11] χ^2=78.7; p=.000

[12] Data for original commitment type was missing for one Continuum of Care funding youth and three other case management youth.

Table 3: Original Offense and Commitment Type for Youth Served (FY 2008-09)				
	Continuum of Care Funding		Other Case Management	
	Number	Percent	Number	Percent
Original Offense Type				
Felony	1020	62.8%	507	66.5%
Misdemeanor	606	37.3%	255	33.5%
Total[13]	1,626	100%	762	100%

The majority of youth (just over 70%) were committed under a non-mandatory sentence. Most remaining youth (approximately 21%) were committed under a mandatory sentence. A small proportion of youth were committed under either a violent or aggravated or repeat sentence type. Definitions of these special sentence types are provided below.

Repeat Offender (Sentence Type) - A juvenile may be sentenced as a repeat offender if he or she has been previously adjudicated a juvenile delinquent and is adjudicated for a delinquent act that constitutes a felony, or if his or her probation is revoked for a delinquent act that constitutes a felony. The court may or may not designate a minimum sentence length.

Aggravated Offender (Sentence Type) – These sanctions specify a time period of three to seven years, during which time a youth must remain in the custody of the Division. Contingent upon court approval, youth may be eligible for non-secure placement, parole, or transfer to the Department of Corrections (adult corrections).

Violent Offender (Sentence Type) - A juvenile may be sentenced as a violent offender if he or she is adjudicated a juvenile delinquent for a delinquent act that constitutes a crime of violence as defined in Section 16-11-309(2), Colorado Revised Statutes.

More than half of youth were originally committed for a felony offense. Just over one-third were originally committed for a misdemeanor offense.

[13] Data for original offense type was missing for 89 Continuum of Care Funding Youth and 36 other case management youth.

Continuum of Care Initiative - Flexible Fund Expenditures

Information regarding the types of services purchased under the Continuum of Care Initiative was tracked by the Division's management regions for FY 2008-09. Tracking data showed expenditures of $5,267,532. This is an $804,979 (18%) increase over last year's spending and represents the 20% flexible spending provision in the Division's Contract Placements Line Item. The line item increased from an initial 10% in FY 2005-06 to 15% in FY 2006-07 and to 20% in FY 2007-08.

Table 4: FY 2008-09 Expenditures by Region

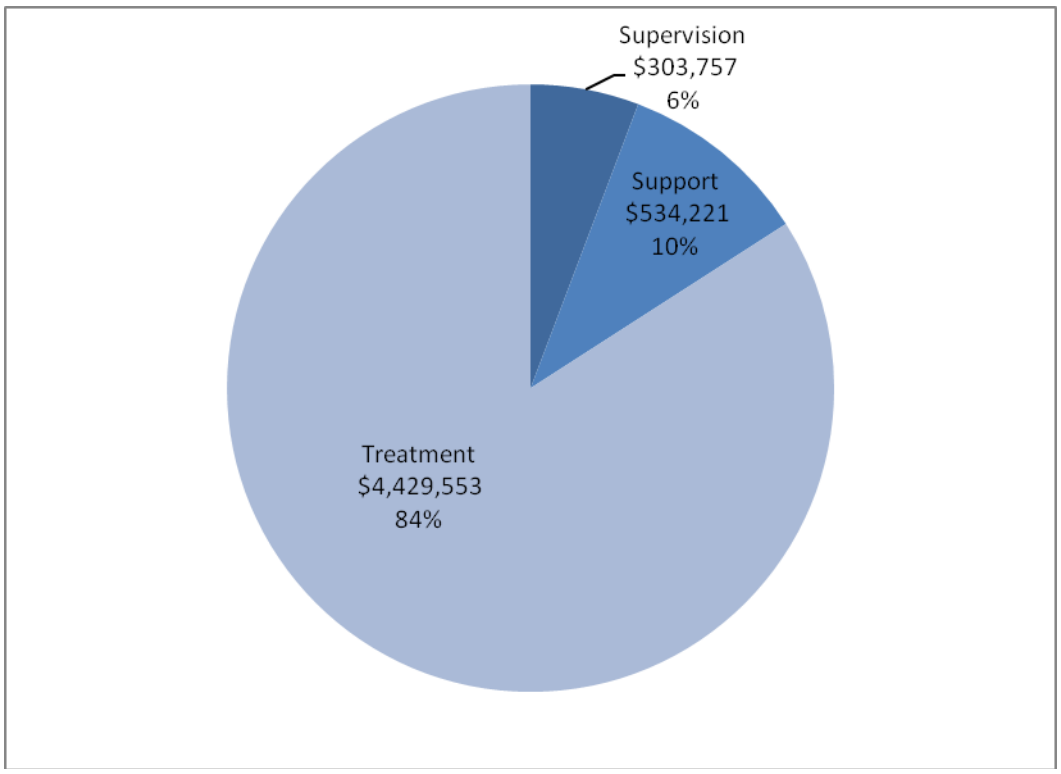
Region	Expenditures	Percent of Total	Percent of Overall Committed Youth
Central	$ 2,015,586	38.5%	43.0%
Northeast	$ 1,153,251	22.0%	27.3%
Southern	$ 1,128,408	21.6%	20.0%
Western	$ 933,039	17.8%	9.6%
Total	**$ 5,230,284**	**100%**	**100%**
Multiple Region	$ 37,249	--	--

Differences are not statistically significant; F=.926; p=.42.

The Southern and Western regions accounted for a slightly larger percent of Continuum of Care Initiative expenditures than their percent of committed youth served. Although the Central and Northeast regions served more youth, their percents of expenditures were somewhat lower. None of these differences, however, were statistically significant. A very small percent of overall expenditures (less than 0.1%) were multiple region expenditures not attributable to a specific management region[14].

[14] An example of this might be the bulk purchase of urinalysis test kits used by multiple regions, or fixed rate contracts utilized by more than one region.

Figure 3: FY 2008-09 Continuum of Care Initiative Expenditures by General Category



The vast majority (84%) of expenditures was dedicated to treatment and treatment-related services (see below for details on treatment expenditures). This percent was consistent across each of the management regions. Another 10 percent of expenditures were for support-related services, while the remaining six percent went to the purchase of supervision services.

Expenditure breakdowns were similar to those of last fiscal year: 86% of last year's expenditures were dedicated to treatment services, compared with 84% this year. The proportion of expenditures dedicated to support services increased slightly (from 6% to 10%), while the proportion spent on supervision stayed roughly the same (8% last year vs. 6% spent this fiscal year).

Fiscal Year 2008-09 expenditures represent an average of $2,761 per youth. This average includes all costs for individual youth for services paid out of Continuum of Care funding, including services provided during the residential placement phase of a youth's commitment. This concept of "backing services in" represents an important component in optimizing the timing of transitions back to the community. The flexibility in funding allows earlier transition planning to occur. Corresponding to the Continuum of Care's emphasis on developing transition services earlier in a youth's commitment, this year's average cost per youth is slightly higher than the average amount spent in FY 2007-08 ($2,636 per youth).

Table 5 (below) shows the distribution of the average expenditures per youth across the Division's four management regions.

Table 5: FY 2008-09 Average Expenditures per Youth		
Region	**Youth Served**	**Average Expenditures**
Central	722	$ 2,580
Northeast	402	$ 2,711
Southern	395	$ 2,501
Western	220	$ 3,843
Total	**1,739**[15]	**$ 2,761**

Costs per youth were significantly higher for the Western region than for the other management regions. This may reflect the greater expense across all three categories (treatment, support and supervision) associated with the need to provide services across a wider, less densely populated, geographical area, with average costs per youth being higher in the Western region for all three categories of service.

In addition, the general amount of service received (larger per youth) also contributes to this increased cost per youth (as well as the overall larger proportion of total expenditures, compared to the proportion of youth served). As noted in Table 4, 17.8 percent of Continuum of Care expenditures occurred in the Western region relative to only 9.6 percent of youth committed in the region.

Table 6, below, shows that all but two of the youth receiving Continuum of Care-funded services in the Western region received treatment services. This represents 99 percent of Western region youth receiving treatment services compared to between 79 and 92 percent of youth in other regions. Additionally, more Western region youth received support services (86% versus between 57% and 66% in other regions). Overall, Western region youth were more likely than youth in other regions to receive services across multiple categories (particularly to receive both treatment and support services).

[15] This includes those youth not under direct DYC supervision (e.g. ICJ youth), but does not include youth who were not affiliated with a specific management region.

Table 6: FY 2008-09 Regional Expenditures by Category								
Region	Total Youth	Total Expenditures	Treatment		Support		Supervision	
			% of youth	% of spending	% of youth	% of spending	% of youth	% of spending
Central	722	$ 2,015,586	79.5%	84.8%	56.8%	7.5%	27.1%	7.7%
Northeast	402	$ 1,153,251	91.8%	89.0%	60.2%	17.7%	40.8%	3.7%
Southern	395	$ 1,128,408	88.4%	78.7%	66.3%	10.7%	35.2%	6.0%
Western	220	$ 933,039	99.1%	84.1%	85.9%	10.1%	34.1%	5.8%
Total[16]	**1,739**[17]	**$ 5,230,284**	**86.8%**	**84.0%**	**63.4%**	**10.0%**	**33.0%**	**6.0%**
Not region-associated[18]	15	$ 37,249	--	--	--	--	--	--

Treatment Expenditures

The total of $4,429,553 in treatment expenditures includes all services targeted to change behavior(s) that will improve or enhance an individual youth's ability to function in the community. This includes an array of skill building and therapeutic services, described in detail below.

The highest proportion of treatment expenditures (40.9%) were spent on community living and social skill development. This includes social and life skills training programs that target the development, modeling, and application of critical life skills for community living discussed below. Given that the average age of youth at the time of their commitment is 16.5 years and the average length of commitment, including parole, is 25.5 months, most youth committed to the Division are minors at the time of their commitment, but are adults at the time they discharge. As a result, a crucial part of transition services provided to youth being discharged includes providing youth with the needed skills to live independently for the first time. During the time youth spend on parole, they have the opportunity to learn general skills needed for pro-social community functioning.

[16] The total (1,739) does include those youth who were not committed to the Division (e.g. ICJ youth), but excludes 9 of those youth who were not affiliated with a specific DYC management region.
[17] Total youth included for average expenditures calculations includes 15 of the 31 other youth served (e.g. ICJ youth from other states) that were associated with a specific management region. Not all 1,746 youth served were directly linked to a management region.
[18] Includes 13 of the 31 youth not committed to the Division (e.g. ICJ youth) and expenditures ($ 37,249) divided across multiple regions.

Table 7 shows the distribution of treatment expenditures.

Table 7: FY 2008-09 Treatment Expenditures by Type of Service		
Service Type	**Expenditures**	**Percent of Total**
Community Living & Social Skill Development	$ 1,810,370	40.9%
Family Therapy	$ 559,054	12.6%
Job/Skills Training	$ 528,108	11.9%
Provider Network Maintenance	$ 367,409	8.3%
Case Management and Planning	$ 367,282	8.3%
Offense Specific Treatment	$ 234,434	5.3%
Individual Therapy	$ 132,488	3.0%
Youth Mentoring	$ 85,221	1.9%
Day Treatment	$ 84,732	1.9%
Art or Recreational Therapy	$ 74,617	1.7%
Restorative Community Justice	$ 66,933	1.5%
Evidence Based Behavior Training[19]	$ 40,977	0.9%
Substance Abuse	$ 34,366	0.8%
Group Therapy	$ 28,976	0.7%
Assessment	$ 14,586	0.3%
Total	**$ 4,429,553**	**100%**

Other youth transitioning from a residential setting return home. Therefore, a significant portion of funds (12.6%) were expended on family therapy programs aimed at supporting youth success by providing caregivers with the skills to monitor youth transitions from placement and promoting healthy family relationships. Research has demonstrated that improvements in family functioning and supervision can greatly decrease a youth's risk to re-offend. These approaches have also been demonstrated as cost effective relative to extended residential placement; funds invested in family treatments can yield a significant cost savings if targeted to the right youth and implemented with fidelity.

Jobs and Skills Training accounted for 12 percent of expenditures. These training programs allow youth to learn skills needed to secure and maintain employment. Because so many youth begin living independently at the time they discharge from the Division, these skills are critical to their successful

[19] Includes Cognitive Behavior Training (CBT); Dialectic Behavior Training (DBT) and Motivation Enhancement Therapy (MET).

transition into the community. Like other services targeting community success through skill building, these interventions can realize significant cost savings if implemented appropriately. The impact of these services is illustrated through the experiences of David (not his real name), a DYC youth who received job skills training as part of his transition to the community. Upon transition home, he began a job at a local supermarket and was successful, facilitating payment of restitution and a positive experience as a contributing member of the community.

Provider Network Maintenance expenditures (8.3%) include payments to service agencies to maintain access and to ensure that treatment services are available based on the size and needs of the population of youth being served. While these costs may not be associated with an individual youth, they are necessary to maintain the needed level of services within communities to support youth throughout community transitions.

Transition Planning (8.3%) is another component of the comprehensive treatment services provided to youth. These services included case management, working with the youth to prepare for parole hearings and to build support systems that will be available to youth once the Division's services end at the time of formal discharge.

Another five percent (5%) of treatment expenditures were directed towards offense-specific treatment designed to assist youth adjudicated for a sex offense. The remaining expenditures were distributed among the following: individual therapy, youth mentoring, day treatment, art or recreational therapy (including animal therapy), restorative community justice (RCJ) programs (including victim empathy training and restitution payment), specific evidence based behavior training (cognitive programs designed to change behavior by targeting thought patterns that lead to problem behavior), substance abuse treatment, group therapy and assessment (general specialized assessments for sexual offenders, traumatic brain injury or individualized psycho-social needs).

Support Expenditures

The table below presents the distribution of support expenditures. Support services are defined as tangible resources purchased on behalf of youth or that youth purchase (for example, with gift cards) to meet needs as the youth begins the process of living (often independently) in the community.

Table 8: FY 2008-09 Support Expenditures by Type of Service

Service Type	Expenditures	Percent of Total
General Living Expenses	$ 148,021	27.7%
Emancipation/Independent Living	$ 117,642	22.0%
Education	$ 93,610	17.5%
Transportation	$ 84,199	15.8%
Professional	$ 42,864	8.0%
Medical	$ 24,075	4.5%
Pro-Social Engagement	$ 23,810	4.5%
Total	**$ 534,221**	**100.0%**

Almost one third of support-related expenditures were dedicated to assisting youth in transition with general living expenses (27.7%). These expenses were largely for youth to purchase food or clothing, often provided in the form of gift cards to grocery or discount stores. Such expenditures also included non-food grocery items (e.g. personal hygiene items) and assistance with phone service (usually pre-paid phone cards). Emancipation and independent living services (22.0%) included both formal emancipation programs that assisted youth with the needed services to begin independent living (education regarding establishing a household, looking for work) and assistance with housing (rent) and employment searches. A fairly signification portion of funds was used to assist youth with ongoing educational expenses (17.5%). This included tuition payments, the purchase of books and other educational supplies, as well as GED or other testing fees. An additional 17.5 percent of expenditures were used to pay various transportation costs (for the youth, family and/or service provider) during the transition process.

Eight percent of support dollars were used for professional services, mainly securing identification and documentation records (e.g. state identification cards, birth certificates, etc.) or translation services. Another eight percent was divided between medical expenses (4.5%) and pro-social engagement activities, such as recreational opportunities (4.5%).

Supervision Expenditures

Supervision expenditures are costs directly related to monitoring youths' activities while in non-residential settings. The table below shows the distribution of supervision expenditures, by specific type of supervision.

Table 9: FY 2008-09 Supervision Expenditures by Type of Service

Service Type	Expenditures	Percent of Total
Tracking and Day Reporting	$ 197,198	64.9%
Substance Use Screening	$ 36,988	12.2%
Offense Specific Supervision	$ 35,219	11.6%
Electronic Home Monitoring/GPS	$ 34,352	11.3%
Total	**$ 303,757**	**100.0%**

Close to two-thirds (64.9%) of all supervision expenditures were spent for tracking and day reporting services for youth. These programs function somewhat like a typical parole-officer/offender relationship with trackers checking on a youth's whereabouts and activities (by calling the youth/family or having pre-determined call-in times) and documenting that the youth is abiding by any release conditions such as attending school or work, or observing curfew.

The remaining expenditures included substance use screening (12.2%), generally in the form of urine analysis for illegal substances, and offense-specific supervision for sex offenders (11.6%), generally comprised of polygraph exams regarding additional offenses. Electronic home monitoring (11.3%) made up the remainder of supervision expenditures.

Assessing Youth Risk and Needs

A comprehensive, empirically validated risk assessment allows the Division to identify and respond to the factors directly contributing to youth offending behavior. Anchored by the Colorado Juvenile Risk Assessment (CJRA), findings from five assessment disciplines are integrated in a Clinical Evaluation Report. The report offers targeted treatment recommendations encompassing overall criminogenic factors, alcohol and drug use, mental health, medical and educational needs. Assessment Specialists, working collaboratively with community partners, create a comprehensive, individualized and interdisciplinary assessment plan for all newly committed juvenile offenders. In the 2007-08 Fiscal Year, the statewide Trails information management system was enhanced to support the Continuum of Care Initiative through integration of the CJRA. Assessment Specialists and Client Managers can now complete the CJRA on the Trails system. Trails highlights the elevated risk domains from the CJRA so that they can be integrated into the Clinical Evaluation Report and the Discrete Case Plan.

Implementation of the CJRA throughout the Division is a cornerstone of the Continuum of Care Initiative. Since 2006, the Division has continued to enhance procedures to ensure that all committed youth have CJRAs completed at specified points in time along the commitment continuum. These assessments help to enhance the decision making process throughout a youth's commitment, from initial residential placement to parole.

Fiscal Year 2008-09 CJRA Implementation

All youth committed during Fiscal Year 2008-09 had a CJRA completed both at the time of initial assessment and, in cases where a youth had been discharged, again at the time of discharge. All but 40 youth who were paroled during the fiscal year had a CJRA completed at the time they moved onto parole.

Table 10: FY 2008-09 CJRA Completion Rates

Time Period	Initial CJRA[20] n=2,158	Parole CJRA[21] n=993	Discharge CJRA[22] n=651
CJRA Completion Rate	100%	96.0%	100%

[20] Only includes youth who were committed after the CJRA initial implementation date of July 1, 2006 and excludes one youth for whom no assessment was completed due to a commitment of only 129 days with credit for 94 days already served.
[21] Only includes youth who were committed after the CJRA was implemented and were paroled as of June 30, 2009.
[22] Only includes youth who were committed after the CJRA was implemented and were discharged as of June 30, 2009.

Based on original assessment validation studies in Washington State, each domain of the CJRA has three ranges of scores: low risk (bottom 33.3% of all scores), moderate risk (the middle 33.3% of scores), and high risk (the top 33.3% of scores). As shown in the table below, more than half of committed youth fall into the highest third of possible scores in the criminal history, relationships, family, substance abuse, attitudes, aggression, and skills domains.

Table 11: Distribution of Initial Scores across All Committed Youth

CJRA Domain	N[23]	Level of Relative Risk		
		Low Risk	Moderate Risk	High Risk
Criminal History	2023	4.9%	15.5%	79.6%
School	2023	53.3%	19.9%	26.8%
Relationships	2023	1.3%	18.1%	80.5%
Family	2023	17.0%	19.6%	63.4%
Substance Abuse	2023	33.7%	11.3%	55.0%
Mental Health	2023	64.8%	22.3%	12.9%
Attitude	2023	2.8%	6.8%	90.4%
Aggression	2023	4.8%	15.6%	79.6%
Skills	2023	10.0%	8.5%	81.5%

Nearly two-thirds of youth fell into the lower risk score range on the mental health domain. However, this does not mean that these youth do not have mental health needs, perhaps even significant ones, only that mental health issues do not seem to be contributing to their risk for re-offending. In fact, scores on the Colorado Client Assessment Record (CCAR), used by the Division of Behavioral Health to assess mental heath needs, confirms that the majority of committed youth have significant mental health needs. Of the youth committed during Fiscal Year 2008-09, more than half scored at the '5' level ("symptoms are present which require formal professional mental health intervention") or higher. Thirty percent (30%) of committed youth scored either a '6' or '7' on the CCAR, where '7' indicates "significant symptoms at multiple domains exist, often requiring external intervention." Only about one-third of committed youth scored between '3' and '1," indicating either "intermittent" or "low-level" (3) or no symptoms (1).[24]

[23] The number of CJRAs used for this analysis is somewhat lower because some assessments were excluded due to missing data.

[24] Colorado Department of Human Services (accessed Sept. 2009). Colorado Client Assessment Record (CCAR) 2006 Blank Form. http://www.cdhs.state.co.us/dmh/PDFs/de_CCAR2006_blank.pdf.

More than half of youth fell into the lower third of risk scores on the school domain. However, because a large number of youth have spent a significant period of time prior to the assessment in commitment placement, the school domain scores often reflect a youth's behavior in a controlled, residential, educational environment and is not necessarily indicative of a youth's school risk following a return to the community. This is a reminder of the important role that Client Managers play in balancing actuarial risk assessment data with clinical judgment in order to build plans that support the actual needs of youth.

Over the past three years of CJRA implementation, the proportion of committed youth with scores in the highest risk range has steadily increased across many of the domains measured by the CJRA.

Table 12: FY 2008-09 CJRA Relative Risk by Domain

CJRA Domain	Proportion of Youth Scoring in the Highest Risk Range		
	FY 2006-07 N=890	FY 2007-08 N=1,506	FY 2008-09 N=2,158[25]
Criminal History	83.0%	80.4%	76.4%
School	23.0%	26.6%	29.7%
Relationships	77.2%	79.6%	83.8%
Family	56.1%	66.9%	64.8%
Substance Abuse	45.9%	57.4%	59.1%
Mental Health	8.3%	12.6%	16.5%
Attitudes	87.6%	89.6%	93.1%
Aggression	82.4%	76.9%	80.5%
Skills	84.5%	80.5%	80.4%

A larger proportion of youth scored in the highest range of risk scores this fiscal year, compared to FY 2006-07, in the school, relationships, family, substance abuse, mental health and attitude risk domains. The research base clearly demonstrates that these elevations, and the complex inter-relations among them, are predictive of delinquent and offending behavior.

While the overall proportion of youth scoring in the high-risk range for mental health remains low, it has doubled in the past three years. Substance abuse risk has also increased substantially. This is consistent

[25] The multiyear analysis of CJRA risk scores includes all initial CJRA assessments, even in cases where some domains may have missing data. This was done to be consistent across analyses done in past years. As a result, the overall proportions in Table 12 vary slightly from those presented in Table 11.

with Division reports of more youth with more acute needs and co-occurring disorders being committed in recent years.

This increase in levels of risk in all but three domains indicates that, on average, youth committed to the Division during this fiscal year have higher risk for re-offending (as well as an elevated and more complex treatment need) than youth served in commitment two years ago.

> Client Managers are addressing criminogenic risk areas in the Discrete Case Plan. Almost all (80%) of plans featured at least one of the top risk domains for treatment.

Using CJRA Results in Case Planning. A preliminary examination of the match between domains targeted by the CJRA and those selected for treatment in the DCP show that elevated risk domains are being targeted for treatment. In 80 percent of cases, at least one of the top domains was targeted for treatment and 2 to 3 of the top domains were targeted in over 60 percent (60.4%) of cases. In case examples reviewed for this report, successful experiences were characterized by explicit attention to matching services to elevated risk areas. While this represents a central aspect of the Continuum of Care model, significant training and ongoing support will be needed to ensure that all youth receive the most effective combination of placement and services.

CJRA Prediction of Pre-Discharge Recidivism Rates

In the current analyses, the only domains predictive of pre-discharge recidivism at initial assessment were the relationships and aggression domains. Higher risk scores on those two domains were predictive of pre-discharge recidivism.[26]

Overall, the dynamic risk domains were predictive of pre-discharge recidivism. The initial CJRA assessment, overall, was predictive of general pre-discharge recidivism and the parole referral CJRA domains, overall, were predictive of recidivism occurring once a youth entered parole. However, because of the high degree of correlation between the domains, few individual domains were predictive on their own.

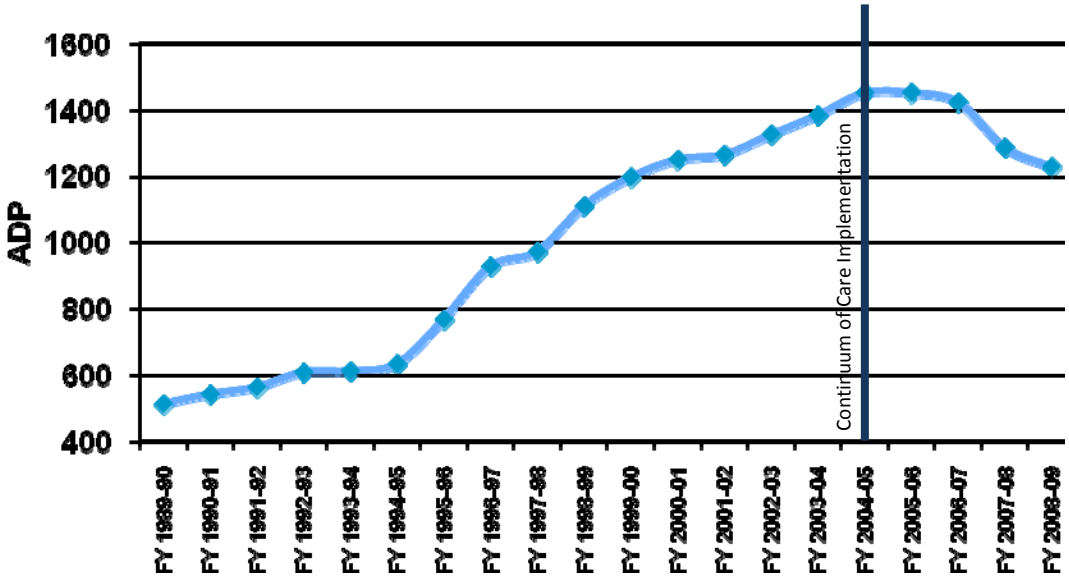
[26] Relationships domain: Beta=.131; Wald χ^2 = 3.96; p=.046. Aggression domain: Beta=.098; Wald χ^2 = 4.79; p=.029.

Continuum of Care Initiative Outcomes

Two of the primary features of the Continuum of Care Initiative, using assessment to appropriately target services and using flexibility in residential funding to optimally manage youth time in residential placement and create effective transitions to non-residential services, potentially allow for a more efficient use of Division resources.

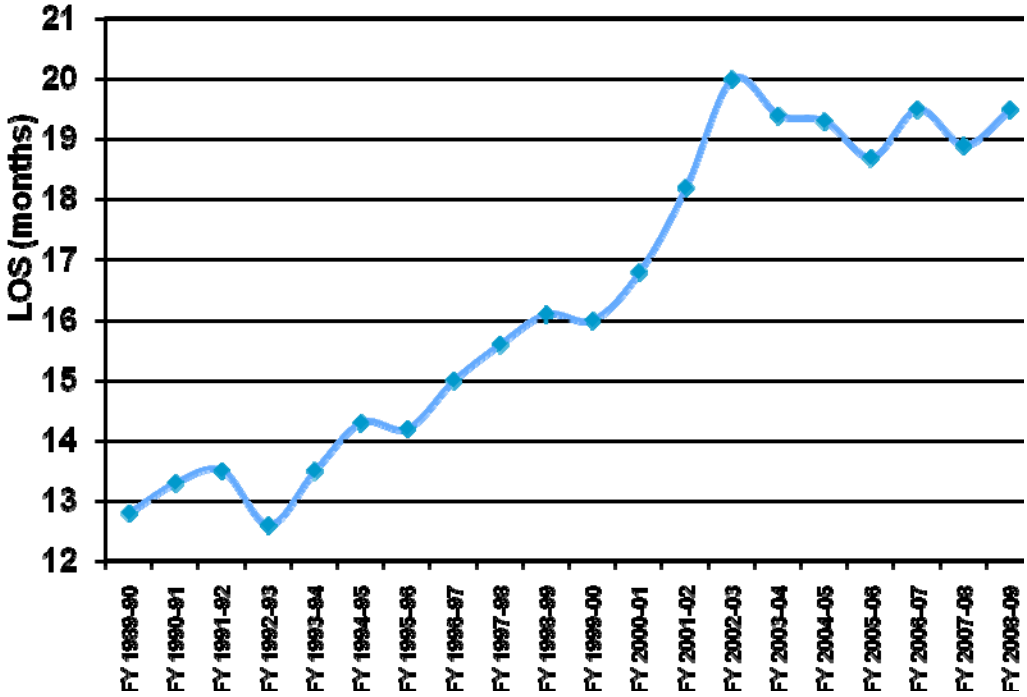
As seen in the figure below, since the implementation of the Continuum of Care Initiative during Fiscal Year 2004-05, a significant increasing trend has been reversed. Average daily population (ADP) in commitment has declined for the past three years. This year's Commitment ADP of 1229.9 represents a 5 percent decline over the past fiscal year.

Figure 4: 20 Year Commitment ADP Trends



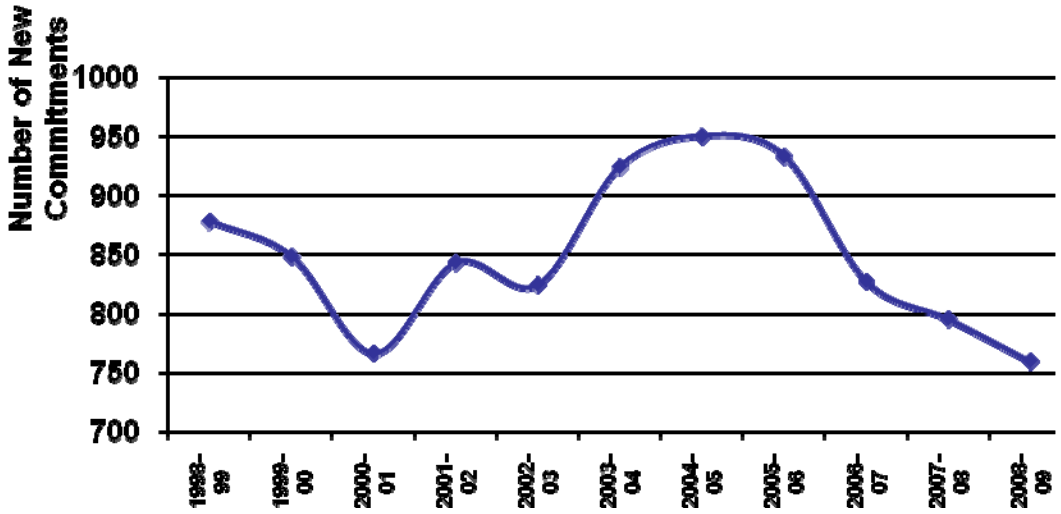
While overall Commitment ADP has shown recent declines, the residential average length of stay (LOS) has continued to fluctuate slightly and has not shown the same level of decrease. The average residential LOS for the current fiscal year (19.0 months) is similar to that in the year directly following implementation of the Continuum of Care Initiative (18.8 months). Figure 5, below, shows the 20-year trends in residential LOS.

Figure 5: 20-Year LOS Trends



This stability in LOS means that declines in ADP continue to be driven by decreases in the numbers of new commitments to the Division. The number of new commitments has decreased from 795 to 760 during this fiscal year (a 4.5% decline).

Figure 6. Division of Youth Corrections New Commitment Trends



While parole LOS did decline significantly over the four years since the implementation of the Continuum of Care Initiative, residential LOS has stayed roughly the same since Fiscal Year 2003-04.

Table 13: FY 2008-09 Commitment LOS

LOS (in days)	Fiscal Year						
	03-04	04-05	Continuum of Care Implemented	05-06	06-07	07-08	08-09
Parole LOS	7.8	7.1		6.6	6.8	6.7	6.6
Residential LOS	19.1	18.9		18.6	19.2	18.5	19.0
Total Commitment LOS	26.9	26.2		25.7	26.0	25.4	25.5

A possible explanation for the relatively stable residential LOS since Continuum of Care Initiative implementation is the increase in risk levels and complexity of treatment needs of youth committed in recent years. As explained earlier, the proportion of youth scoring in the highest range of risk scores across many of the domains measured by the CJRA has increased over the past few years. It is possible that Continuum of Care services have prevented a potential increase in LOS that might have been driven by increased risk if the ability to appropriately match services to need was not available. Similarly, in case examples reviewed for this report, youth featured a complicated mix of elevated dynamic risk domains, suggesting a set of interventions longer in duration would likely be needed to address their criminogenic risk.

Mitigating Risk for Re-Offending

As discussed previously, committed youth tended to score in the high risk range of risk scores, based on original "norms" established in the validation of the risk assessment instrument in Washington State. Clearly this indicates that, as a whole, committed youth tend to present a high risk for re-offending, when compared to the probation population in Washington State used for the tool validation.

In examining whether or not risk was mitigated specifically for youth committed to the Division, new score ranges were determined based on the overall distributions of scores across the committed population. Because the purpose of the CJRA is to determine the areas of greatest risk and need for targeting services, successful mitigation of risk should show decreases in risk scores for youth where the initial assessment score was elevated enough to warrant a need for treatment in that area.

Dynamic risk scores measure risk factors that can be changed through intervention. Results point to significant decreases in dynamic risk for Continuum of Care youth.

Tables 14 and 15, below, show the distribution of CJRA scores falling into the high-risk range (based on the distribution of scores across all completed assessments) at the initial assessment and at discharge from the Division. For example, at assessment, 69.5 percent of youth scored in the high range of scores on the Relationships risk (dynamic) domain and the proportion of youth scoring in the high range decreased 19.3 percent between assessment and discharge. Shaded rows indicate significant improvement[27] (either as a reduction of the proportion of youth with risk scores in the high range or an increase in the proportion of youth with protective factor scores in the high range).

[27] Individual paired t-tests were performed to detect statistically significant declines in overall scores. In the shaded results, all tests were significant at the p<.05 level.

Table 14: Changes in CJRA Risk Levels – Risk Factors			
Risk Factors by Domain[28]	**Assessment to Discharge and Change**		
	Percent in High Range of Scores at Assessment	**Percentage in the High Range at Discharge**	**% Change**
School – D3			
3B – Dynamic Risk (1-22)	40.80%	25.70%	-37.01%
Relationships – D6			
6B – Dynamic Risk (3-8)	69.50%	56.10%	-19.28%
Family - Current Living Arrangements - D7			
7B – Dynamic Risk (13-34)	31.60%	23.80%	-24.68%
Alcohol and Drugs - D8			
8B – Dynamic Risk (11-24)	31.70%	16.70%	-47.32%
Mental Health - D9			
9B – Dynamic Risk (1-4)	24.90%	21.90%	-12.05%
Attitudes / Behaviors - D10			
10B – Dynamic Risk (10-23)	30.00%	22.40%	-25.33%
Aggression - D11			
11B – Dynamic Risk (7-13)	27.00%	16.00%	-40.74%
Skills - D12			
12B – Dynamic Risk (7-18)	36.40%	15.80%	-56.59%

This table points to the effectiveness of the Continuum of Care Initiative in the most direct way – put simply, the underlying principles upon which the Initiative is built lay out a pathway from assessing risk to case planning and targeted, evidence-based intervention. The intent of these strategies is to reduce criminogenic risk. The data presented above demonstrates this reduction. The proportion of youth in

[28] *Number in parentheses to the right of items indicates the ratings included in the risk or protective group. For example, for the Relationships domain, the dynamic item contained scores from 0 to 8. Based on a review of the distribution of scores at all three points in time, a score of 3 (3 to 8) was chosen as the cutoff so that the top one-third (33%) of youth were in the high risk group at initial assessment. The same cutoff (3) was used at all three points in time. For all items with a range of possible ratings, a review of the ratings distribution was conducted to determine the cutoff.*

the high-risk range decreased significantly between initial assessment and discharge across all of the risk domains, with the exception of the mental health domain[29]. The proportion of youth in the high-risk range decreased substantially (by approximately 50%) on the alcohol and drug use, aggression and skills domains. It is reasonable to interpret these findings as supporting of the Continuum of Care approach in that dynamic risk factors would only be expected to decrease if they were successfully identified and targeted for treatment. The lack of findings for the mental health domain is similarly not surprising in that the underlying factors related to this measure are often long-lasting and less responsive to short term intervention.

[29] The average mental heath score did decrease, but the decline was not statistically significant (t=1.03; p>.05.).

Table 15: Changes in CJRA Risk Levels – Protective Factors			
Protective Factors by Domain	**Assessment to Discharge and Change**		
	Percent in High Range of Scores at Assessment	**Percentage in the High Range at Discharge**	**% Change**
School – D3			
3B – Protective (1-17)	42.90%	31.50%	-26.57%
Use of Free Time – D4			
4B - Protective (1-6)	38.00%	52.10%	37.11%
Employment – D5			
5B – Protective (3-7)	41.00%	72.00%	75.61%
Relationships – D6			
6B – Protective (3-10)	30.20%	56.00%	85.43%
Family - Current Living Arrangements - D7			
7B – Protective (13-23)	20.00%	27.50%	37.50%
Alcohol and Drugs - D8			
8B – Protective (1-2)	4.60%	9.50%	106.52%
Mental Health - D9			
9B – Protective (1-3)	22.30%	20.50%	-8.07%
Attitudes / Behaviors - D10			
10B – Protective (6-18)	39.00%	57.10%	46.41%
Aggression - D11			
11B – Protective (3-8)	32.30%	54.50%	68.73%
Skills - D12			
12B – Protective (3-28)	34.90%	70.90%	103.15%

As with Table 14 (risk factors) above, the increases seen for protective factors (in Table 15) again points to the effectiveness of the strategies being employed in the Continuum of Care Initiative. The proportion of youth in the high protective score range increased between assessment and discharge for all protective domains except for mental health and school. Similar to the discussion for risk factors, above, the absence of increases for protective factors related to mental health is not surprising in that the mental health domain includes factors that are slow to change and less likely to shift over the time frames of this sample. The lack of change in the school protective factors is a function of the assessment tool's design. Specifically, the school section of the CJRA is geared towards youth functioning in community-based public school settings. Thus, any changes brought about by treatment while under commitment would not be evident at the time of discharge but instead would be expected to manifest after the youth has spent time in a community school setting post-discharge.

> Reductions in dynamic risk scores, along with increases in protective factors, offer strong support for the Continuum of Care model. Moreover, the research base is clear in drawing the link between reduced risk factors, increased protective factors and reductions in delinquent and re-offending behavior.

Taken as a whole, the changes in risk and protective factors portrayed in the preceding two tables offer strong support for the Continuum of Care model. The national research base is clear in drawing direct links between decreases in risk factors, and increases in protective factors, predicting reduced criminal and delinquent behavior.

Cost Efficiency – The Link Between Assessment, Case Planning, Treatment and Risk Reduction

While currently available data does not allow a true analysis of cost-benefit or return on investment for the Continuum of Care, several observations can be made pointing to the Initiative as a cost effective set of strategies. There is a substantial research base (e.g., Aos, Phipps, Barnoski & Lieb 2001) in comparative economics that examines whether, or how much, a program's benefits are likely to outweigh its costs. The general model followed in these studies involves searching for research-based evidence about what works and what doesn't to lower offending behavior, and then estimating the comparative economics that these programs could have for taxpayers. In order to conduct such an analysis for the Continuum of Care Initiative, we would need detailed information regarding the exact programs youth receive along with information about the quality of implementation of those programs and the recidivism experiences of youth who participated in them.

However, the data available at the time of this report does offer encouragement for the efficiency and cost effectiveness of the Initiative. Available data depicts a pathway that begins with the purchase of interventions in specific areas using Continuum of Care funds and leads to the provision of services in those areas and to the reduction of related criminogenic risk. By following this pathway, we can demonstrate that Initiative funds are being deployed in a way that is supported by available local data

and national research, and that these funds are yielding decreases in targeted criminogenic risk areas for the DYC population.

This cost efficiency pathway is exemplified by the Initiative's expenditures for family therapies. Last year's Continuum of Care Annual Evaluation Report noted that family risk scores were not improving significantly for youth served. DYC leadership addressed this finding by making family treatments a priority, directing Client Managers to attend to this risk area in case planning and making funds available for family interventions for youth whose risk scores warranted such intervention. In the current year, the $559,054 spent on family interventions represented 12.6% of the total treatment related dollars and yielded an almost twenty-five percent reduction in family-related risk between initial assessment and discharge. The national research base has demonstrated that high quality family interventions such as Multisystemic Therapy and Functional Family Therapy can yield very large returns on investment (in the range of $28-$45 for every dollar spent) because of their success in reducing future offending.

Continuum of Care Initiative investment in programs targeting specific risk areas represents an efficient and cost-effective approach. Corresponding reductions in risk and increases in protective factors are encouraging and point to a positive return on investment for Colorado taxpayers.

Job/Skills training presents a similarly encouraging scenario, with FY 2008-09 investments of $528,108 in this area representing 11.9% of total expenditures. Related reductions in risk and increases in protective factors suggest that these investments paid off. Specifically, risk related to skills in this area decreased over 50% while protective factors increased over 100%. While cost benefit studies show widely varying results depending on the type and quality of program, returns on investment for job/skills training programs can be significant.

Parole Discharge Outcomes

Table 16: Parole Adjustment and Status at Discharge					
Parole Adjustment at Discharge	**Fiscal Year**				
	FY04-05 n=831	**CoC Implemented**	**FY05-06 n=763**	**FY07-08[30] n=924**	**FY08-09 n=857**
Excellent	7.8%		8.0%	13.6%	35.1%
Good	4.9%		4.6%	5.8%	0.5%
Satisfactory	49.1%		52.2%	44.5%	20.0%
Unsatisfactory	30.0%		28.0%	30.0%	35.1%
Parole Suspended/Revoked	2.4%		1.3%	1.7%	0.4%
No Parole	2.8%		3.1%	2.8%	7.4%
Unknown/Missing	3.2%		2.7%	1.3%	2.8%
School/Job Status at Discharge					
Enrolled in School/Employed	73.9%		76.4%	75.5%	70.6%
Not enrolled or employed	26.1%		23.6%	24.5%	29.4%

Client managers rated parole adjustment at discharge as "excellent" for more than one third of youth (35.1%), a dramatic increase over past years. However, the proportion of "unsatisfactory" ratings have also increased slightly, meaning that this change mostly represents youth moving from a "good" or "satisfactory" rating to "excellent" rather than a decrease in the number of youth with an "unsatisfactory" rating.

The proportion of youth enrolled in school or employed at the time of parole discharge has been relatively unchanged over the past five years. This year, there was a slight decline in the proportion of discharged youth who were either working or enrolled in school at the time they discharged from parole. This may be, at least in part, a reflection of the economic difficulties facing the state and the increased overall unemployment figures for the entire population.

[30] Commitment data extracts analyzed during FY 2006-07 did not contain parole discharge variables.

Pre-Discharge Recidivism and Recommitment Rates

As shown below, while pre-discharge recidivism was lower during this fiscal year than in the baseline year prior to Continuum of Care Initiative implementation, it was slightly higher than the rate has been in the past three years. This difference, however, was not statistically significant.

Table 17: Pre-Discharge Recidivism Rates

Pre-Discharge Recidivism	Fiscal Year						
	03-04	04-05	CoC Implemented	05-06	06-07	07-08	08-09
Yes	33.0%	39.1%		32.4%	33.5%	33.3%	34.7%
No	77.0%	61.8%		67.6%	66.5%	66.7%	65.3%

Pre-discharge recidivism rates within the Division have fluctuated only slightly over the last four fiscal years. In order to better understand these rates, we compared Colorado's experience with that of other states. However, it is difficult to place these rates into a national context due to wide variations in how recidivism rates are measured across systems, including the time frames used and how a new offense is defined. Only two states (Colorado and Maryland) use court filings (as opposed to arrest and conviction) as a measure of a new offense for the purpose of recidivism reporting. In a recent (2006) report, the National Criminal Justice Reference Service (NCJRS) reported an average 12-month post discharge recidivism rate of 55 percent for these states. However, none of the studies cited by NCJRS included pre-discharge recidivism (only measuring recidivism 12 months post-commitment discharge). Other studies of recidivism (across 10 states) use re-adjudication or conviction as a measure of recidivism. Across these states, the average recidivism rate for 12 months post-discharge was 33.3 percent, similar to the rates experienced in Colorado.

Rates of recommitment have declined in the past two years, compared to the years directly before and after the implementation of the Continuum of Care Initiative. While the decline was not statistically significant, it points to the ability of the Continuum of Care strategies to efficiently move youth from residential placement to the community while maintaining positive youth behavior outside the context of a restrictive residential placement.

Table 18: Recommitment Rates						
Recommitment	**Fiscal Year**					
	04-05	**CoC Implemented**	**05-06**[31]	**06-07**	**07-08**	**08-09**
Yes	25.0%			25.0%	22.1%	22.2%
No	75.0%			75.0%	87.9%	87.8%

Declines in recommitment rates are an indication that Continuum of Care strategies can support youth without the structure of a restrictive residential placement.

[31] The 2006 data set does not include this information.

Observations and Recommendations

The Colorado Division of Youth Corrections is in the fourth year of a comprehensive systems improvement effort – the Continuum of Care Initiative. At its essence, the Initiative builds on an empirically based risk and needs assessment process to align effective interventions and strategies based on youths' criminogenic needs and risk to re-offend. The Continuum of Care is a best practice model that promotes a full continuum of assessment, case planning and interventions that reduce risk and ultimately reduce the likelihood of re-offending behavior. This initiative has brought significant attention and improvements to the Division's continuum of services from initial (assessment) services through commitment and parole. The flexible funding authorization contained in Footnote 41 of House Bill 08-1375 is an important component of the overall Continuum of Care Initiative. The Division of Youth Corrections is using this added flexibility to support the implementation of a set of integrated system improvements based on research-based principles of effective practice. This report represents the fourth year of evaluation for the Continuum of Care Initiative. As an external review of the Initiative based on available data, this evaluation continues to point to positive progress in this system change effort.

Most notably, the Division of Youth Corrections continues to prioritize and move forward with an evidence-based approach to management and implementation. Leadership utilizes the Division's Five Key Strategies (discussed on page 1 of this report) in concert with the five principles of the Continuum of Care Initiative (page 2) to evaluate new efforts and measure the success of ongoing programs.

> Available data suggest that the Continuum of Care Initiative is being implemented as intended and in keeping with national best practice.

An Effective Approach – The current juvenile justice literature base clearly points to the strategies authorized through the footnote as the most appropriate and effective approach to managing services for juvenile offenders (e.g., Barnoski & Aos, 2005; NCJFCJ 2009). In fact, a consistent finding across research and program evaluations has been the centrality of targeting treatment for juvenile offenders based on individualized assessment of criminogenic risk and need factors. The Continuum of Care Initiative is built on effective juvenile justice strategies that have been proven through research and practice to be effective.

- Following assessment, the Initiative emphasizes a coordinated continuum of care with a broad array of program and service options that are sequenced and combined to create a range of intervention options that ensure the appropriate treatment, education, training, and care compatible with the youth's specific needs.
- Second, it emphasizes community-based options when appropriate. Instead of removing youth from their home environment, community-based services impact the youth's total environment by addressing problems in the community where they develop, and by establishing the long-term support necessary to sustain progress.

- Third, the Continuum of Care Initiative features individualized programming that is sufficiently intensive and comprehensive to accommodate the individual needs and potentials of the youth and their families.
- Fourth, the Initiative attends to aftercare and re-integration so that youth continue receiving the support of treatment services following their treatment in a residential facility.

A system change effort like the Continuum of Care Initiative takes time to implement fully and must take into account the inter-dependency of all parts of the system – both state-run and contracted. From Assessment Services and Client Managers to placements and treatment providers, complex assessment information for each youth must be integrated into a case plan that is then communicated across the system so that the same criminogenic risk and needs factors for a given youth are being addressed in each component of the system. This systemic perspective is critical for long-term success, but necessarily suggests that the system change will be developmental and not immediate. This final section of the report discusses notable successes and ongoing efforts in the Continuum of Care.

Successes in the Continuum of Care Initiative

The Colorado Juvenile Risk Assessment (CJRA) is fully implemented across the system. As completion rates for the CJRA approach 100%, all youth served through the Division are receiving case management that is based on empirically supported risk assessment at multiple points in their commitment.

The Continuum of Care Initiative continues to identify and serve youth who enter the system as a high risk for re-offending. CJRA risk and needs data demonstrate that youth served through the initiative enter services at a high level of risk to re-offend, most across multiple risk domains. This indicates that the Division continues to target resources to those youth who represent the highest delinquency costs in terms of the social cost of re-offense as well as costs stemming from returns to the juvenile justice system.

As a whole, the CJRA is driving significant system improvements – and youth risk for re-offending is decreasing.

Case planning targets criminogenic risk factors for each youth. Through integration of the CJRA into the Trails data system and coordination with the Discrete Case Plan that drives care planning for committed youth, services for youth are linked closely to each youth's criminogenic risks and needs. Both at the time of initial assessment (by Assessment Services) and during development of the Discrete Case Plan (by Client Managers), empirical, actuarial data is combined with clinical judgment and knowledge of individual youth factors to build targeted placements and services.

While we recognize that significant training and ongoing quality assurance is necessary to ensure this practice is realized throughout the system, case examples reviewed for this report yielded promising samples of youth whose Client Managers used all available data to match services to their individual

risks and needs, and who received services from residential placement through community transition that allowed them to succeed in the community.

Criminogenic risk decreases for youth receiving Continuum of Care Initiative services. CJRA data demonstrates that dynamic risk scores decreased significantly for youth receiving services. The proportion of youth with high-range risk scores decreased from assessment to discharge across all of the dynamic risk domains. Similarly, the proportion scoring in the high protective factor score range increased across most domains. This suggests that the Continuum of Care Initiative is appropriately identifying and targeting treatment to areas of criminogenic risk.

Recidivism and recommitment rates remain flat. While this year's rate of pre-discharge recidivism (34.7%) is marginally higher than the past two years, it remains lower than the baseline year's rate of 39.1 percent. This year's rate of recommitment (22.2%) is unchanged from last year and remains slightly lower than past years. In the context of a population that appears to bring greater complexity and multiple risk areas requiring intervention, this stability in recidivism and recommitment may represent a meaningful success for the Continuum of Care.

Data-driven ongoing quality assurance. Last year's evaluation report noted that, while CJRA data revealed improvements for several dynamic risk areas, there was no improvement in the important family risk domain. Leadership in the Division took note of this finding and worked to increase attention to the family domain and ensure youth and families with risk in this area were identified and served. While available data does not allow us to explore in detail how this area was enhanced, risk assessment data for this report demonstrates a significant reduction in family-related dynamic risk.

Areas for Ongoing Attention

In a system improvement effort as comprehensive as the Continuum of Care, available data often lags behind the pace of change. As DYC leadership pushes forward with the Initiative, the Research Unit, Assessment Services and others, along with the TriWest evaluation team, are working to identify data that will allow us to better understand the workings of the Continuum and support quality assurance across the Initiative.

Linking assessment, case planning and intervention. The Integration of CJRA and related assessment data into case planning is clearly improving, but available data does not currently allow us to track how well actual services are targeted to match the youth's criminogenic needs. Using an example from earlier in this report, a youth with a drug or alcohol problem may be at higher risk for re-offending, but may also be a good candidate for successful community transition if that problem can be addressed effectively. Only through careful linking of assessment, case planning and treatment can we follow this pathway and ensure that the system is working as intended. Attention to this area will support the next phase of implementation and help ensure that resources are being used most efficiently to reduce risk and recidivism.

Better definition and tracking of expenditures for services. Expenditure tracking continues to show that the vast majority of funds are being spent on treatment and transition services. However, there is a need to better define expenditure categories and improve data entry and tracking of actual services. Without a precise and accurate tracking of the services each youth receives, it is not possible to understand how well those services actually match each youth's needs or how specific services appear to impact risk and recidivism.

Need to understand drivers for youth lengths of stay. The FY 2008-09 average length of stay (LOS) for residential placement was 19.0 months, virtually unchanged from the average LOS during the baseline year (FY 2004-05). An important overall goal of the Initiative has been to transition youth out of residential placement more quickly so that they can be served more efficiently and effectively in the community. Assessment and anecdotal evidence suggest that increases in the seriousness and complexity of the criminogenic risk for the population may run counter to efforts to decrease residential LOS. Further exploration is needed to identify data that will help in understanding and addressing this pattern.

Ongoing system improvement. As discussed throughout this report, and in prior reports, the Division of Youth Corrections is engaged in systematic efforts to implement the integrated strategies of the Continuum of Care Initiative. As described in the body of this report, improvements have been made in the assessment and case planning processes. Strategies to bolster the service array of evidence-based services continue, along with data-driven quality assurance efforts.

These efforts are exemplified by the CJRA Oversight Committee, established to support training and fidelity in the implementation of the CJRA across the Division. This committee, convened in 2009, has developed a workplan that includes designing and implementing CJRA fidelity tracking and quality assurance plans; developing a standard CJRA supervision model and certification plan; managing CJRA data for ongoing evaluation and reporting; and, establishing a communication plan related to the CJRA including an annual report and newsletter.

Appendix

Colorado Juvenile Risk Assessment

DOMAIN 1: Criminal History Record of Delinquency Petitions Resulting in Adjudication, Diversion, or Deferred Adjudication/Disposition	
Delinquency petitions, rather than offenses, are used to assess the persistence of re-offending by the youth. Include only delinquency petitions that resulted in an adjudication, diversion, deferred adjudication, or deferred disposition (regardless of whether successfully completed).	
1. **Age at first offense:** *The age at the time of the offense for which the youth was referred to juvenile court for the first time on a non-traffic misdemeanor or felony that resulted in adjudication, diversion, deferred adjudication, or deferred disposition.*	O Over 16 O 16 O 15 O 13 to 14 O Under 13
Felony and misdemeanor delinquency petitions: *Items 2 and 3 are mutually exclusive and should add to the total number of delinquency petitions that resulted in adjudication, diversion, deferred adjudication, or deferred disposition.*	
2. **Misdemeanor delinquency petitions:** *Total number of delinquency petitions for which the most serious offense was a non-traffic misdemeanor that resulted in adjudication, diversion, deferred adjudication, or deferred disposition (regardless of whether successfully completed).*	O None or one O Two O Three or four O Five or more
3. **Felony delinquency petitions:** *Total number of delinquency petitions for a felony offense that resulted in adjudication, diversion, deferred adjudication, or deferred disposition (regardless of whether successfully completed).*	O None O One O Two O Three or more
Against-person or weapon delinquency petitions: *Items 4, 5, and 6 are mutually exclusive and should add to the total number of delinquency petitions that involve an against-person or weapon offense, including sex offenses, that resulted in an adjudication, diversion, deferred adjudication, or deferred disposition (regardless of whether successfully completed).*	
4. **Weapon delinquency petitions:** *Total delinquency petitions for which the most serious offense was a firearm/weapon charge or a weapon enhancement finding.*	O None O One or more
5. **Against-person misdemeanor delinquency petitions:** *Total number of delinquency petitions for which the most serious offense was an against-person misdemeanor – a misdemeanor involving threats, force, or physical harm to another person or sexual misconduct (assault, coercion, harassment, intimidation, etc.).*	O None O One O Two or more
6. **Against-person felony delinquency petitions:** *Number of delinquency petitions involving force or physical harm to another person including sexual misconduct (homicide, manslaughter, assault, robbery, kidnapping, rape, domestic violence, harassment, criminal mistreatment, intimidation, coercion, etc.)*	O None O One or two O Three or more
Sex offense delinquency petitions: *Items 7 and 8 are mutually exclusive and should add to the total number of delinquency petitions that involve a sex offense or sexual misconduct that resulted in adjudication, diversion, deferred adjudication, or deferred disposition.*	
7. **Sexual misconduct misdemeanor delinquency petitions:** *Number of delinquency petitions for which the most serious offense was a sexual misconduct misdemeanor including obscene phone calls, indecent exposure, obscenity, pornography, or public indecency, or misdemeanors with sexual motivation.*	O None O One O Two or more
8. **Felony sex offense delinquency petitions:** *Delinquency petitions for a felony sex offense or involving sexual motivation including carnal knowledge, child molestation, communication with minor for immoral purpose, incest, indecent exposure, indecent liberties, promoting pornography, rape, sexual misconduct, or voyeurism*	O None O One O Two or more
9. **Court orders where youth served at least one day confined in detention:** *Total court and modification orders for which the youth served at least one day physically confined in a county detention facility. A day served includes credit for time served.*	O None O One O Two O Three or more
10. **Court orders where youth served at least one day confined under DYC:** *Total number of court orders and modification orders for which the youth served at least one day confined under DYC authority. A day served includes credit for time served.*	O None O One O Two or more
11. **Escapes:** *Total number of attempted or actual escapes that resulted in adjudication.*	O None O One O Two or more
12. **Failure-to-appear in court warrants:** *Total number of failures-to-appear in court that resulted in a warrant being issued. Exclude failure-to-appear warrants for non-criminal matters.*	O None O One O Two or more
DOMAIN 2: Demographics	
1. **Gender:**	O Male O Female

DOMAIN 3A: School History	
1. **Youth is a special education student or has a formal diagnosis of a special education need:** *(Check all that apply.)*	☐ No special education need ☐ Learning ☐ Mental retardation ☐ Behavioral ☐ ADHD/ADD
2. **History of expulsions and suspensions since the first grade:**	O No expel/suspend O 4 or 5 O 1 expel/suspend O 6 or 7 O 2 or 3 O More than 7
3. **Age at first expulsion or suspension:**	O No expulsions O 14 to 15 years old O 5 to 9 years old O 16 to 18 years old O 10 to 13 years old
4. **Youth has been enrolled in a community school during the last 6 months, regardless of attendance:**	O No, graduated/GED and not attending school, do not complete Domain 3B O No, dropped-out, expelled, or in out of home placement for more than six months (do not complete Domain 3B) O Yes, must complete Domain 3B
DOMAIN 3B: Current School Status	
For Initial Assessments, "current" is the most recent term in last 6 months; for Re-assessments and Final Assessments, "current" is the last 4 weeks in the most recent term.	
1. **Youth's current school enrollment status, regardless of attendance:** *If the youth is in home school as a result of being expelled or dropping out, check the expelled or dropped out box; otherwise check enrolled, if in home school.*	O Graduated/GED O Suspended O Enrolled full-time O Dropped out O Enrolled part-time O Expelled
2. **Type of school in which youth is enrolled:** **Name of School** _____	O Public academic O Private academic O Vocational O Home school O Alternative O College O GED program O Other _____
3. **Youth believes there is value in getting an education:**	O Believes getting an education is of value O Somewhat believes education is of value O Does not believe education is of value
4. **Youth believes school provides an encouraging environment for him or her:**	O Believes school is encouraging O Somewhat believes school is encouraging O Does not believe school is encouraging
5. **Teachers, staff, or coaches the youth likes or feels comfortable talking with:**	O Not close to any teachers, staff, or coaches O Close to 1 O Close to 3 O Close to 2 O Close to 4 or more
6. **Youth's involvement in school activities during most recent term:** *School leadership; social service clubs; music, dance, drama, art; athletics; other extracurricular activities.*	O Involved in 2 or more activities O Involved in 1 activity O Interested but not involved in any activities O Not interested in school activities
7. **Youth's conduct in the most recent term:** *Fighting or threatening students; threatening teachers/staff; overly disruptive behavior; drug/alcohol use; crimes (e.g., theft, vandalism); lying, cheating, dishonesty.*	O Recognition for good behavior O No problems with school conduct O Problems reported by teachers O Problem calls to parents O Calls to police
8. **Number of expulsions and suspensions in the most recent term:**	O No expel/suspend O 2 or 3 O 1 expel/suspend O Over 3
9. **Youth's attendance in the most recent term:** *Partial-day absence means attending majority of classes and missing minority. Full-day absence means missing majority of classes. A truancy petition is equal to 7 unexcused absences in a month or 10 in a year.*	O Good attendance; few excused absences O No unexcused absences O Some partial-day unexcused absences O Some full-day unexcused absences O Truancy petition/equivalent or withdrawn
10. **Youth's academic performance in the most recent school term:**	O Honor student (mostly As) O Above 3.0 (mostly As and Bs) O 2.0 to 3.0 (mostly Bs and Cs, no Fs) O 1.0 to 2.0 (mostly Cs and Ds, some Fs) O Below 1.0 (some Ds and mostly Fs)
11. **Interviewer's assessment of likelihood the youth will stay in and graduate from high school or an equivalent vocational school:**	O Very likely to stay in school and graduate O Uncertain if youth will stay and graduate O Not very likely to stay and graduate

DOMAIN 4A: Historic Use of Free Time	
1. **History of structured recreational activities within the past 5 years:** *Youth has participated in structured and supervised pro-social community activities, such as religious group/church, community group, cultural group, club, athletics, or other community activities.*	O Involved in 2 or more structured activities O Involved in 1 structured activity O Never involved in structured activities
2. **History of unstructured pro-social recreational activities within the past 5 years:** *Youth has engaged in activities that positively occupy the youth's time, such as reading, hobbies, etc.*	O Involved in 2 or more pro-social unstructured activities O Involved in 1 pro-social unstructured activity O Never involved in pro-social unstructured activities
DOMAIN 4B: Current Use of Free Time (For Initial Assessments and Re-assessments, "current" means behaviors during the last six months.	
1. **Current interest and involvement in structured recreational activities:** *Youth participates in structured and supervised pro-social community activities, such as religious group/church, community group, cultural group, club, athletics, or other community activity.*	O Currently involved in 2 or more structured activities O Currently involved in 1 structured activity O Currently interested but not involved O Currently not interested in any structured activities
2. **Types of structured recreational activities in which youth currently participates:** *(Check all that apply.)*	☐ No structured recreational activities ☐ Athletics ☐ Community/cultural group ☐ Hobby group or club ☐ Religious group/church ☐ Volunteer organization
3. **Current interest and involvement in unstructured recreational activities:** *Youth engages in activities that positively occupy his or her time, such as reading, hobbies, etc.*	O Currently involved in 2 or more unstructured activities O Currently involved in 1 unstructured activity O Currently interested but not involved O Currently not interested in any unstructured activities

DOMAIN 5A: Employment History	
1. **History of employment:**	O Too young for employment consideration O Never been employed O Has been employed
2. **History of successful employment:**	O Never successfully employed O Has been successfully employed
3. **History of problems while employed:**	O Never fired or quit because of problems O Fired or quit because of poor performance O Fired or quit because he or she could not get along with employer or coworkers
4. **History of positive personal relationship(s) with past employer(s) or adult coworker(s):**	O Never had any positive relationships O Had 1 positive relationship O Had 2 or more positive relationships
DOMAIN 5B: Current Employment **(For Initial Assessments and Re-assessments, "current" refers to the last 6 months)**	
1. **Understanding of what is required to maintain a job:**	O Lacks knowledge of what it takes to maintain a job O Has knowledge of abilities to maintain a job O Has demonstrated ability to maintain a job
2. **Current interest in employment:**	O Currently employed O Not employed but highly interested in employment O Not employed but somewhat interested O Not employed and not interested in employment O Too young for employment consideration
3. **Current employment status:**	O Not currently employed O Employment is currently going well O Having problems with current employment
4. **Current positive personal relationship(s) with employer(s) or adult coworker(s):**	O Not currently employed O Employed but no positive relationships O At least 1 positive relationship

DOMAIN 6A: History of Relationships	
1. **History of positive adult non-family relationships not connected to school or employment:** *Adults, who are not teachers and not part of the youth's family, who can provide support and model pro-social behavior, such as religious leader, club member, community person, etc.*	O No positive adult relationships O 1 positive adult relationship O 2 positive adult relationships O 3 or more positive adults relationships
2. **History of anti-social friends/companions:** *Anti-social peers are youths hostile to or disruptive of the legal social order; youths who violate the law and the rights of others. (Check all that apply.)*	☐ Never had consistent friends or companions ☐ Had pro-social friends ☐ Had anti-social friends ☐ Been a gang member/associate
DOMAIN 6B: Current Relationships (For Initial Assessments, "current" means behaviors during the last six months, for Re-assessments and Final Assessments, "current" means behaviors during the last four weeks)	
1. **Current positive adult non-family relationships not connected to school or employment:** *Adults, who are not teachers and not part of the youth's family, who can provide support and model pro-social behavior, such as religious leader, club member, community person, etc.*	O No positive adult relationships O 1 positive adult relationship O 2 positive adult relationships O 3 or more positive adults relationships
2. **Current pro-social community ties:** *Youth feels there are people in his or her community who discourage him or her from getting into trouble or are willing to help the youth.*	O No pro-social community ties O Some pro-social community ties O Has strong pro-social community ties
3. **Current friends/companions youth actually spends time with:** (*Check all that apply.)*	☐ No consistent friends or companions ☐ Pro-social friends ☐ Anti-social friends ☐ Gang member/associate
4. **Currently in a "romantic," intimate, or sexual relationship:**	O Not romantically involved with anyone O Romantically involved with a pro-social person O Romantically involved with an anti-social person/criminal
5. **Currently admires/emulates anti-social peers:**	O Does not admire, emulate anti-social peers O Somewhat admires, emulates anti-social peers O Admires, emulates anti-social peers
6. **Current resistance to anti-social peer influence:**	O Does not associate with anti-social peers O Usually resists going along with anti-social peers O Rarely resists goes along with anti-social peers O Leads anti-social peers

DOMAIN 7A: Family History	
1. **History of court-ordered or DSHS voluntary out-of-home and shelter care placements exceeding 30 days:** *Exclude DYC commitments.*	O No out-of-home placements exceeding 30 days O 1 out-of-home placement O 2 out-of-home placements O 3 or more out-of-home placements
2. **History of running away or getting kicked out of home:** *Include times the youth did not voluntarily return within 24 hours, and include incidents not reported by or to law enforcement.*	O No history of running away or being kicked out O 1 instance of running away/kicked out O 2 to 3 instances of running away/kicked out O 4 to 5 instances of running away/kicked out O Over 5 instances of running away/kicked out
3. **History of petitions filed:** *Include all petitions regardless of whether the petition was granted. (Check all that apply.)*	☐ No petitions filed ☐ Youth-at-risk ☐ CHINS ☐ ARP ☐ Dependency
4. **History of jail/imprisonment of persons who were ever involved in the household for at least 3 months:** *(Check all that apply.)*	☐ No jail/imprisonment history in family ☐ Mother/female caretaker ☐ Father/male caretaker ☐ Older sibling ☐ Younger sibling ☐ Other member
5. **Youth currently living under any "adult supervision":** *Adult supervision must be someone who is responsible for the youth's welfare, either legally or with parental consent. For Initial Assessments, "current" means within the last six months, for Re-assessments and Final Assessments, "current" means within the last four weeks.*	O No, living with peers without adult supervision, do not complete Domain 7B O No, living alone without adult supervision, do not complete Domain 7B O No, transient without adult supervision, do not complete Domain 7B O Yes, living under adult supervision, must complete Domain 7B

DOMAIN 7B: Current Living Arrangements

(For Initial Assessments, current means behaviors during the last six months, for Re-assessments and Final Assessments, current means behaviors during the last four weeks)

1. **All persons with whom youth is currently living:** *(Check all that apply.)*	☐ Living alone ☐ Biological mother ☐ Non-biological mother ☐ Older sibling(s) ☐ Grandparent(s) ☐ Long-term parental partner(s) ☐ Youth's romantic partner ☐ Foster/group home	☐ Transient (street, moving around) ☐ Biological father ☐ Non-biological father ☐ Younger sibling(s) ☐ Other relative(s) ☐ Short-term parental partner(s) ☐ Youth's child ☐ Youth's friends

2. **Annual combined income of youth and family:**	O Under $15,000 O $15,000 to $34,999 O $35,000 to $49,999 O $50,000 and over
3. **Jail/imprisonment history of persons who are currently involved with the household:** *(Check all that apply.)*	☐ No jail/imprisonment history of persons currently in household ☐ Mother/female caretaker ☐ Father/male caretaker ☐ Older sibling ☐ Younger sibling ☐ Other member
4. **Problem history of parents who are currently involved with the household:** *(Check all that apply.)*	☐ No problem history of parents in household ☐ Parental alcohol problem history ☐ Parental drug problem history ☐ Parental physical health problem history ☐ Parental mental health problem history ☐ Parental employment problem history

5. **Problem history of siblings who are currently involved with the household:** *(Check all that apply.)*	☐ No siblings currently in household ☐ No problem history of siblings in household ☐ Sibling alcohol problem history ☐ Sibling drug problem history ☐ Sibling physical health problem history ☐ Sibling mental health problem history ☐ Sibling employment problem history
6. **Support network for family:** *Extended family and/or family friends who can provide additional support to the family.*	O No support network O Some support network O Strong support network
7. **Family willingness to help support youth:**	O Consistently willing to support youth O Inconsistently willing to support youth O Little or no willingness to support youth O Hostile, berating, and/or belittling of youth
8. **Family provides opportunities for youth to participate in family activities and decisions affecting the youth:**	O No opportunities for involvement provided O Some opportunities for involvement provided O Opportunities for involvement provided
9. **Youth has run away or been kicked out of home:** *Include times youth did not voluntarily return within 24 hours, and include incidents not reported by or to law enforcement.*	O Has not run away/kicked out of home O Has run away/kicked out O Is currently kicked out of home or is a runaway
10. **Family member(s) youth feels close to or has good relationship with:** *(Check all that apply.)*	☐ Does not feel close to any family member ☐ Feels close to mother/female caretaker ☐ Feels close to father/male caretaker ☐ Feels close to male sibling ☐ Feels close to female sibling ☐ Feels close to extended family
11. **Level of conflict between parents, between youth and parents, among siblings:**	O Some conflict that is well managed O Verbal intimidation, yelling, heated arguments O Threats of physical abuse O Domestic violence: physical/sexual abuse
12. **Parental supervision:** *Parents know whom youth is with, when youth will return, where youth is going, and what youth is doing.*	O Consistent good supervision O Sporadic supervision O Inadequate supervision
13. **Parental authority and control:**	O Youth usually obeys and follows rules O Youth sometimes obeys or obeys some rules O Youth consistently disobeys and/or is hostile
14. **Consistent appropriate punishment for bad behavior:** *Appropriate means clear communication, timely response, and response proportionate to conduct.*	O Consistently appropriate punishment O Consistently overly severe punishment O Consistently insufficient punishment O Inconsistent or erratic punishment
15. **Consistent appropriate rewards for good behavior:** *Appropriate means clear communication, timely response, and response proportionate to conduct; rewards mean affection, praise, etc.*	O Consistently appropriate rewards O Consistently overly indulgent/overly protective O Consistently insufficient rewards O Inconsistent or erratic rewards
16. **Parental characterization of youth's anti-social behavior:**	O Disapproves of youth's anti-social behavior O Minimizes, denies, justifies, excuses behavior, or blames others/circumstances O Accepts youth's anti-social behavior as okay O Proud of youth's anti-social behavior

DOMAIN 8A: Alcohol and Drug History	
Disrupted functioning involves having a problem in any of these five life areas: education, family conflict, peer relationships, crime, or health, and usually indicates treatment is warranted. Use that contributes to criminal behavior typically precipitates the commission of a crime; there is evidence or reason to believe the youth's criminal activity is related to alcohol/drug use.	
1. **History of alcohol use:** *(Check all that apply.)*	☐ No past alcohol use ☐ Past alcohol use ☐ Alcohol caused family conflict ☐ Alcohol disrupted education ☐ Alcohol caused health problems ☐ Alcohol interfered with keeping pro-social friends ☐ Alcohol contributed to criminal behavior
2. **History of drug use:** *(Check all that apply.)*	☐ No past drug use ☐ Past drug use ☐ Drugs caused family conflict ☐ Drugs disrupted education ☐ Drugs caused health problems ☐ Drugs interfered with keeping pro-social friends ☐ Drugs contributed to criminal behavior
3. **History of delinquency petitions for alcohol/drug assessment:**	O Never referred for drug/alcohol assessment O Diagnosed as no problem O Referred but never assessed O Diagnosed as abuse O Diagnosed as dependent/addicted
4. **History of attending alcohol/drug <u>education classes</u> for an alcohol/drug problem:**	O Never attended drug/alcohol education classes O Voluntarily attended drug/alcohol education classes O Attended classes by parent, school, or other agency request O Attended classes at court direction
5. **History of participating in alcohol/drug <u>treatment program</u>:**	O Never participated in treatment program O Participated once in treatment program O Participated several times in treatment programs
6. Youth currently using alcohol or drugs: *For Initial Assessments, current is last six months; for Re-assessments/Final Assessments, it's 4 weeks*	O No current use, do not compete Domain 8B O Current use, must complete domain 8B

DOMAIN 8B: Current Alcohol and Drugs (For Initial Assessments, current is the last six months, for Re-assessments/Final Assessments, it's the last four weeks)	
1. **Current alcohol use:** *(Check all that apply.)*	☐ No current alcohol use ☐ Current alcohol use ☐ Alcohol causing family conflict ☐ Alcohol disrupting education ☐ Alcohol causing health problems ☐ Alcohol interfering with keeping pro-social friends ☐ Alcohol contributing to criminal behavior
2. **Current drug use:** *(Check all that apply.)*	☐ No current drug use ☐ Current drug use ☐ Drugs causing family conflict ☐ Drugs disrupting education ☐ Drugs causing health problems ☐ Drugs interfering with keeping pro-social friends ☐ Drugs contributing to criminal behavior
3. **Type of drugs currently used:** *(Check all that apply.)*	☐ No current drug use ☐ Amphetamines (uppers/speed/ecstacy) ☐ Barbiturates (Tuinal/Seconal/downers) ☐ Cocaine (coke) ☐ Cocaine (crack/rock) ☐ Hallucinogens (LSD/acid/mushrooms/GHB) ☐ Heroine ☐ Inhalants (glue/gasoline) Marijuana/hashish ☐ Other opiates (Dilaudid/Demerol/Percodan/Codeine/Oxycontin) ☐ Phencyclidine (PCP/angel dust) ☐ Tranquilizers/sedatives (Valium/Libnum/Dalmane/ Ketamine) ☐ Other drugs (List in comment)
4. **Current alcohol/drug treatment program participation:**	☐ Alcohol/drug treatment not warranted ☐ Not currently attending needed alcohol/drug treatment program ☐ Currently attending alcohol/drug treatment program ☐ Successfully completed alcohol/drug treatment program

DOMAIN 9A: Mental Health History	
History of suicidal ideation:	O Has never thought about suicide O Has had serious thoughts about suicide O Has made a plan to commit suicide O Has attempted to commit suicide
Include suspected incidents of abuse, whether or not substantiated, but exclude reports proven to be false.	
History of physical abuse: *(Check all that apply.)*	☐ Not a victim of physical abuse ☐ Physically abused by family member ☐ Physically abused by someone outside the family
History of sexual abuse: *(Check all that apply.)*	☐ Not a victim of sexual abuse ☐ Sexually abused by family member ☐ Sexually abused by someone outside the family
History of being a victim of neglect:	O Not a victim of neglect O Victim of neglect
History of ADD/ADHD: *Confirmed by a licensed mental health care professional.*	O No history of ADD/ADHD O Diagnosed with ADD/ADHD O Only ADD/ADHD medication prescribed O Only ADD/ADHD treatment prescribed O ADD/ADHD medication and treatment prescribed
History of mental health problems: *Such as schizophrenia, bi-polar, mood, thought, personality, and adjustment disorders. Exclude conduct disorder, oppositional defiant disorder, substance abuse, and ADD/ADHD. Confirmed by a licensed mental health care professional.*	O No history of mental health problem(s) O Diagnosed with mental health problem(s) O Only mental health medication prescribed O Only mental health treatment prescribed O Mental health medication and treatment prescribed
Currently has health insurance:	O No health insurance O Public insurance (Medicaid) O Private insurance
Current mental health problem status: *For Initial Assessments, "current" is the last 6 months; for Re-assessments and Final Assessments, "current" is the last 4 weeks*	O No current mental health problem(s), do not complete Domain 9B O Current mental health problem(s), must complete Domain 9B
DOMAIN 9B: Current Mental Health (For Initial Assessments, "current" means behaviors during the last six months, for Re-assessments and Final Assessments, "current" means behaviors during the last four weeks)	
1. Current suicidal ideation:	O Does not have thoughts about suicide O Has serious thoughts about suicide O Has recently made a plan to commit suicide O Has recently attempted to commit suicide
1. **Currently diagnosed with ADD/ADHD:** *Confirmed by a licensed mental health professional..* **Type of medication: _____**	O No ADD/ADHD diagnosis O No ADD/ADHD medication currently prescribed O Currently taking ADD/ADHD medication O ADD/ADHD medication currently prescribed, but not taking
2. **Mental health treatment currently prescribed excluding ADD/ADHD treatment:**	O No current mental health problem O No mental health treatment currently prescribed O Attending mental health treatment O Treatment currently prescribed, but not attending
3. **Mental health medication currently prescribed excluding ADD/ADHD medication:** **Type of medication: _____**	O No current mental health problem O No mental health medication currently prescribed O Currently taking mental health medication O Mental health medication currently prescribed, but not taking
4. **Mental health problems currently interfere in working with the youth:**	O No current mental health problem O Mental health problem(s) do not interfere in work with youth O Mental health problem(s) interfere in work with youth

DOMAIN 10: Attitudes/Behaviors **(For Initial Assessments, "current" is within the last 6 months; for Re-assessments and Final Assessments, "current" is within the last 4 weeks.)**	
1. **Primary emotion when committing crime(s) within the last 6 months:**	O Nervous, afraid, worried, ambivalent, uncertain, or indecisive O Hyper, excited, or stimulated O Unconcerned or indifferent O Confident or brags about not getting caught
2. **Primary purpose for committing crime(s) within the last 6 months:**	O Anger O Revenge O Impulse O Sexual desire O Money or material gain, including drugs O Excitement, amusement, or fun O Peer status, acceptance, or attention
3. **Optimism:** *Youth talks about future in positive way with plans or aspirations of a better life that could include employment, education, raising a family, travel, or other pro-social life goals.*	O High aspirations: sense of purpose, commitment to better life O Normal aspirations: some sense of purpose O Low aspirations: little sense of purpose or plans for better life O Believes nothing matters; he or she will be dead before long
4. **Impulsive; acts before thinking:**	O Uses self-control; usually thinks before acting O Some self-control; sometimes thinks before acting O Impulsive; often acts before thinking O Highly Impulsive; usually acts before thinking
5. **Belief in control over anti-social behavior:**	O Believes he or she can avoid/stop anti-social behavior O Somewhat believes anti-social behavior is controllable O Believes his or her anti-social behavior is out of his or her control
6. **Empathy, remorse, sympathy, or feelings for the victim(s) of criminal behavior:**	O Has empathy for his or her victim(s) O Has some empathy for his or her victim(s) O Does not have empathy for his or her victim(s)
7. **Respect for property of others:**	O Respects property of others O Respects personal property but not publicly accessible property: "It's not hurting anybody." O Conditional respect for personal property: "If they are stupid enough to leave it out, they deserve losing it." O No respect for property: "If I want something, it should be mine."
8. **Respect for authority figures:**	O Respects most authority figures O Does not respect authority figures, and may resent some O Resents most authority figures O Defies or is hostile toward most authority figures
9. **Attitude toward pro-social rules/conventions in society:**	O Believes pro-social rules/conventions apply to him or her O Believes some pro-social rules/conventions sometimes apply to him or her O Does not believe pro-social rules/conventions apply to him or her O Resents or is defiant toward pro-social rules/conventions
10. **Accepts responsibility for anti-social behavior:**	O Accepts responsibility for anti-social behavior O Minimizes, denies, justifies, excuses, or blames others O Accepts anti-social behavior as okay O Proud of anti-social behavior
11. **Youth's belief in successfully meeting conditions of DYC commitment or other court supervision:**	O Believes he or she will be successful O Unsure if he or she will be successful O Does not believe he or she will be successful

DOMAIN 11: Aggression	
For Initial Assessments, rate items 1 to 4 based on the last 6 months; for Re-assessments and Final Assessments use the last 4 weeks.	
1. **Tolerance for frustration:**	O Rarely gets upset over small things or has temper tantrums O Sometimes gets upset over small things or has temper tantrums O Often gets upset over small things or has temper tantrums
2. **Hostile interpretation of actions and intentions of others in a common non-confrontational setting:**	O Primarily positive view of intentions of others O Primarily negative view of intentions of others O Primarily hostile view of intentions of others
3. **Belief in yelling and verbal aggression to resolve a disagreement or conflict:**	O Believes verbal aggression is rarely appropriate O Believes verbal aggression is sometimes appropriate O Believes verbal aggression is often appropriate
4. **Belief in fighting and physical aggression to resolve a disagreement or conflict:**	O Believes physical aggression is never appropriate O Believes physical aggression is rarely appropriate O Believes physical aggression is sometimes appropriate O Believes physical aggression is often appropriate
For Initial Assessments, include the entire history of reports; for Re-assessments and Final Assessment include reports within the last 4 weeks.	
5. **Reports/evidence of violence not included in criminal history:** *(Check all that apply.)*	☐ No reports/evidence of violence ☐ Violent outbursts, displays of temper, uncontrolled anger indicating potential for harm ☐ Deliberately inflicting physical pain ☐ Using/threatening with a weapon ☐ Fire starting ☐ Violent destruction of property ☐ Animal cruelty
6. **Reports of problem with sexual aggression not included in criminal history:** *(Check all that apply.)*	☐ No reports/evidence of sexual aggression ☐ Aggressive sex ☐ Sex for power ☐ Young sex partners ☐ Child sex ☐ Voyeurism ☐ Exposure

DOMAIN 12: Skills **(Use a general pattern of current behavior and not a single instance.)**	
1. **Consequential thinking:**	O Does not understand there are consequences to actions O Understands there are consequences to actions O Identifies consequences of actions O Acts to obtain desired consequences—good consequential thinking
2. **Goal setting:**	O Does not set goals O Sets unrealistic goals O Sets somewhat realistic goals O Sets realistic goals
3. **Problem-solving:**	O Cannot identify problem behaviors O Identifies problem behaviors O Thinks of solutions for problem behaviors O Applies appropriate solutions to problem behaviors
4. **Situational perception:** *Ability to analyze the situation, choose the best pro-social skill, and select the best time and place to use the pro-social skill.*	O Cannot analyze the situation for use of a pro-social skill O Can analyze but not choose the best pro-social skill O Can choose the best skill but cannot select the best time and place O Can select the best time and place to use the best pro-social skill
5. **Dealing with others:** *Basic social skills include listening, starting a conversation, having a conversation, asking a question, saying thank you, introducing yourself, introducing other people, and giving a compliment. Advanced social skills include asking for help, joining in, giving instructions, following instructions, apologizing, and convincing others.*	O Lacks basic social skills in dealing with others O Has basic social skills, lacks advanced skills in dealing with others O Sometimes uses advanced social skills in dealing with others O Often uses advanced social skills in dealing with others
6. **Dealing with difficult situations:** *Includes making a complaint, answering a complaint, dealing with embarrassment, dealing with being left out, standing up for a friend, responding to frustration, responding to failure, dealing with contradictory messages, dealing with accusation, getting ready for a difficult conversation, and dealing with group pressure.*	O Lacks skills in dealing with difficult situations O Rarely uses skills in dealing with difficult situations O Sometimes uses skills in dealing with difficult situations O Often uses skills in dealing with difficult situations
7. **Dealing with feelings/emotions:** *Includes knowing his or her feelings, expressing feelings, understanding the feelings of others, dealing with someone else's anger, expressing affection, dealing with fear, and rewarding oneself.*	O Lacks skills in dealing with feelings/emotions O Rarely uses skills in dealing with feelings/emotions O Sometimes uses skills in dealing with feelings/emotions O Often uses skills in dealing with feelings/emotions
8. **Monitoring of internal triggers, *distorted thoughts,* that can lead to trouble:**	O Cannot identify internal triggers O Identifies internal triggers O Actively monitors/controls internal triggers
9. **Monitoring of external triggers, *events or situations,* that can lead to trouble:**	O Cannot identify external triggers O Identifies external triggers O Actively monitors/controls external triggers
10. **Control of impulsive behaviors that get youth into trouble:** *Reframing, replacing anti-social thoughts with pro-social thoughts, diversion, relaxation, problem solving, negotiation,*	O Never had a problem with impulsive behavior O Does not know techniques to control impulsive behavior O Knows techniques to control impulsive behavior O Uses techniques to control impulsive behavior
11. **Control of aggression:** *Includes asking permission, sharing thoughts, helping others, negotiating, using self control, standing up for one's rights, responding to teasing, avoiding trouble with others, and keeping out of fights.*	O Never had a problem with aggression O Lacks alternatives to aggression O Rarely uses alternatives to aggression O Sometimes uses alternatives to aggression O Often uses alternatives to aggression