Continuum of Care: Youth Transitions and Non-Residential Services

Annual Report

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Colorado Department of Human Services
Children, Youth and Families
Division of Youth Corrections (DYC)

TRIWEST GROUP

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Submitted to:
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Executive Summary

The Commitment Continuum of Care

The Division of Youth Corrections (DYC) Commitment Continuum of Care (referred to in this report simply as the Continuum of Care) model is an integrated approach to providing a complete range of programs and services that meet the changing needs of youth and families at every phase, from commitment to the point of discharge from parole. Successful implementation of the Continuum of Care supports the mission of DYC by protecting public safety, improving outcomes for youth and families and effectively using resources.

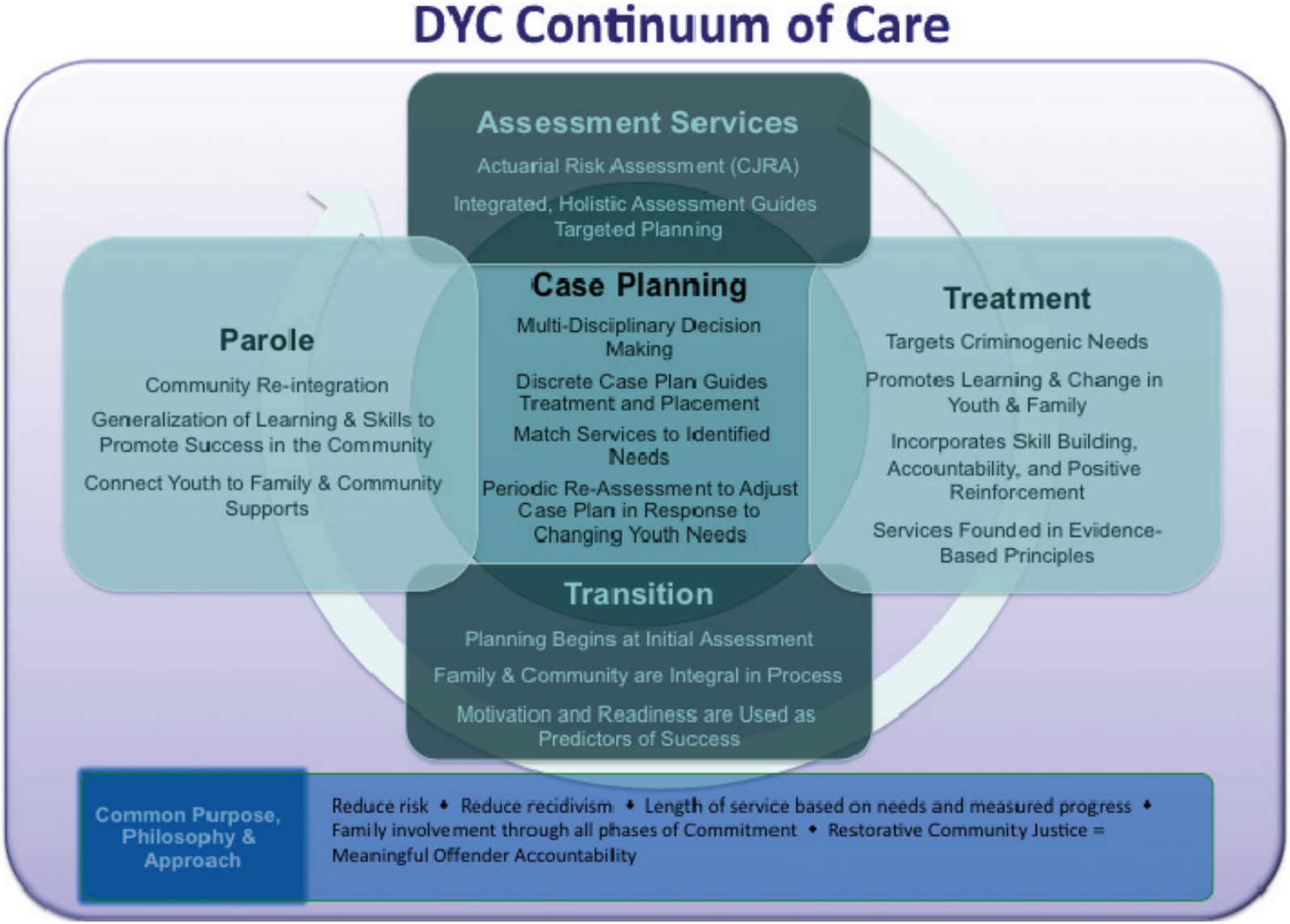
DYC's Continuum of Care is an integrated set of strategies involving state-of-the-art assessment, enhanced treatment services within residential facilities, and successful transitions to appropriate community-based services.

The elements of the Continuum of Care flow from the Division's Five Key Strategies[1]:

1. **Right Service at the Right Time**
2. **Quality Staff**
3. **Proven Practice**
4. **Safe Environment**
5. **Restorative Justice Principles**

The figure on the following page illustrates the complex and integrated nature of the Continuum of Care. While the figure portrays the components of the Continuum of Care as one-dimensional and discrete, they are complementary and inter-related, and they must be implemented together in order to yield the full benefits of the Continuum of Care. For example, a youth entering Division of Youth Corrections (DYC) care receives a criminogenic risk assessment that is used to build a targeted case plan matching the specific needs of the youth and family. As the youth and family progress through their case plan, re-assessment will occur and the case plan revised accordingly to meet the changing needs of the youth and family. This cycle of assessment, case planning and treatment will be repeated periodically until discharge from parole. Another important component is supporting the youth and family as they transition from higher levels of service or placement to lower levels and ultimately back into the community. Case planning is managed through a collaborative, multi-disciplinary process guided by a set of principles and purposes, including reducing risk and recidivism, tying length of services to assessed need and progress, family involvement, restorative community justice, and accountability.

[1] The Five Key Strategies are presented in greater detail in the body of this report.


DYC Continuum of Care
Assessment Services
Actuarial Risk Assessment (CJRA)
Integrated, Holistic Assessment Guides Targeted Planning
Case Planning
Multi-Disciplinary Decision Making
Discrete Case Plan Guides Treatment and Placement
Match Services to Identified Needs
Periodic Re-Assessment to Adjust Case Plan in Response to Changing Youth Needs
Parole
Community Re-integration
Generalization of Learning & Skills to Promote Success in the Community
Connect Youth to Family & Community Supports
Treatment
Targets Criminogenic Needs
Promotes Learning & Change in Youth & Family
Incorporates Skill Building, Accountability, and Positive Reinforcement
Services Founded in Evidence-Based Principles
Transition
Planning Begins at Initial Assessment
Family & Community are Integral in Process
Motivation and Readiness are Used as Predictors of Success
Common Purpose, Philosophy & Approach
Reduce risk • Reduce recidivism • Length of service based on needs and measured progress • Family involvement through all phases of Commitment • Restorative Community Justice = Meaningful Offender Accountability

A Structured, Division-Wide Improvement Process

Since its inception in FY 2005-06, the Continuum of Care has evolved from a budgetary demonstration initiative to a holistic approach to system improvement across the Division of Youth Corrections. Guided by the Continuum of Care Oversight Committee, made up of DYC leadership and representatives from across the operating divisions of the organization, an integrated set of six (6) sub-committees[2] and work groups drives a continuous process to bring operations in line with the elements of the Continuum of Care and Five Key Strategies.

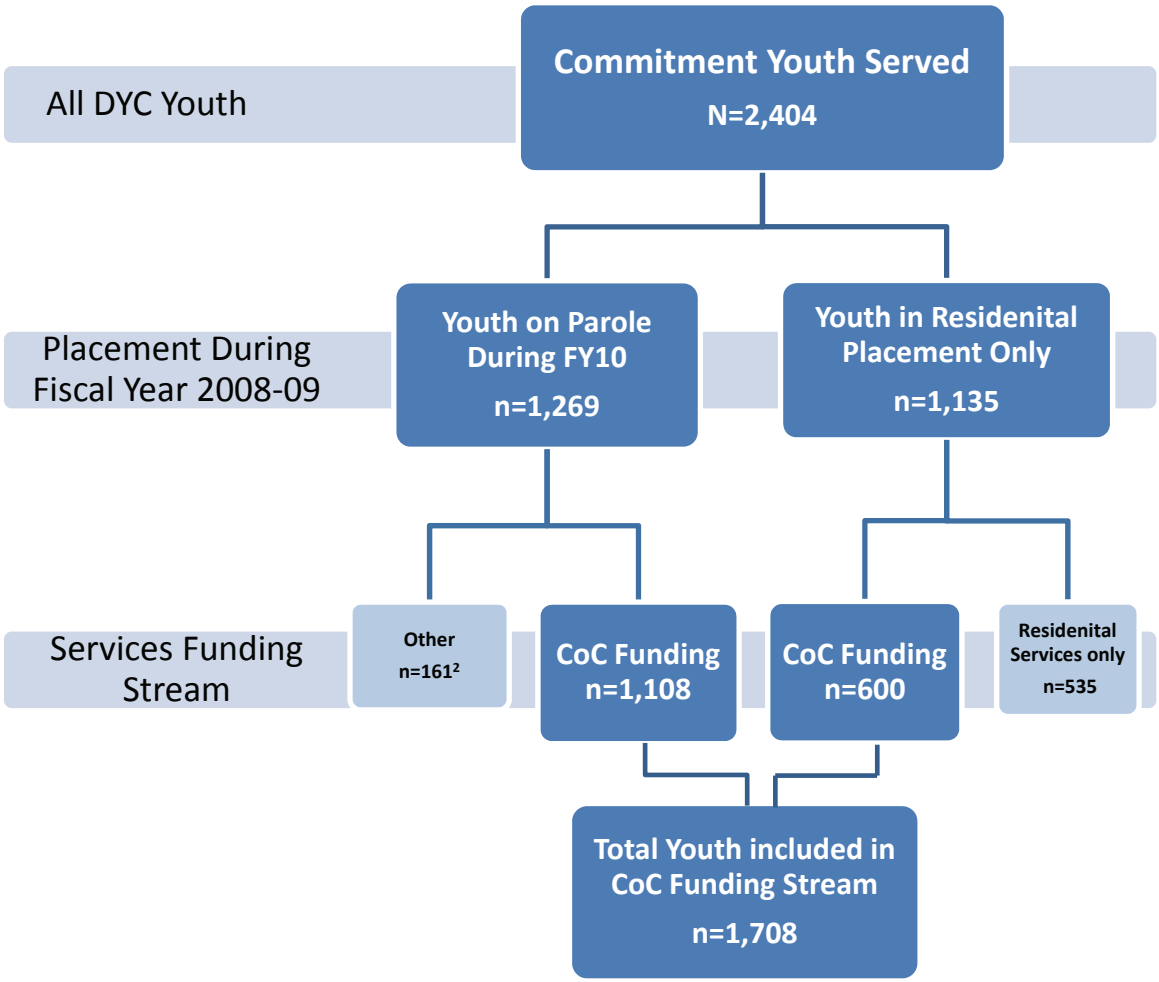
Describing Youth in the Continuum of Care

Youth Movement through the Continuum of Care

The Continuum of Care begins with initial commitment and continues throughout residential placement; including time on parole. Youth follow different paths through the Continuum, according to individual needs and circumstances. The figure on the following page illustrates the distribution of committed youth across different funding and placement types.

[2] The Continuum of Care Oversight Committee and working sub-committees are described in more detail in the body of the report.

FY 2009-10 Committed Youth



A total of 2,404 committed youth were served during FY 2009-10. Of these youth, 1,269 were served on parole status at some point during the year, while the remaining 1,135 were in residential placement during the entire fiscal year. As seen in the figure above, the vast majority of parole youth (87%, n=1,108) received transition and non-residential services paid through the parole program line item. The remaining 13 percent of paroled youth did not receive services paid for during this fiscal year. However, most of those youth (80%) received non-residential services in the prior fiscal year (FY 2008-09)[3]. The remaining 33 "other" youth did not receive services because their clinical assessment demonstrated no clinical indication of need.

[3] 128 paroled youth who did not receive services during FY 2009-2010 did receive services during FY 2008-2009.

Many committed youth who received residential services only, without release to parole, also received transition services (n=600). This practice lays the foundation for optimally supporting youth as they move from residential placement into the community (by starting transition services well before a youth leaves residential placement) and is vital to managing reintegration as well as to achieving successful community dispositions.

Characteristics of Committed Youth

FY 2009-10 Demographic Distribution of Committed Youth		
	Transition & Non-Residential Services	
	Number	**Percent**
Gender		
Female	241	14.1%
Male	1,467	85.9%
Total	**1,708**	**100%**
Race/Ethnicity		
American Indian/Alaskan Native	35	2.0%
Asian	13	0.8%
Black or African American	317	18.6%
Hispanic	602	35.3%
Native Hawaiian/Pacific Islander	2	0.1%
White	734	43.0%
Unable to Determine	5	0.3%
Total	**1,708**	**100%**
Average Age at Commitment	16.6 years	

Original Commitment and Offense Type for Youth Served				
	FY 2008-09		FY 2009-10	
	Number	Percent	Number	Percent
Original Commitment Type				
Non-Mandatory	1,776	70.8%	1,688	70.2%
Mandatory	546	21.8%	526	21.9%
Repeat	145	5.8%	135	5.6%
Violent	10	0.4%	18	0.7%
Aggravated	32	1.3%	37	1.5%
Total[4]	**2,509**	**100%**	**2,404**	**100%**
Original Commitment Charge				
Felony	1,527	63.9%	1,469	63.7%
Misdemeanor	861	36.1%	838	36.3%
Total[5]	**2,388**	**100%**	**2,307**	**100%**

Assessing Youth Risk and Needs

DYC assesses each youth for criminogenic risks and needs using the Colorado Juvenile Risk Assessment (CJRA). This assessment helps client managers identify the specific areas in a youth's life that directly contribute to his or her delinquent behavior and target treatment plans to mitigate the risks and enhance protective factors to reduce the youth's overall likelihood for re-offending.

The use of a comprehensive, empirically validated risk assessment allows DYC to identify and respond to the factors directly contributing to youth offending behavior. Anchored by the Colorado Juvenile Risk Assessment (CJRA), each youth's Clinical Evaluation Report, created by the DYC Assessment Services team to summarize results, integrates findings from five assessment disciplines. The report offers targeted treatment recommendations encompassing: 1) overall criminogenic factors, 2) alcohol and drug use, 3) mental health, 4) medical and 5) educational needs. Assessment Specialists, working collaboratively with community partners, create a comprehensive, individualized and interdisciplinary assessment plan for all newly committed juvenile offenders.

[4] Data for original commitment type was missing for four committed youth.
[5] Data for original charge type was missing for 122 committed youth in FY 2008-09 and 94 youth in FY 2009-10.

Increasing Severity and Complexity of Risk for Re-offending

As shown in the table below, more than half of committed youth fall into the highest third of possible scores in the domains of criminal history, relationships, family, substance abuse, attitudes, aggression, and skills.

Distribution of Initial Scores Across All Committed Youth FY 2009-10				
CJRA Domain	N	Level of Relative Risk[6]		
		Low Risk	Moderate Risk	High Risk
Criminal History	2,404	4.7%	15.6%	79.7%
School	2,404	49.0%	22.0%	29.0%
Relationships	2,404	1.4%	16.0%	82.6%
Family	2,404	15.5%	19.0%	65.5%
Substance Abuse	2,404	31.5%	11.2%	57.2%
Mental Health	2,404	58.7%	24.9%	16.4%
Attitudes and Behavior	2,404	1.4%	5.6%	93.0%
Aggression	2,404	3.6%	17.9%	78.4%
Skills	2,404	7.9%	9.5%	82.7%

Further, as shown below, there is a trend toward increasing proportions of youth falling into the highest risk range on most of the CJRA dynamic risk domains. Even though the overall numbers of youth committed to DYC have been declining, an emerging pattern of more severe and complex needs of committed youth has become apparent.

Criminogenic risk assessment highlights a trend toward increasing complexity and severity in the pattern of risks and needs presented by youth committed to DYC.

Nearly two-thirds of youth (65%) scored in the high risk range in five or more of the domains, with the average youth scoring in the high range in four of the nine domains that yield risk scores[7]. This is further evidence of the trend toward increasingly complex needs among the youth and families being served and underscores the importance of flexibility and responsiveness as DYC deploys resources to meet these needs[8]. The positive outcomes achieved through the Continuum of Care are particularly noteworthy in light of this trend.

[6] Percentages in this table may not add to 100% due to rounding.
[7] Employment and Use of Free Time domains have only static protective factor scores and no risk scores.
[8] Please refer to the body of this report for a discussion of the increasing complexity in presenting risk and needs among committed youth.

Effectiveness of the Continuum of Care

The Continuum of Care is built on a foundation of evidence demonstrating that assessment and individualized case planning that addresses every phase of a youth's commitment and targets the primary causes of the youth's delinquency will yield the best possible outcomes for youth and families (Nelson, 2000).

The CJRA process allows DYC staff to track changes in risk as a result of treatment and adjust case plans accordingly.

Reducing the Risk of Re-Offending

As discussed in the previous section, the CJRA process is designed not only to measure a youth's initial level of risk and need, but also to assess the mitigation of risk factors as the youth moves through the commitment Continuum of Care and into the community. Use of the CJRA enables DYC to examine changes in dynamic risk factors that are predicted by the theory of change underlying the Continuum of Care. Put simply, the underlying principles for the Continuum of Care 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.

In order to facilitate interpretation of the risk mitigation findings presented below, it is useful to revisit the Continuum of Care CJRA risk assessment process. Every youth entering DYC commitment undergoes an initial assessment as he or she enters care. This assessment supports case planning and serves as a benchmark as it reflects the youth's risk profile at the time he or she enters DYC. As such, this initial assessment is an indication of the risk that each youth posed in the community that is to be addressed through commitment and treatment in the Continuum of Care. The second assessment point depicted in the figures on the following pages represents the youth's risk profile as he or she leaves a restrictive residential placement for community parole. While in placement, the youth participates in intensive treatment and is maintained in a controlled, supportive living environment within a residential milieu. As the youth transitions to community parole, he or she once again is faced with an open environment (often the same community in which the youth originally offended) that is inherently more conducive to risk-related behavior and cognitions. Thus, the third assessment point depicted in the figures on the following pages illustrates the youth's dynamic risk levels on meaningful criminogenic domains at the time he or she discharges from DYC.

Reductions in criminogenic risks achieved by interventions during residential placement were largely maintained as youth transitioned into the community.

The figures on the following pages show significant decreases in dynamic risk scores across most domains from the time of the initial CJRA assessment to the time youth leave residential placement and enter parole. The reduction in risk across the three different points in time is impressive for at least three important reasons. First, the precipitous reduction in risk from initial assessment to parole **was clinically maintained** between parole and discharge from parole. This finding is more dramatic in certain key domains, many of which are most highly correlated with recidivism and most influenced by environmental context. For example:

- In the **Family** domain, the average risk score dropped from over 10 at Initial Assessment to under 7 by parole and then dropped further to 5.5 between parole and discharge. The average risk score was nearly cut in half from assessment to discharge. As mentioned earlier, the Family domain was a particular focus of service enhancement in the past fiscal year, and this data suggest a significant impact of those efforts.
- In the **Aggression** domain, an average risk score of just under 5 was reduced to under 2. A score of less than 2 was maintained at discharge from parole.
- In the **Skills** domain, a score of over 7 was reduced to less than 1 from initial assessment to parole. An average score of less than 1 was maintained even at discharge.

Dramatic reductions in risk related to family factors speak directly to the success of DYC's efforts to target this domain and enhance services in this area.

The latter finding in the Skills domain is illustrative of the clinical reality revealed by the CJRA risk domain trends analyses, and points to two additional reasons that the reduction in risk scores was so impressive in FY 2009-2010. First, the findings in the Skills domain illustrate what is often called a "**floor effect**" in longitudinal and statistical analyses. That is, the reduction from parole to discharge was so great that there was very little room for improvement between parole and discharge. **Especially with a population of youth representing the highest level of criminogenic risk at intake, it is very difficult to decrease the risk between parole and discharge when the risk level already has decreased to an average of below one (1) on the scale. Clinically significant *maintenance* of that reduction in risk represents a powerful positive change and exceeds the results that might reasonably be expected based on the contextual challenges faced by these youth in their home communities.**

Although this point is perhaps most dramatically illustrated by the trend analysis of the **Skills** domain, other domains are informative as well. For example, in the **Substance Abuse** domain, an average score of over 8 at initial assessment was reduced to a negligible 0.6 at parole. By the time of discharge, after youth had spent time away from the supportive residential treatment environment, the average score increased to a little over 2. However, there is little chance that, in this population of offending youth, an average score of 0.6 could be further decreased between parole and discharge.

The discussion of trends in average scores for the **Substance Abuse** domain raises a third important reason that the findings of reduction in risk are so impressive: *maintenance of a clinically significant reduction in risk from initial assessment to discharge underscores how difficult it is **when youth move from a highly supportive and controlled environment to a largely uncontrolled environment.** Yet, that is exactly what the analysis of trends in CJRA data reveals.* In the case of the Substance Abuse domain, a clinically significant drop in average scores from initial assessment to parole was essentially maintained at discharge, despite the fact that youth have much more access to illicit substances and exposure to peers who use substances in the community. The decrease from an average score of over 8 (representing a "high" risk) to a score of just over 2 (representing a "low" risk) at discharge represents a very significant reduction in risk, whereas, the slight rise of less than 2 points from parole to discharge is of marginal clinical significance, and remains within the "low" risk level based on large scale validation

studies. Again, this analysis suggests that the clinical services delivered between initial assessment and discharge led to a very large and clinically meaningful reduction in risk.

The trend in the **Attitudes and Behavior** domain is very similar to the trend in the Substance Abuse domain. A score of 8 was dramatically lowered to a score of 3 between initial assessment and parole. Between parole and discharge, the average score rises only slightly, and at a clinically insignificant rate. Again, the dramatic, clinically significant decrease that was seen between initial assessment and parole is maintained at discharge. These achievements in key domains (that are highly correlated with recidivism) underscore the capacity of the Continuum of Care system to keep risk levels low, even when youth are placed in much less controlled environments.

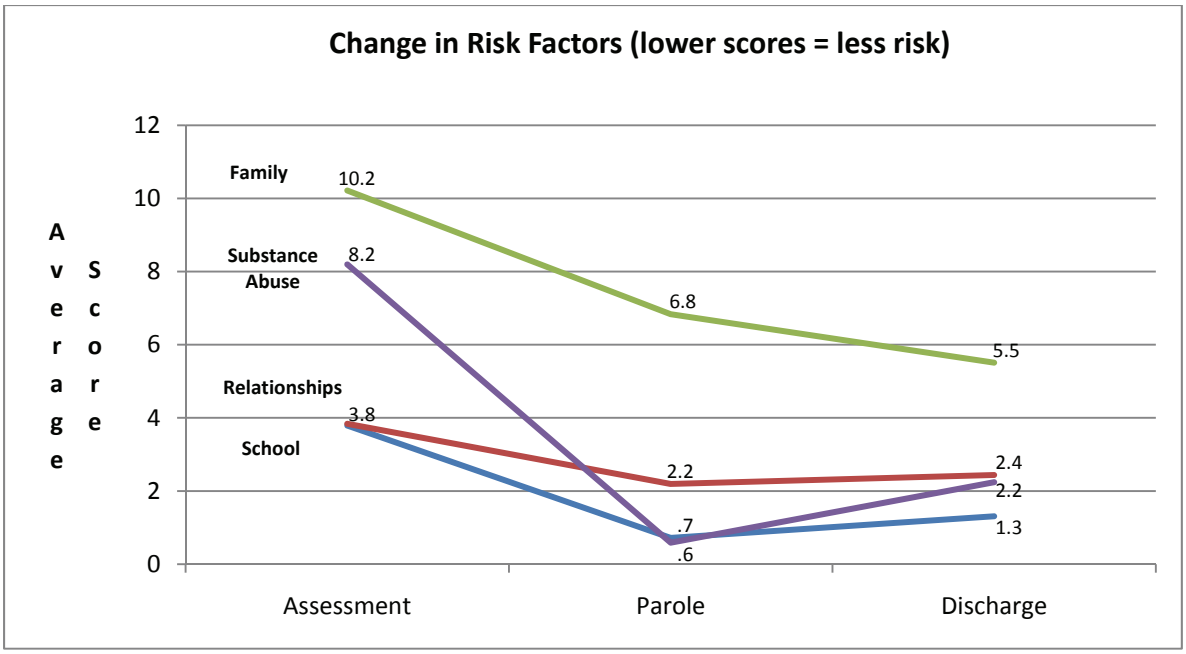
At the time of discharge from DYC commitment, youth exhibit marked decreases in criminogenic risk factors.

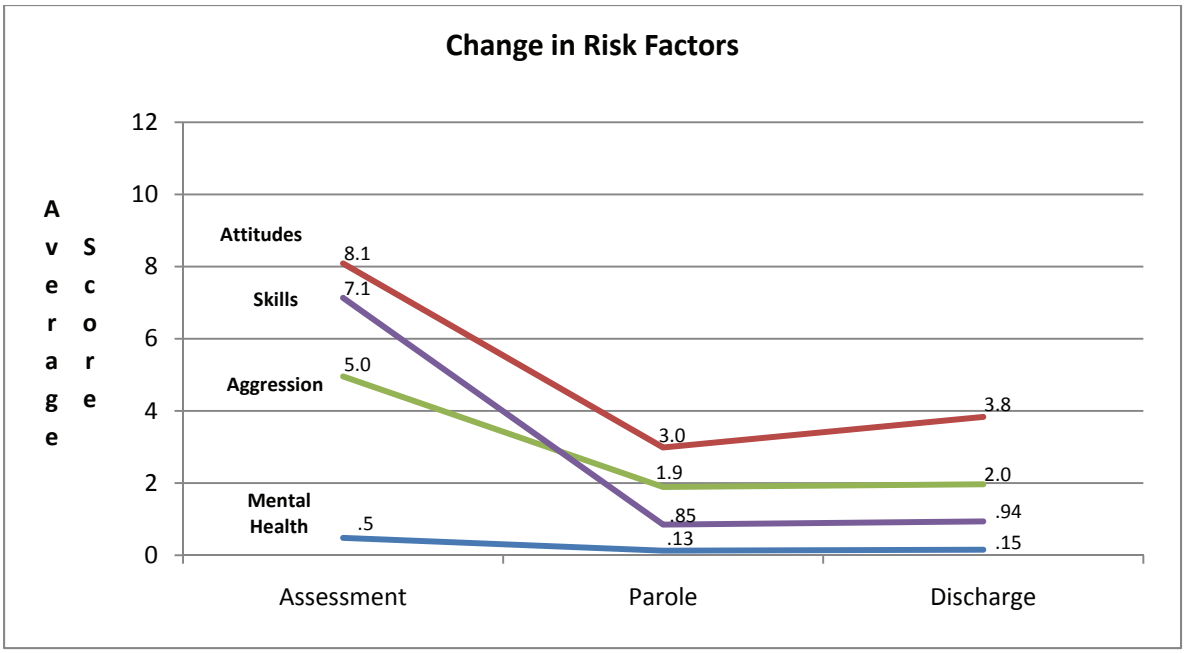
In order to respond to public safety concerns, the clinically significant reduction in risk from initial assessment to discharge must be demonstrated if the Continuum of Care is to be justified. This is what the data shows. At the same time, being able to effectuate and maintain a clinically significant reduction in risk is also important because maintaining youth in the community, versus highly restrictive settings, keeps costs down. Further, it ensures a better developmental trajectory for youth (e.g., it reduces their risk of ending up in the adult correctional system). Thus, **from both a financial and a humanitarian perspective, and from both a near-term and a longer-term perspective, the findings on CJRA risk reduction trends are highly encouraging.**

The pattern of changes between initial assessment, parole and discharge support the structure and "theory of change" underlying the Continuum of Care.

Thus, taken as a whole, the four graphs[9] on the following pages offer strong support for the effectiveness of the Continuum of Care strategies. Put simply, youth enter commitment with elevated risk factors across a wide range of domains proven to predict re-offending. Moreover, youth tend to enter commitment with relatively low levels of protective factors known to buffer the impact of risk and help youth resist the influence of risk factors in the environment. The data presented in these figures suggests that the treatment offered during commitment is effective in bringing about dramatic reductions in the criminogenic risk factors known to predict re-offending. Following transition from restrictive residential placement to community parole, gains (reductions in risk and increases in protective factors) are largely maintained. This supports the Continuum of Care process and theory of change that is based on providing intensive services tailored to each youth derived from assessment data, and supporting successful transitions and generalization of treatment gains to the community through services that bridge residential and community placement.

[9] Please note that analyses are presented across multiple graphs simply to facilitate interpretation by avoiding the appearance of a jumble of intersecting lines.

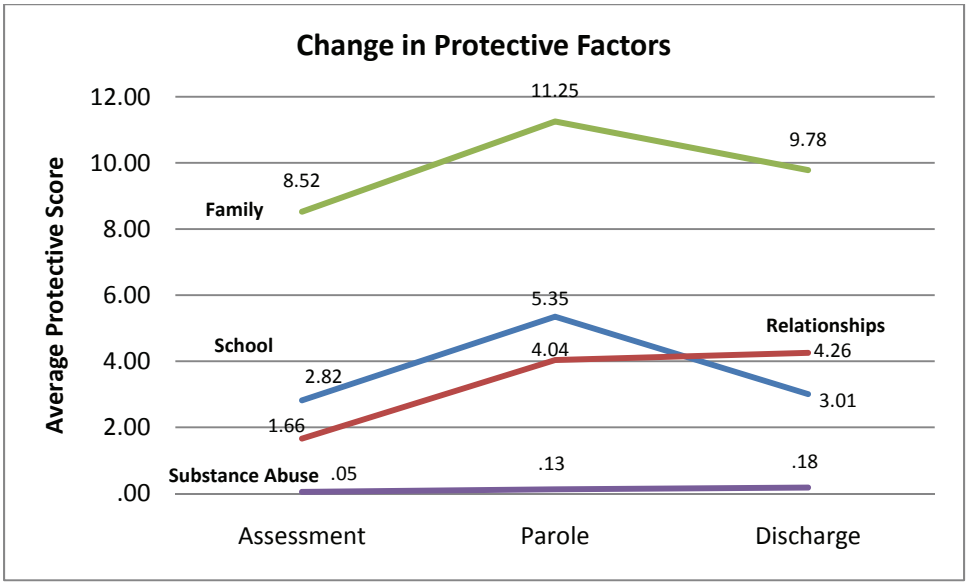


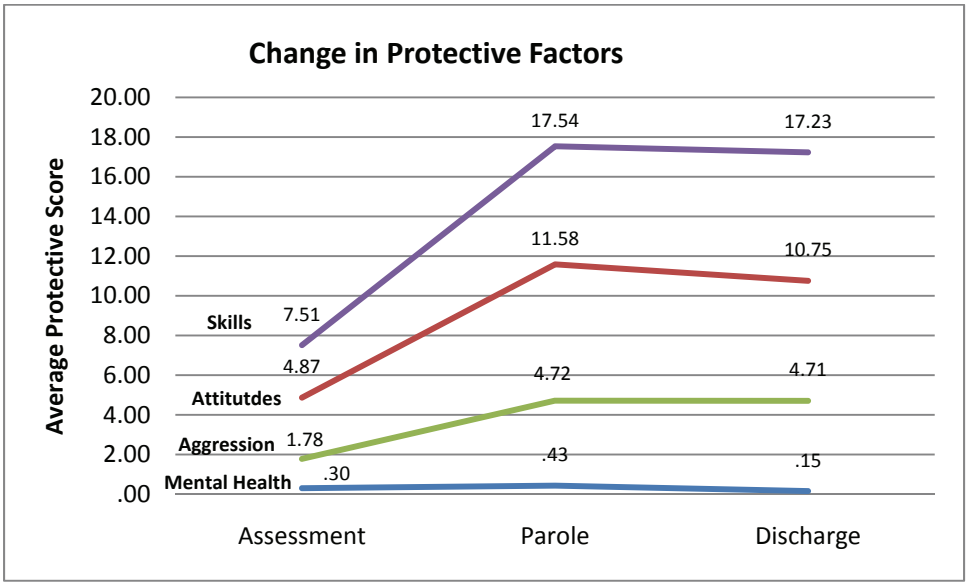


While the two graphs above depict changes in dynamic (changeable) risk factors from initial assessment through parole and discharge, the following two figures[10] present corresponding changes in dynamic protective factors for youth committed to DYC. The research literature (e.g., Barnoski, 2004) consistently demonstrates that, while risk factors strongly predict recidivism, the relationship between protective

[10] Again, please note that analyses are presented across multiple graphs simply to facilitate interpretation by avoiding the appearance of a jumble of intersecting lines.

factors and recidivism is less clear. While there is some evidence that the presence of protective factors may buffer youth from exposure to risk factors, the relationship is neither simple nor linear. However, the pattern of change across the three assessment time points mirrors the pattern seen for risk factors and offers support for the effectiveness of the treatment strategies employed through the Continuum of Care: youth experience marked gains in protective factors while participating in intense intervention in a closed milieu, and these gains are largely sustained when youth transition to parole and back to the community.





Pre-Discharge Recidivism and Recommitment Rates

Pre-discharge recidivism was lower during FY 2009-2010, in comparison to the baseline year prior to Continuum of Care implementation, just as it has been ever since the Continuum of Care was implemented in 2005-2006 (See Table 5, below).

Pre-Discharge Recidivism Rates							
Pre-Discharge Recidivism	Fiscal Year						
	2004-05	CoC Implemented	2005-06	2006-07	2007-08	2008-09	2009-10[11]
Yes	39.1%		38.5%	33.5%	35.8%	37.9%	34.6%
No	60.9%		61.5%	66.5%	64.2%	62.1%	65.4%

Pre-discharge recidivism rates have fluctuated only slightly over the last five fiscal years. In order to better understand these rates, it is useful to explore the construct of recidivism and how it is measured. For more detail on measuring recidivism, please see the full body of the report.

The table below shows that annual recommitments have declined in the past six years. This trend points to the ability of 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. Recommitment rates in Colorado compare favorably with other states[12].

Annual Number and Proportion of Recommitments							
Recommitment	Fiscal Year						
	2004-05	CoC Imple-mented	2005-06	2006-07	2007-08	2008-09	2009-10
Number Recommitted	277		283	256	205	213	157
Percent of Youth Served	9.3%		8.8%	8.1%	7.6%	8.5%	6.5%

[11] Recidivism data for FY 2009-10 is preliminary at this time. Based on past recidivism analyses, it is anticipated that these numbers will increase slightly as more time for charges to be formally filed in court is allowed.
[12] See body of report for more discussion.

Transition and Non-Residential Services Expenditures

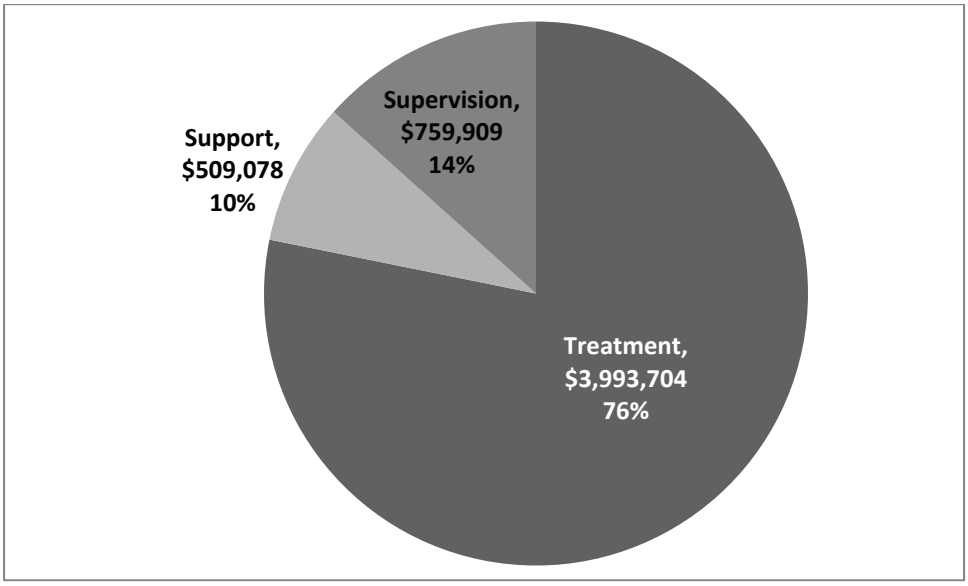
The transition and non-residential services that are provided as part of the Continuum of Care are funded through two appropriations. The 2009 Long Bill (SB09-259) line item 11(C): Community Programs: Parole Program Services provides funding to assist in successful transition from commitment to parole. Services provided in this appropriation may include Wraparound services, Tracking, Day Treatment, and other Community-Based services. The second appropriation capturing Continuum of Care expenses is the 2009 Long Bill (SB09-259) line item 11(B): Institutional Programs Personal Services. This appropriation captures salaries and personal services costs for program, supervisory and support staff at DYC institutions, including those costs that are related to delivering transition services in the Continuum of Care.

The total FY 2009-10 appropriation for Parole Program Services is $5,983,518. Of this, $5,880,540.87 was spent directly on parole and transition services for the youth DYC serves. A minimal amount of expense ($15,558.95) was over-accrued as an expense in the appropriation and was reverted back to the general fund in FY 2010-11.

FY 2009-10 Expenditures	
Expenditure Description	**Amount**
Direct services paid through Savio Parole Program Services line item (480)	$5,334,249.17
Other direct services not paid through Savio	$3,879.74
Child placement agencies[13]	$103,157.28
Behavioral health concepts[14]	$439,254.68
Authorizations (payables) not expended	$15,558.95
Total	**$5,896,099.82**
Funds not expended	$87,418.18
Total Appropriation	**$5,983,518.00**
ARRA credits	$199,839.82
Funds not expended	$87,418.18
Total FY 2009-10 funds reverted to General Fund	$287,258.00

[13] Child Placement Agencies provide foster care placements for youth in the community. These are community-based placements (homes) that support youth who may not have a viable family to return to.
[14] Behavioral Health Concepts refer to funds that support treatment services at the Treatment Program at Mount View – part of the residential component of the Continuum of Care.

FY 2009-10 Continuum of Care Expenditures by General Category
Direct Service Dollars Associated with Individual Youth



The vast majority (76%) of expenditures was dedicated to treatment and treatment-related services (see below for details on treatment expenditures). This percentage was consistent across each of the management regions. Another 10 percent of expenditures were for support-related services that help to provide youth with tangible goods and services (e.g., clothing, transportation and housing) needed to establish independent living. The remaining 14 percent went to the purchase of surveillance-based supervision services, primarily electronic home monitoring (EHM) and substance use monitoring (urinalysis, etc.).

When considering overall expenditures, as well as average expenditures across youth served, it is important to note that these funds encompass all non-residential and transition services, including those that may have been received during the time a youth was in residential placement. On average, youth received services for 7.6 months during this fiscal year alone, which exceeds the 6-month mandatory parole period and is greater than the current average parole LOS of 6.8 months. These FY 2009-10 expenditures represent an average monthly cost of $550 per youth. The bulk of this report only accounts for expenditures in the just completed (FY 2009-10) fiscal year. When examining all of the services provided to youth served during this fiscal year (including not only services paid during this fiscal year, but also including services from the last fiscal year), it is apparent that, in keeping with the Continuum of Care model, youth begin to receive transition services well before their parole period. For youth served in this fiscal year who were matched to services from the last two years, transition services began on average 4.5 months prior to a youth's actual parole date.

In keeping with the Continuum of Care model, youth receive transition services beginning 4.5 months prior to parole.

Treatment Expenditures

The total of $3,993,704 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 (44.1%) was spent on community transition service packages. These "packaged services" contain a combination of treatment (generally skill building), supervision, support (via resources/referrals) and advocacy for families and youth transitioning out of residential placement. These services are purchased as a package and generally cannot be broken into amounts based on individual service types. Packages are generally offered in a low/high or a low/medium/high level of intensity with corresponding differences in the types, amounts, frequencies, durations, and costs of services.

Job and skills training represented 14.9 percent of treatment expenditures. These expenditures were used for vocational or life skills training (often including social skill building). Another 12.6 percent of services were expended on family treatment programs; either evidence-based family therapy programs (specifically FFT and MST), or other family preservation and training services.

Treatment expenditures for Independent Living Skills programs (6.9%) primarily targeted the provision of skill training in general life skills and social skills to youth who are either emancipating legally or who will otherwise be living on their own when they return to the community. Experiential therapy and traditional individual therapy each made up approximately five (5) percent of expenditures. Experiential therapy programs are those that include artistic expression, recreation or animal assisted therapy in their treatment models.

Offense-based treatment (for youth committed for a sexually-based offense) made up 3.8 percent of expenditures. This expenditure almost exclusively represents offenders convicted of an offense featuring sexually abusive behavior. However, there are some domestic violence offenders included in this category.

Bundled, or packaged, services decrease DYC's capacity to ensure that youth receive targeted care matched to their criminogenic risk and protective factors.

Advocacy and Case Management made up two (2) percent of all treatment expenditures. This includes treatment program-specific case management (including providing DYC client managers with case notes and summary reports) as well as general advocacy work to help link family and children to community resources.

The remaining expenditures were spread among six different services types, each of which represented less than two (2) percent of expenditures: Specialized Assessment and Evaluations (offender specific, neurological, substance abuse, etc.), Evidence-Based Treatment (based on cognitive-behavioral treatment models), Day Treatment, Substance Abuse, and Group Therapy.

FY 2009-10 Treatment Expenditures by Type of Service		
Service Type	**Expenditures**	**Percent of Total**
Community Transition	$ 1,760,724	44.1%
Job/Skills Training	$ 593,082	14.9%
Family Services	$ 294,707	7.4%
Independent Living	$ 274,368	6.9%
Family Therapy (FFT & MST)	$ 207,499	5.2%
Experiential Therapy	$ 196,743	4.9%
Individual therapy	$ 173,915	4.4%
Offense Specific Treatment	$ 150,036	3.8%
Advocacy and Case Management	$ 80,241	2.0%
Restorative Justice	$ 73,541	1.8%
Specialized Assessment and Evaluation	$ 55,203	1.4%
Evidence-based Behavior Training	$ 43,250	1.1%
Day Treatment	$ 42,783	1.1%
Substance Abuse Treatment	$ 43,404	1.1%
Group therapy	$ 4,208	0.1%
Total	**$ 3,993,704**	**100%**

Continuum of Care Quality Initiatives

The Leadership Team of the Division of Youth Corrections has established a well-specified structure of responsibility and leadership for the ongoing implementation of the Continuum of Care. Anchored by the Continuum of Care Implementation Oversight Committee, a group of DYC leaders and representatives of all phases of the Continuum, DYC has put in place a set of goals, objectives and action steps. While the Oversight Committee meets at least monthly to establish priorities and review progress, sub-committees work on an ongoing basis to implement local and statewide initiatives. These sub-committees are listed below[15].

- Evidence Based Practices (EBP) Committee
- Motivational Interviewing Oversight Sub-Committee
- CJRA Oversight Sub-Committee
- Multi-Disciplinary Team (MDT) Steering
- Communications Facility Restorative Community Justice (RCJ) Committee

[15] See body of report for more discussion of this work.

Observations and Recommendations

The Colorado Division of Youth Corrections is in the fifth year of a comprehensive systems improvement effort – the Continuum of Care. The Continuum of Care 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. A best practice model, the Continuum promotes a full array of assessment, case planning and interventions that reduce risk and ultimately reduce the likelihood of re-offending behavior. Most notably, the Division of Youth Corrections continues to prioritize and move forward with an evidence-based approach to management and implementation. Led by the Continuum of Care Oversight Committee, DYC leadership is putting in place an integrated set of structures to support high quality implementation across the entire organization.

As an external review of the initiative based on available data, this evaluation continues to point to positive progress in this system change effort.

A system change effort like the Continuum of Care 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 as discussed in prior reports, necessitates that the desired change will not be immediate, but will unfold in a developmental way over time.

Observations

Criminogenic risk decreases for youth receiving Continuum of Care services. CJRA data demonstrates that dynamic risk scores decrease significantly for youth receiving services. Through Continuum of Care strategies, DYC is significantly reducing risk from the time a youth is committed to the time a youth goes on parole, and is maintaining those gains when the youth enters the community.

Treatment continues to represent the majority of expenditures, but a growing proportion of funds being spent on surveillance (Supervision) suggests a trend that should be monitored and addressed by DYC leadership.

Data-driven decision making. The monitoring (tracking) of services provided through the Continuum of Care has improved immensely over the past five years. However, the use of bundled or "packaged" non-residential services reduces DYC's capacity to examine and control the specific services a youth is receiving.

The Continuum of Care has evolved from a discrete initiative to a holistic system improvement process. The Continuum of Care has become a cornerstone of DYC's philosophy and systems

improvement efforts. This success demonstrates the potential for positive change when an organization is given the flexibility to innovate and become more nimble in providing optimal services.

The Continuum of Care continues to identify and serve youth who enter the system at a high risk for re-offending. CJRA risk and needs data demonstrates 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 or adult justice system.

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 service 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. The CJRA Oversight Committee is developing and implementing quality assurance protocols necessary to support quality practice throughout the system.

In the context of a youth population that grows more complex and requires greater intervention, the stability in recidivism and recommitment represents a meaningful success for the Continuum of Care.

Recidivism and recommitment rates remain flat. Pre-discharge recidivism (34.6%) remains stable and is significantly lower than the baseline year's rate of 39.1 percent. The percentage of committed youth being recommitted has decreased in the past five years. In the context of a population that appears to bring greater complexity and multiple risk areas requiring intervention, these relatively positive, stable trends in recidivism and recommitment represent meaningful successes for the Continuum of Care.

Ongoing system improvement. The Division of Youth Corrections is engaged in systematic efforts to implement the integrated strategies of the Continuum of Care. Strategies to bolster the service array of evidence-based services continue, along with data-driven quality assurance efforts. These efforts are exemplified by the Continuum of Care Oversight Committee and related sub-committees.

Recommendations for Ongoing Attention

Linking assessment, case planning and intervention. Only through careful linking of assessment, case planning and treatment can we follow this pathway and ensure that the system is working as intended.

Unbundle packaged services so that Client Managers can ensure that youth receive targeted services matching their risk and needs. The packaging of services, while convenient for the provider and billing systems, masks the actual services received by youth and challenges the Continuum of Care in living up

to “the right services at the right time” by creating a black box of services in which targeting services to individual needs is difficult and linking outcomes to services is impossible.

Need to understand drivers for youth lengths of stay. Assessment and anecdotal evidence suggests 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.

Continue to encourage and support the use of evidence-based practices across all state-operated and contracted programs. The work of the Evidence Based Practices Committee represents an important step forward. It is important that these efforts continue.

Continue to promote Multi-Disciplinary Teams (MDTs) to carefully map out and coordinate transition services prior to youth release on parole. MDTs represent the vital link between assessing a youth’s criminogenic risks and needs and ensuring that services provided to the youth directly respond to those needs.

Continue focusing efforts on increasing youth engagement in the community as part of the transition effort. While a residential environment may provide a forum for instruction, until the youth can apply new skills in his or her own environment, with continued reinforcement and support, they are not likely to be sustained in a less rigorous environment filled with opportunities for youth to make the same mistakes and engage in the same behaviors that led to their original commitment.

Continue training efforts to assure staff have the knowledge and competencies to deliver effective interventions. It is important that DYC staff have the ongoing training and support to link assessment results to those interventions that hold the most promise for changing each specific youth’s delinquent behavior.

Develop greater capacity for evidence-based family interventions for youth returning to family homes, as well as independent living services for older youth. These services can have a significant impact on a youth’s successful return to the community, but only if interventions are delivered with fidelity to evidence-based practice.

Continuum of Care:
Youth Transitions and Non-Residential Services

Annual Report

Fiscal Year 2009-2010
July 1, 2009 –June 30, 2010

Colorado Department of Human Services
Children, Youth and Families
Division of Youth Corrections (DYC)

Introduction and Background

The Commitment Continuum of Care

The Division of Youth Corrections (DYC) Commitment Continuum of Care (referred to in this report simply as the Continuum of Care) model is an integrated approach to providing a complete range of programs and services that meet the changing needs of youth and family at every phase, from commitment to the point of discharge from parole. Successful implementation of the Continuum of Care supports the mission of DYC by protecting public safety, improving outcomes for youth and families, and effectively using resources.

DYC's Continuum of Care 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 elements of the Continuum of Care flow from the Division's Five Key Strategies and are founded upon evidence-based principles. Examples of the Continuum's elements are listed below with each of the Five Key Strategies:

1. **Right Service at the Right Time**
   - Use of actuarial risk assessment tools to identify criminogenic risk, needs and protective factors
   - Individualized, targeted case planning, treatment, milieu and transition services
   - Ongoing review of youth progress
   - Engagement of youth and families with their natural communities

2. **Quality Staff**
   - Hiring of qualified, licensed and certified personnel
   - Continuous staff training, coaching, and technical assistance
   - Educational instruction/training and demonstrated knowledge in evidence-based principles and practices
   - Collaborative and integrated approach toward assessment, case planning, treatment, milieu and transition services

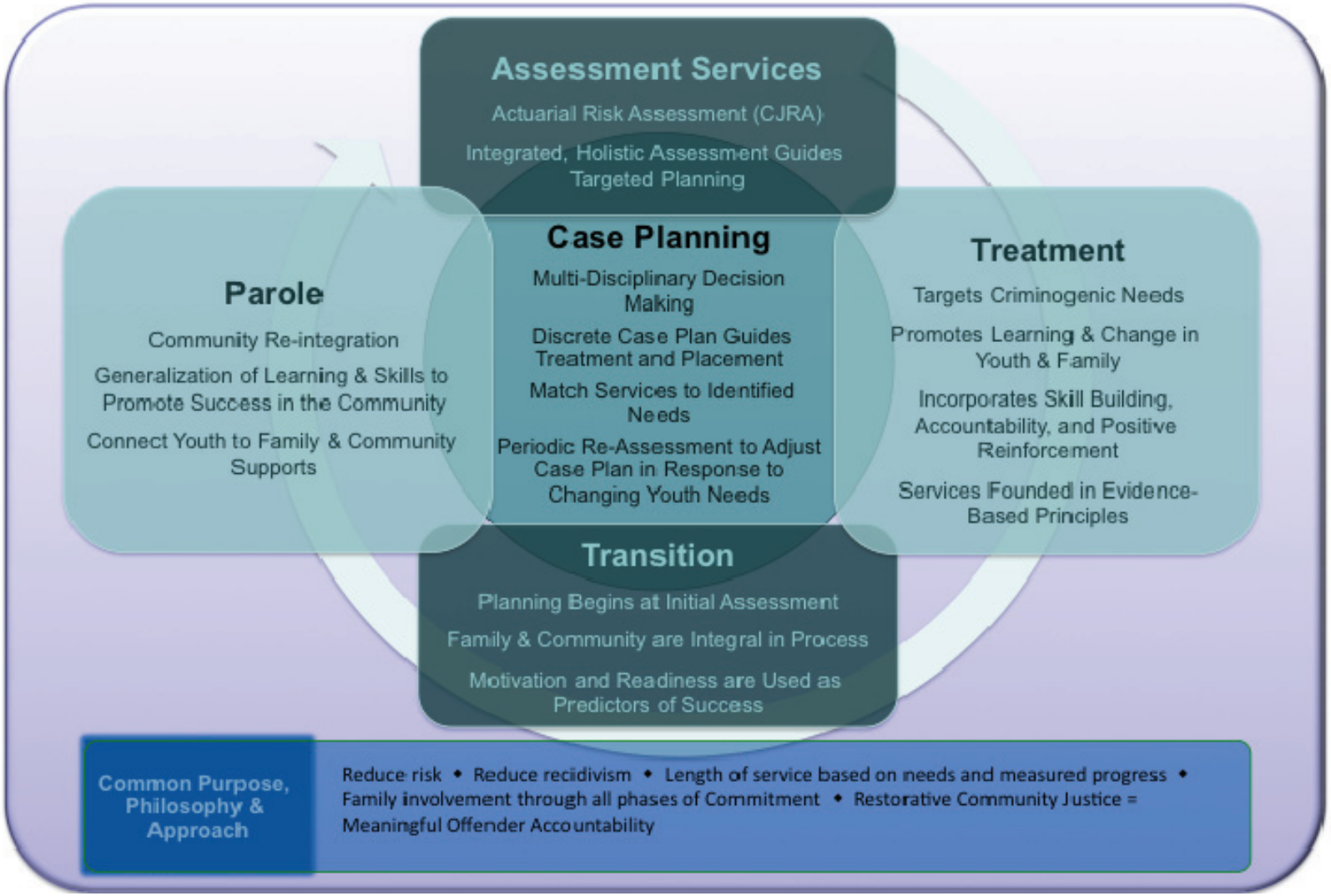
3. **Proven Practice**
   - Employ state-of-the-art, research-supported assessment, case planning, treatment, milieu and transition services
   - Apply strengths-based assessment, case planning, treatment, milieu and transition services
   - Measurement of assessment, case planning, treatment, milieu and transition services outcomes to produce reliable data to inform decision making
   - Implementation of evidence-based principles and practices

4. **Safe Environment**
   - Initial and ongoing safety training, support, and technical assistance
   - Individualized and youth appropriate supervision, interventions, and care
   - Apply lowest level of intervention necessary to maintain youth and staff safety
   - Uphold empirically supported classification, placement, and service decisions

5. **Restorative Justice Principles**
   - Integrated application of Restorative Community Justice (RCJ) philosophy, practices, and activities
   - Attend to victim rights, youth accountability, and community restoration
   - Reinforce responsibility for repairing relational disharmony, impact, and harm
   - Provide specialized skills training and development in RCJ principles

Figure 1, on the following page, illustrates the complex and integrated nature of the Continuum of Care. While the figure portrays the components of the Continuum of Care as one-dimensional and discrete, they are complementary and inter-related, and they must be implemented together in order to yield the full benefits of the Continuum of Care. For example, a youth entering Division of Youth Corrections (DYC) care receives a criminogenic risk assessment that is used to build a targeted case plan matching the specific needs of the youth and family. As the youth and family progress through their case plan, re-assessment will occur and the case plan revised accordingly to meet the changing needs of the youth and family. This cycle of assessment, case planning and treatment will be repeated periodically until discharge from parole. Another important component is supporting the youth and family as they transition from higher levels of service or placement to lower levels and ultimately back into the community. Case planning is managed through a collaborative, multi-disciplinary process guided by a set of principles and purposes, including reducing risk and recidivism, tying length of services to assessed need and progress, family involvement, restorative community justice, and accountability.

DYC Continuum of Care



History and Development of the Continuum of Care

In an effort to better address the first of the Division's five key strategies – "the right service at the right time " – DYC sought authorization from the General Assembly to flexibly deploy funds from DYC's Purchase of Contract Placements line item. The 2006 Long Bill (HB 06–1385) included footnote 41 that authorized 5% of the Purchase of Contract Placements line item to be used for a demonstration of enhanced flexibility in treating and transitioning youth from residential to non-residential settings. This initial footnote represents the enabling foundation for the Continuum of Care. Since that time and through the current fiscal year (2009-10) DYC has used this funding flexibility to support the implementation of a set of integrated system improvements that center on research-based principles of effective practice. This comprehensive model, known as the Continuum of Care, aims to optimize the availability of the most effective services in the most appropriate settings to meet the rehabilitation needs of juvenile offenders in custody.

Following is an excerpt from the footnote for the current fiscal year:

Footnote 26 of House Bill 10-1376:

It is the intent of the General Assembly that up to 5.0 percent of the total General Fund appropriation to line items in the Institutional Programs section and up to 5.0 percent of the General Fund appropriation to the Community Programs, Purchase of Contract Placements line item may be transferred to the Community Programs, Parole Program Services line item to provide treatment, transition, and wrap-around services to youth in the Division of Youth Correction's system in residential and non-residential settings and/or to the Community Programs, S.B.91-94 Programs line item to support community-based alternatives to secure detention placements.

The flexibility afforded by the footnote allowed DYC to more deliberately work to ensure that each youth received responsive and tailored services based on his or her criminogenic needs at each phase of involvement with DYC and in alignment with the first of DYC's Five Key Strategies – the "right service at the right time." The emphasis on risk-based assessment, individualized planning and targeted treatment that follows each youth across all phases of commitment is closely aligned with a well-established national research base, which demonstrates that investing resources in transition services that move youth purposefully from a residential setting into the community protects public safety and leads to better youth and family outcomes.

The Continuum of Care has evolved from an "initiative" or discrete strategy to a way of doing business across the Division of Youth Corrections.

A Structured, Division-Wide Improvement Process

Since its inception in FY 2005-06, the Continuum of Care has evolved from a budgetary demonstration initiative to a holistic approach to system improvement across the Division of Youth Corrections. Guided by the Continuum of Care Oversight Committee, made up of DYC leadership and representatives from across the operating divisions of the organization, an integrated set of six (6) sub-committees and work groups drives a continuous process to bring

operations in line with the elements of the Continuum of Care and Five Key Strategies introduced at the beginning of this section. The Continuum of Care sub-committees and quality improvement initiatives are described later in this report (see *Continuum of Care Quality Initiatives*, page 36).

As this evolution occurred, funding for transitional and non-residential services evolved from its origins as a flexible carve-out from the Purchase of Contract Placements line item. This was originally necessary because the budget line item for these services was eliminated. This fiscal year, DYC has an appropriation in the Long Bill (HB10-1376) specifically designated for parole program services, creating a more stable funding source to advance the work of the Continuum of Care. It is vital that this stable funding remain available as the Continuum of Care drives continual system improvements within DYC, such as more individualized, family-centered services that reduce criminogenic risk and lead to a more expedited, yet safer transition of youth back into the community.

An Effective Strategy: Supporting Transitions from Residential Placement to the Community

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), DYC has devoted considerable resources to more effective and efficient transitions between residential and community-based intervention strategies. After enhancing targeted treatment capacity in state-operated commitment programs in FY 2006-07 with the Sol Vista Youth Services Center, and adding 29 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 focused on building capacity to link youth to appropriate evidence-based community and family-based services.

In the Continuum of Care model, the process of community re-entry or transition is pro-active and comprehensive. It begins at the time of initial assessment and continues through residential placement and throughout the time of parole into the community. Successful transition is resource-intensive and requires collaboration across systems and a continuum of community services and supports (Altschuler & Armstrong, 1994). Key components of successful transition include the following:

- Prepare youth for progressively increased responsibility and freedom in the community.
- Facilitate youth-community interaction and involvement.
- Work with the youth and targeted community support systems, such as schools and family, on qualities needed for constructive interaction and the youth's successful community adjustment.
- Monitor and test the youth and community on their ability to deal with each other productively.

A Washington State study to determine the extent to which transition planning would predict lower levels of juvenile recidivism found that transition planning, including the provision of community services, is an essential component of community reintegration and is associated with lower rates of recidivism during the first year post-discharge (Trupin, Turner, Stewart, & Wood, 2004). Further, research examining strategies and programs in juvenile justice has determined that youth who received more extensive transition planning and support were less likely to re-offend and more likely to

experience community success (Aos, et al., 2004; Schmidt, & Salsbury 2009). While specific effects varied across programs, findings pointed to the importance of integrated treatment and transition models consistent with the strategies set forth in the Continuum of Care.

The Current Report

The original footnote was accompanied by a Request for Information (RFI, formally a footnote report), that asked DYC to report on the amount of funds expended, the number of youth served and the types of services purchased with these funds. The Continuum of Care began as an initiative developed to respond to the opportunities for increased flexibility allowed by the original footnote. The initiative centered on a portion of funds that were flexibly deployed to meet the needs of youth during reentry to the community. As noted, this discrete initiative, and the flexible funds associated with it, has evolved to become a Division-wide strategy of providing a comprehensive continuum of services beginning at assessment and continuing through parole and discharge. With the changing and increasingly limiting fiscal environment, and with a newly designated line item, both the footnote and accompanying RFI have lost relevance. However, as part of its ongoing commitment to data-driven system improvement, DYC continues to submit an annual evaluation report that responds to the RFI and explores progress in meeting its overall system goals.

The FY 2009-10 Annual Report continues to examine the implementation and impacts of the Continuum of Care. Specifically, the report describes the integrated use of the Colorado Juvenile Risk Assessment (CJRA) in supporting targeted case planning, treatment and transitions, and how individual youth risk and needs information drives case planning and service delivery across the system. The report also uses CJRA data to describe the youth served by DYC in terms of their risk and protective factor profiles.

Reflecting DYC's mission to reduce the risk posed by youth to community safety, and to themselves, CJRA data is used to describe outcomes such as reductions in risk for youth served, as well as changes in pre-discharge recidivism, re-commitments, and lengths of service. Finally, the current report includes a discussion of conclusions and recommendations that are derived from the analyses of services, risk factors, and outcomes.

Data Sources

Data for this report comes from five primary sources:

1. **The DYC Provider Network Management Database,** developed and hosted by Savio (an independent, non-profit organization based in Denver), documents non-residential services purchased by DYC and bills providers on DYC's behalf. For each youth receiving services, the database tracks the amount of funds expended (costs), the types of services purchased, and the service provider for each youth served.

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

3. **DYC Risk Assessment Data -**The Colorado Juvenile Risk Assessment (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 better protect youth against existing risk). Please see Appendix A to review the contents of the full CJRA.

4. **DYC's Research and Evaluation Unit provided recidivism data** for each youth served. For youth committed during FY 2009-10, only pre-discharge recidivism data was available. Pre-discharge recidivism is defined by DYC 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 DYC as a filing for a new offense occurring in the 12 months after discharge. This information was not available for youth committed during FY 2009-10 because the necessary 12 months (plus additional time for records to be entered and analyzed) has not yet elapsed.

5. The **Judicial Branch's Management Information System** is examined by the DYC Research and Evaluation unit to determine whether a new offense (recidivist act) has occurred prior to discharge. Only those filings (felony and misdemeanor) entered into the Judicial data system are included in these recidivism measures. Traffic, municipal, status, and petty offenses are excluded from this recidivism evaluation.

   At DYC's request, the Colorado Judicial Department prepared a data file containing all filings that occurred within the fiscal year for all persons under 25 years of age. The DYC Research and Evaluation unit uses this file (carefully matched using a multi-step process to create a variable

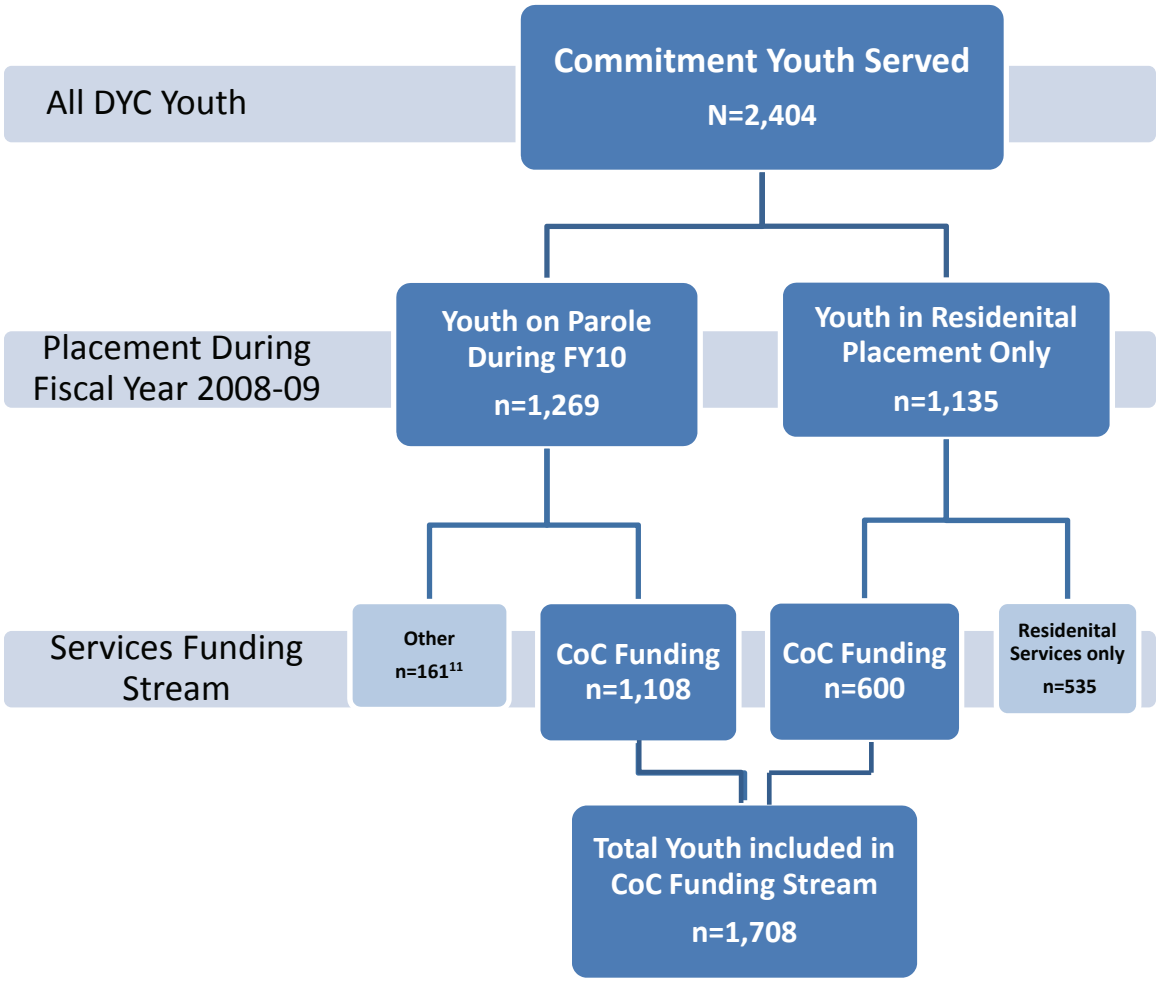
indicating whether or not a youth recidivated prior to DYC discharge) and sends that variable (matched to youth Trails ID number) to TriWest to be included in analysis files. For more detail on the methodology for calculating recidivism, please refer to the Annual DYC recidivism report (available at http://www.cdhs.state.co.us/dyc/Research.htm

Describing Youth in the Continuum of Care

Youth Movement through the Continuum of Care

The Continuum of Care begins with initial commitment and continues throughout residential and community placement, including time on parole. Youth follow different paths through the Continuum, according to individual needs and circumstances. As a result, not all committed youth served during this fiscal year received direct transition services funded by the parole program services line item tracked by the DYC Provider Network Management Database. Some youth received residential services only and were too early in their residential placement to be ready for transition services. Others received non-residential services through other case management and funding streams. The figure below illustrates the distribution of committed youth across different funding and placement types.

Figure 2: FY 2009-10 Committed Youth



A total of 2,404 committed youth were served during FY 2009-10. Of these youth, 1,269 were served on parole status at some point during the year, while the remaining 1,135 were in residential placement during the entire fiscal year. As seen in Figure 2, the vast majority of parole youth (87%, n=1,108) received transition and non-residential services paid through the parole program line item, and were tracked through the Savio database. Thirteen (13) percent of paroled youth did not receive services paid for during this fiscal year. However, most of those youth (80%) received non-residential services in the prior fiscal year (FY 2008-09)[16]. The remaining 33 "other" youth did not receive services because their clinical assessment demonstrated no clinical indication of need.

Many committed youth who remained in residential placement during FY 2009-10 also received transition services (n=600). As mentioned previously, this practice lays the foundation for optimally supporting youth as they move from residential placement into the community (by starting transition services well before a youth leaves residential placement) and is vital to managing reintegration as well as to achieving successful community dispositions. Often, whether or not a youth receives transition services during residential placement is dependent upon how close a youth is to his/her parole date.

There were another eight (8) youth[17] not committed to the Division of Youth Corrections that were identified in the DYC Provider Network Management Database as receiving some services through the parole program services stream. Some of these youth were being supervised in Colorado through the Interstate Compact on Juveniles (ICJ) and were not officially committed to DYC, but DYC provided services based on an agreement among the states to assist in supervising paroled youth moving from another jurisdiction. A total of 1,708 committed youth received direct services recorded in the Savio database. 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 are no significant demographic differences between youth receiving transition and non-residential services and those only in residential placement or who received other support.

[16] 128 paroled youth who did not receive services during FY 2009-2010 did receive services during FY 2008-2009.
[17] These youth are not reflected in the graphic, or in any of the total youth served tables.

Table 1: FY 2009-10 Demographic Distribution of Committed Youth		
	Transition & Non-Residential Services	
	Number	**Percent**
Gender		
Female	241	14.1%
Male	1,467	85.9%
Total	**1,708**	**100%**
Race/Ethnicity		
American Indian/Alaskan Native	35	2.0%
Asian	13	0.8%
Black or African American	317	18.6%
Hispanic	602	35.3%
Native Hawaiian/Pacific Islander	2	0.1%
White	734	43.0%
Unable to Determine	5	0.3%
Total	**1,708**	**100%**
Average Age at Commitment	16.6 years	

Commitment Offenses, Re-Offending and Need for Services

Over a fourth of youth committed to DYC carry mandatory minimum sentences.

Initial commitment types have remained relatively stable over the past several years. Table 2 on the following page demonstrates that the distribution of the types of commitment for fiscal year 2009-10 is almost identical to last fiscal year. As DYC continues to examine the average length of service for youths' total commitment period and for residential placement, it is important to note that more than a quarter of the commitment population continues to be committed under sentence types that carry a mandatory minimum duration, adding to the challenge of reducing lengths of service through case planning and targeted intervention.

Table 2: Original Commitment and Offense Type for Youth Served				
	FY 2008-09		FY 2009-10	
	Number	Percent	Number	Percent
Original Commitment Type				
Non-Mandatory	1,776	70.8%	1,688	70.2%
Mandatory	546	21.8%	526	21.9%
Repeat	145	5.8%	135	5.6%
Violent	10	0.4%	18	0.7%
Aggravated	32	1.3%	37	1.5%
Total[18]	**2,509**	**100%**	**2,404**	**100%**
Original Commitment Charge				
Felony	1,527	63.9%	1,469	63.7%
Misdemeanor	861	36.1%	838	36.3%
Total[19]	**2,388**	**100%**	**2,307**	**100%**

Assessing Youth Risk and Needs

DYC assesses each youth for criminogenic risks and needs using the Colorado Juvenile Risk Assessment (CJRA). This assessment helps client managers identify the specific areas in a youth's life that directly contribute to his or her delinquent behavior and target treatment plans to mitigate the risks and enhance protective factors to reduce the youth's overall likelihood for re-offending.

The use of a comprehensive, empirically validated risk assessment allows DYC to identify and respond to the factors directly contributing to youth offending behavior. Anchored by the Colorado Juvenile Risk Assessment (CJRA), each youth's Clinical Evaluation Report, created by the DYC Assessment Services team to summarize results, integrates findings from five assessment disciplines. The report offers targeted treatment recommendations encompassing: 1) overall criminogenic factors, 2) alcohol and drug use, 3) mental health, 4) medical and 5) educational needs. Assessment Specialists, working collaboratively with community partners, create a comprehensive, individualized and interdisciplinary assessment plan for all newly committed juvenile offenders. Implementation of the CJRA throughout DYC is a cornerstone of the Continuum of Care. Since 2006, DYC has continued to enhance procedures to ensure that all committed youth have CJRAs completed at specified points in time along the

[18] Data for original commitment type was missing for four committed youth.
[19] Data for original charge type was missing for 122 committed youth in FY 2008-09 and 94 youth in FY 2009-10.

commitment continuum. These assessments help to improve the decision-making process throughout a youth's commitment, from initial residential placement to parole.

Increasing Severity and Complexity of Risk for Re-offending

Based on original assessment validation studies in Washington State, each domain of the CJRA has three ranges of scores: low risk (the bottom lower 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 Table 3 below, more than half of committed youth fall into the highest third of possible scores in the domains of criminal history, relationships, family, substance abuse, attitudes, aggression, and skills.

Table 3: Distribution of Initial Scores Across All Committed Youth FY 2009-10

CJRA Domain	N	Level of Relative Risk[20]		
		Low Risk	Moderate Risk	High Risk
Criminal History	2,404	4.7%	15.6%	79.7%
School	2,404	49.0%	22.0%	29.0%
Relationships	2,404	1.4%	16.0%	82.6%
Family	2,404	15.5%	19.0%	65.5%
Substance Abuse	2,404	31.5%	11.2%	57.2%
Mental Health	2,404	58.7%	24.9%	16.4%
Attitudes and Behavior	2,404	1.4%	5.6%	93.0%
Aggression	2,404	3.6%	17.9%	78.4%
Skills	2,404	7.9%	9.5%	82.7%

Further, as shown below, there is a trend toward increasing proportions of youth falling into the highest risk range on many of the CJRA dynamic risk domains. This emerging pattern of more severe and complex needs of committed youth will further challenge resources across the Continuum of Care.

Criminogenic risk assessment highlights a trend toward increasing complexity and severity in the pattern of risks and needs presented by youth committed to DYC.

Nearly two-thirds of youth (65%) scored in the high risk range in five or more of the domains, with the average youth scoring in the high range in four of the nine domains that yield risk scores[21]. This is further evidence of the trend toward increasingly complex needs among the youth and families being served and underscores the importance of flexibility and responsiveness as DYC deploys resources to meet these needs. The positive outcomes achieved through the Continuum of Care are particularly noteworthy in light of this trend.

[20] Percentages in this table may not add to 100% due to rounding.
[21] Employment and Use of Free Time domains have only static protective factor scores, no risk scores.

Complex and elevated patterns on the CJRA are consistent with findings from the DYC Assessment Services. For example, a recent survey of DYC youth indicates that approximately one-third of committed youth exhibit one or more risk factors for traumatic brain injury related to substance use, prenatal exposure or trauma. Similarly, just over 33% of youth seen by DYC's Assessment Services received a neuropsychological consultation, evaluation or referral.

Anecdotal reports related to the challenges of successfully treating and transitioning youth with complex mental health, social and even neurological challenges are supported by research noting that youth with such problems require a large amount of treatment and support in order to successfully transition back into the community and avoid recidivism (e.g., Trupin et al, 2004).

Table 4 on the following page illustrates the complex interplay among psychosocial risk factors and criminal history for youth entering DYC care. While the proportion of committed youth scoring in the highest range of risk for criminal behavior and history has remained relatively constant over the past four years at around 80%, the accompanying risks related to mental health (most markedly) and substance use have increased significantly since FY 2006-07 and FY 2007-08. This pattern presents a challenge to DYC and the Continuum of Care. Increasingly elevated psychosocial risks, in the context of stable risks related to criminal behavior, suggests a committed population requiring greater treatment and support in order to achieve successful outcomes. This suggestion is supported when considering that the CJRA dynamic risk scores were predictive of recidivism. Those youth who did commit a new offense prior to discharge had significantly higher average scores on each CJRA domain than those who did not commit a new offense prior to discharge. In the face of this challenging profile of youth, the recidivism data presented later in this report is especially noteworthy.

The pattern of increasingly elevated psychosocial risks, in the context of stable risks related to criminal behavior, suggests a committed population requiring greater treatment and support in order to achieve successful outcomes.

Table 4: Relative Risk by Domain, Four-Year Trends
Note: ↑ indicates a higher risk over FY 2006-07

CJRA Domain	Proportion of Youth Scoring in the Highest Risk Range				
	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	
	N=890	N=1,506	N=2,158[22]	N=2,404	
Criminal History	83.0%	80.4%	76.4%	79.7%	
School	23.0%	26.6%	29.7%	29.0%	↑
Relationships	77.2%	79.6%	83.8%	82.6%	↑
Family	56.1%	66.9%	64.8%	65.5%	↑
Substance Abuse	45.9%	57.4%	59.1%	57.2%	↑
Mental Health	8.3%	12.6%	16.5%	16.4%	↑
Attitudes	87.6%	89.6%	93.1%	93.0%	↑
Aggression	82.4%	76.9%	80.5%	78.4%	
Skills	84.5%	80.5%	80.4%	82.7%	

[22] In previous years, not all committed youth had a completed initial CJRA assessment; therefore, these numbers may not reflect all youth served in previous fiscal years.

Effectiveness of the Continuum of Care

The Continuum of Care is built on a foundation of evidence demonstrating that assessment and individualized case planning that addresses every phase of a youth's commitment and targets the primary causes of the youth's delinquency will yield the best possible outcomes for youth and families (Nelson, 2000).

Reducing the Risk of Re-Offending

The CJRA process allows DYC staff to track changes in risk as a result of treatment and adjust case plans accordingly.

As discussed in the previous section, the CJRA process is designed not only to measure a youth's initial level of risk and need, but also to assess the mitigation of risk factors as the youth moves through the commitment Continuum of Care and into the community. Use of the CJRA enables DYC to examine changes in dynamic risk factors that are predicted by the theory of change underlying the Continuum of Care. Put simply, the underlying principles for the Continuum of Care 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.

Reductions in criminogenic risks achieved by interventions during residential placement were largely maintained as youth transitioned into the community.

In order to facilitate interpretation of the risk mitigation findings presented below, it is useful to revisit the Continuum of Care CJRA risk assessment process. Every youth entering DYC commitment undergoes an initial assessment as he or she enters care. This assessment supports case planning and serves as a benchmark as it reflects the youth's risk profile at the time he or she enters DYC. As such, this initial assessment is an indication of the risk that each youth posed in the community that is to be addressed through commitment and treatment in the Continuum of Care. The second assessment point depicted in the figures on the following pages represents the youth's risk profile as he or she leaves a restrictive residential placement for community parole. While in placement, the youth participates in intensive treatment and is maintained in a controlled, supportive living environment within a residential milieu. As the youth transitions to community parole, he or she once again is faced with an open environment (often the same community in which the youth originally offended) that is inherently more conducive to risk-related behavior and cognitions. Thus, the third assessment point depicted in the figures below illustrates the youth's dynamic risk levels on meaningful criminogenic domains at the time he or she discharges from DYC.

The figures on the following pages show significant decreases in dynamic risk scores across most domains from the time of the initial CJRA assessment to the time youth leave residential placement and enter parole. The reduction in risk across the three different points in time is impressive for at least three important reasons. First, the precipitous reduction in risk from initial assessment to parole **was clinically maintained** between parole and discharge from parole. This finding is more dramatic in

certain key domains, many of which are most highly correlated with recidivism and most influenced by environmental context. For example:

- In the **Family** domain, the average risk score dropped from over 10 at Initial Assessment to under 7 by parole and then dropped further to 5.5 between parole and discharge. The average risk score was nearly cut in half from assessment to discharge. As mentioned earlier, the Family domain was a particular focus of service enhancement in the past fiscal year, and this data suggest a significant impact of those efforts.

Dramatic reductions in risk related to family factors speak directly to the success of DYC's efforts to target this domain and enhance services in this area.

- In the **Aggression** domain, an average risk score of just under 5 was reduced to under 2. A score of less than 2 was maintained at discharge from parole.
- In the **Skills** domain, a score of over 7 was reduced to less than 1 from initial assessment to parole. An average score of less than 1 was maintained even at discharge.

The latter finding in the Skills domain is illustrative of the clinical reality revealed by the CJRA risk domain trends analyses, and points to two additional reasons that the reduction in risk scores was so impressive in FY 2009-2010. First, the findings in the Skills domain illustrate what is often called a "**floor effect**" in longitudinal and statistical analyses. That is, the reduction from parole to discharge was so great that there was very little room for improvement between parole and discharge. **Especially with a population of youth representing the highest level of criminogenic risk at intake, it is very difficult to decrease the risk between parole and discharge when the risk level already has decreased to an average of below one (1) on the scale. Clinically significant *maintenance* of that reduction in risk represents a powerful positive change and exceeds the results that might reasonably be expected based on the contextual challenges faced by these youth in their home communities.**

Although this point is perhaps most dramatically illustrated by the trend analysis of the **Skills** domain, other domains are informative as well. For example, in the **Substance Abuse** domain, an average score of over 8 at initial assessment was reduced to a negligible 0.6 at parole. By the time of discharge, after youth had spent time away from the supportive residential treatment environment, the average score increased to a little over 2. However, there is little chance that, in this population of offending youth, an average score of 0.6 could be further decreased between parole and discharge.

The discussion of trends in average scores for the **Substance Abuse** domain raises a third important reason that the findings of reduction in risk are so impressive: *maintenance of a clinically significant reduction in risk from initial assessment to discharge underscores how difficult it is **when youth move from a highly supportive and controlled environment to a largely uncontrolled environment.** Yet, that is exactly what the analysis of trends in CJRA data reveals.* In the case of the Substance Abuse domain, a clinically significant drop in average scores from initial assessment to parole was essentially maintained at discharge, despite the fact that youth have much more access to illicit substances and exposure to peers who use substances in the community. The decrease from an average score of over 8

(representing a "high" risk) to a score of just over 2 (representing a "low" risk) at discharge represents a very significant reduction in risk, whereas, the slight rise of less than 2 points from parole to discharge is of marginal clinical significance, and remains within the "low" risk level based on large scale validation studies. Again, this analysis suggests that the clinical services delivered between initial assessment and discharge led to a very large and clinically meaningful reduction in risk.

At the time of discharge from DYC commitment, youth exhibit marked decreases in criminogenic risk factors.

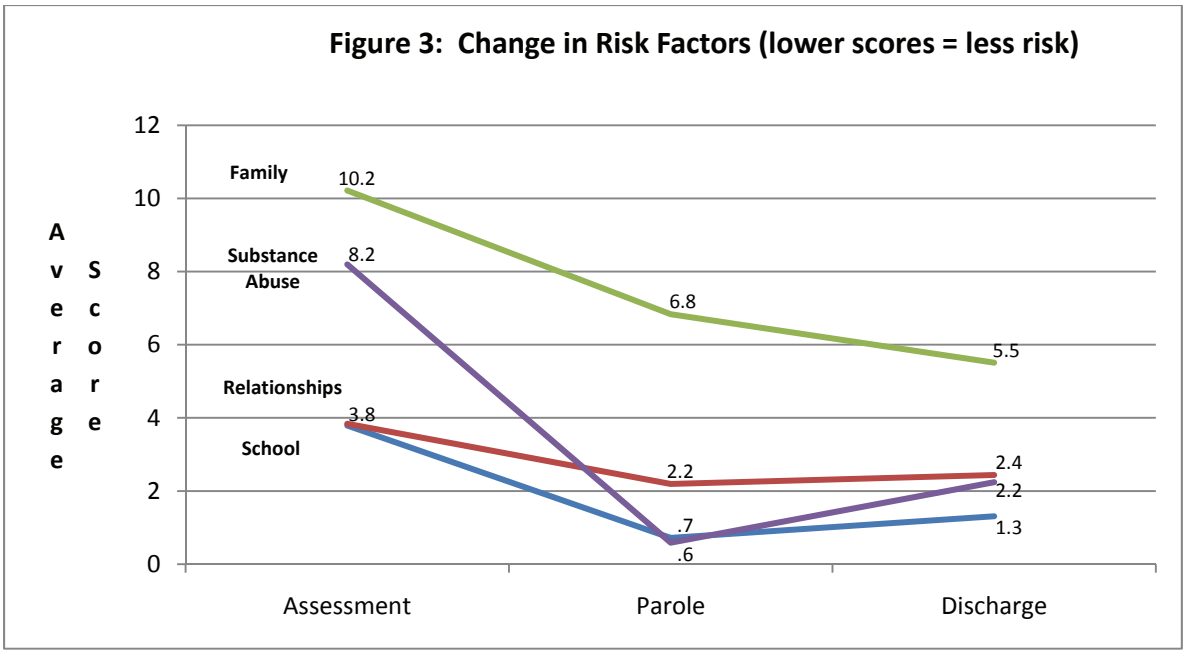
The trend in the **Attitudes and Behavior** domain is very similar to the trend in the Substance Abuse domain. A score of 8 was dramatically lowered to a score of 3 between initial assessment and parole. Between parole and discharge, the average score rises only slightly, and at a clinically insignificant rate. Again, the dramatic, clinically significant decrease that was seen between initial assessment and parole is maintained at discharge. These achievements in key domains (that are highly correlated with recidivism) underscore the capacity of the Continuum of Care system to keep risk levels low, even when youth are placed in much less controlled environments.

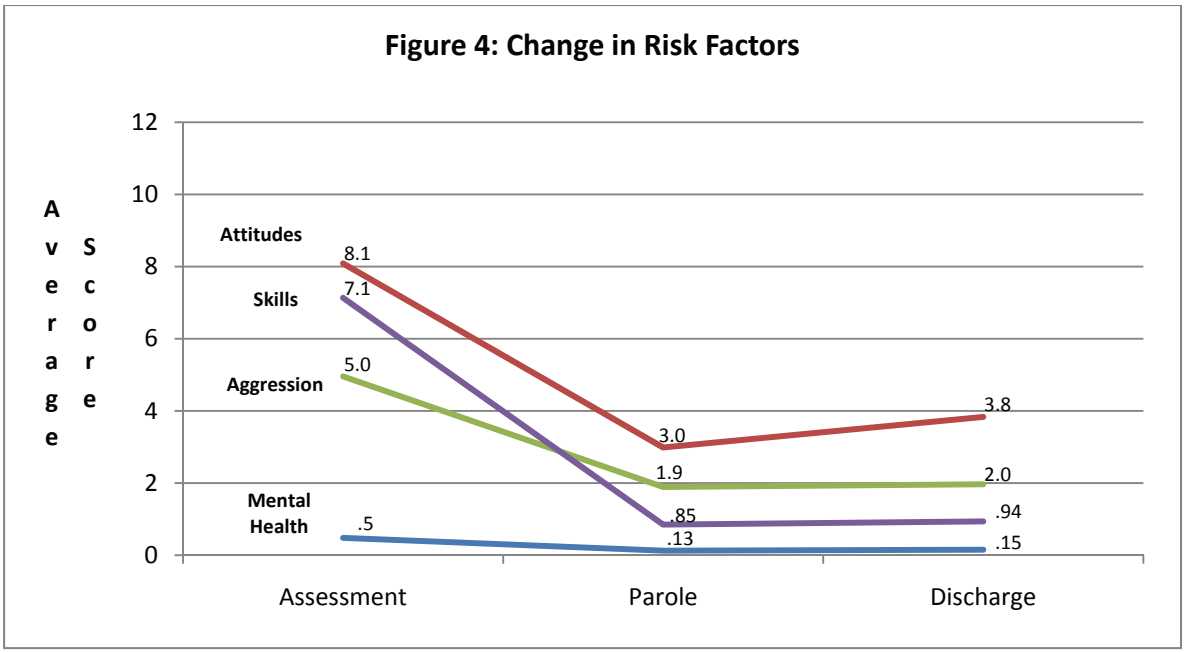
The pattern of changes between initial assessment, parole and discharge support the structure and "theory of change" underlying the Continuum of Care.

In order to respond to public safety concerns, the clinically significant reduction in risk from initial assessment to discharge must be demonstrated if the Continuum of Care is to be justified. This is what the data shows. At the same time, being able to effectuate and maintain a clinically significant reduction in risk is also important because maintaining youth in the community, versus highly restrictive settings, keeps costs down. Further, it ensures a better developmental trajectory for youth (e.g., it reduces their risk of ending up in the adult correctional system). Thus, **from both a financial and a humanitarian perspective, and from both a near-term and a longer-term perspective, the findings on CJRA risk reduction trends are highly encouraging.**

Thus, taken as a whole, Figures 3 through 6[23] on the following pages offer strong support for the effectiveness of the Continuum of Care strategies. Put simply, youth enter commitment with elevated risk factors across a wide range of domains proven to predict re-offending. Moreover, youth tend to enter commitment with relatively low levels of protective factors known to buffer the impact of risk and help youth resist the influence of risk factors in the environment. The data presented in these figures suggests that the treatment offered during commitment is effective in bringing about dramatic reductions in the criminogenic risk factors known to predict re-offending. Following transition from restrictive residential placement to community parole, gains (reductions in risk and increases in protective factors) are largely maintained. This supports the Continuum of Care process and theory of change that is based on providing intensive services tailored to each youth derived from assessment data, and supporting successful transitions and generalization of treatment gains to the community through services that bridge residential and community placement.

[23] Please note that analyses are presented across multiple graphs simply to facilitate interpretation by avoiding the appearance of a jumble of intersecting lines.

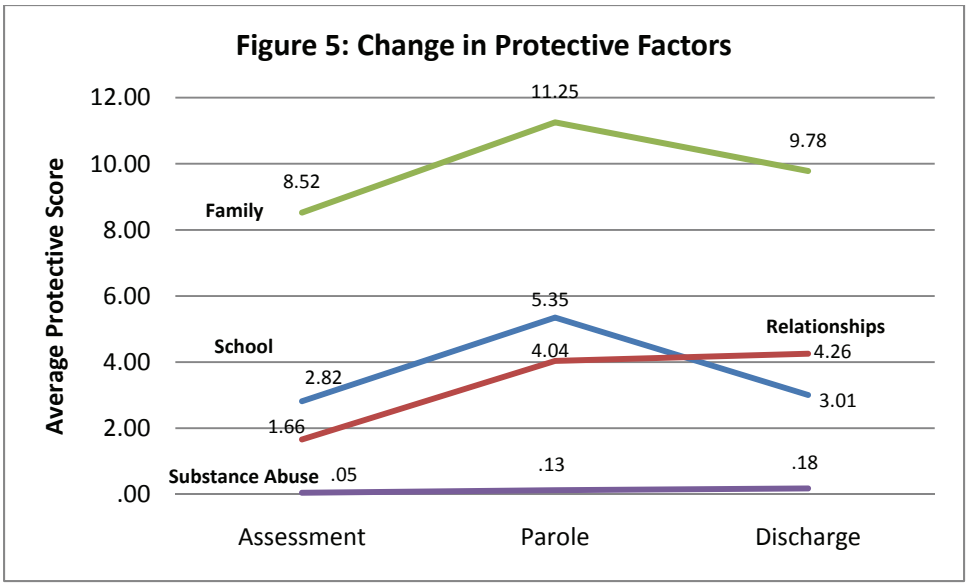


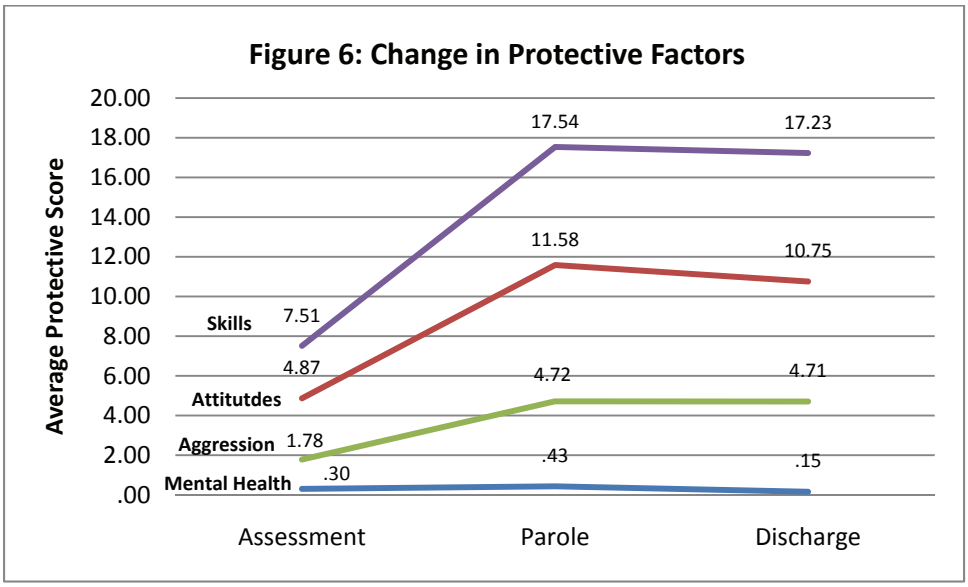


While Figures 3 and 4, above, depict changes in dynamic (changeable) risk factors from initial assessment through parole and discharge, the following two figures[24] present corresponding changes in dynamic protective factors for youth committed to DYC. The research literature (e.g., Barnoski, 2004) consistently demonstrates that, while risk factors strongly predict recidivism, the relationship between protective factors and recidivism is less clear. While there is some evidence that the presence of

[24] Again, please note that analyses are presented across multiple graphs simply to facilitate interpretation by avoiding the appearance of a jumble of intersecting lines.

protective factors may buffer youth from exposure to risk factors, the relationship is neither simple nor linear. However, the pattern of change across the three assessment time points mirrors the pattern seen for risk factors and offers support for the effectiveness of the treatment strategies employed through the Continuum of Care: youth experience marked gains in protective factors while participating in intense intervention in a closed milieu, and these gains are largely sustained when youth transition to parole and back to the community.





Pre-Discharge Recidivism and Recommitment Rates

Pre-discharge recidivism was lower during FY 2009-2010, in comparison to the baseline year prior to Continuum of Care implementation, just as it has been ever since the Continuum of Care was implemented in 2005-2006 (See Table 5, below).

Table 5: Pre-Discharge Recidivism Rates

Pre-Discharge Recidivism	Fiscal Year						
	2004-05	CoC Implemented	2005-06	2006-07	2007-08	2008-09	2009-10[25]
Yes	39.1%		38.5%	33.5%	35.8%	37.9%	34.6%
No	60.9%		61.5%	66.5%	64.2%	62.1%	65.4%

Pre-discharge recidivism rates have fluctuated only slightly over the last five fiscal years. In order to better understand these rates, it is useful to explore the construct of recidivism and how it is measured.

What is recidivism? Recidivism is the repetition of criminal behavior. However, a recidivism rate may reflect any number of possible measures of repeated offending – arrest, court referral, conviction, correctional commitment, and correctional status changes within a given period of time. Typically, the only available statistical indicators of criminal behavior are official records of these system events. In this report, pre-discharge recidivism is defined and reported as a filing for a new felony or misdemeanor offense that occurred prior to discharge (while the youth is under DYC supervision) from the Division of Youth Corrections.

Tables 6 and 7 show that rates of recommitment have declined in the past three years, compared to the years directly before and after the implementation of the Continuum of Care. This trend points to the ability of 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.

[25] Recidivism data for FY 2009-10 is preliminary at this time. Based on past recidivism analyses, it is anticipated that these numbers will increase slightly as more time for charges to be formally filed in court is allowed.

Table 6: Recommitment Rates							
Recommitment	Fiscal Year						
	2004-05	CoC Implemented	2005-06	2006-07	2007-08	2008-09	2009-10
Yes	24.8%		25.6%	22.9%	21.9%	22.3%	21.2%
No	75.0%		74.4%	77.1%	78.1%	77.7%	78.8%

The table above shows the rates of recommitment for youth across the past six fiscal years. These numbers represent all recommitments for youth who were served in FY 2009-10, even if the recommitment occurred in a past fiscal year. The table below shows recommitments just occurring within the fiscal year. This table is more illustrative of the reductions in recommitments that have been achieved.

Table 7: Annual Number and Proportion of Recommitments							
Recommitment	Fiscal Year						
	2004-05	CoC Imple-mented	2005-06	2006-07	2007-08	2008-09	2009-10
Number Recommitted	277		283	256	205	213	157
Percent of Youth Served	9.3%		8.8%	8.1%	7.6%	8.5%	6.5%

As shown in Tables 6 and 7 above, both the proportion and overall number of recommitments have dropped this fiscal year, which could contribute to the lower average daily population (ADP) reported previously. Over the past three years, the number of recommitments has declined 63 percent. Overall, the data reveals an impressive, steady decline in the number of recommitments since the Continuum of Care implementation began.

Putting the numbers in context – In order to understand the recidivism rates experienced in Colorado, as indicated by recommitments, the reader may ask, "How does this compare to other states?" Unfortunately it is difficult to find an "apples to apples" comparison across states with diverse juvenile justice systems and indicators of recidivism. However, the following data provides a reasonable overview of state experiences and a useful comparison for Colorado's recidivism (recommitment) rates of 20% (2009-10) to 25% (2006-07) experienced over the past four years.

- States that measure recidivism using re-arrest (Florida, New York, Virginia) average 55% recidivism.

- States that measure recidivism using referrals to court (Maryland) report 45% recidivism.
- States that measure recidivism based on reconviction (Alaska, Florida, Georgia, Kentucky, Maryland, North Dakota, Oklahoma, Virginia) average 33% recidivism.
- States that measure recidivism using recommitment / re-incarceration (Arizona, Ohio, Texas) average 25% recidivism.

The latter statistic, from a group of states most similar to Colorado in the way they define recidivism, suggests that Colorado is "in the ballpark" with other states. However, the fact that recidivism has declined steadily in recent years, and dipped below the average rate of recidivism from similar states, indicates that Colorado's rates may have the potential to set a benchmark for other states.

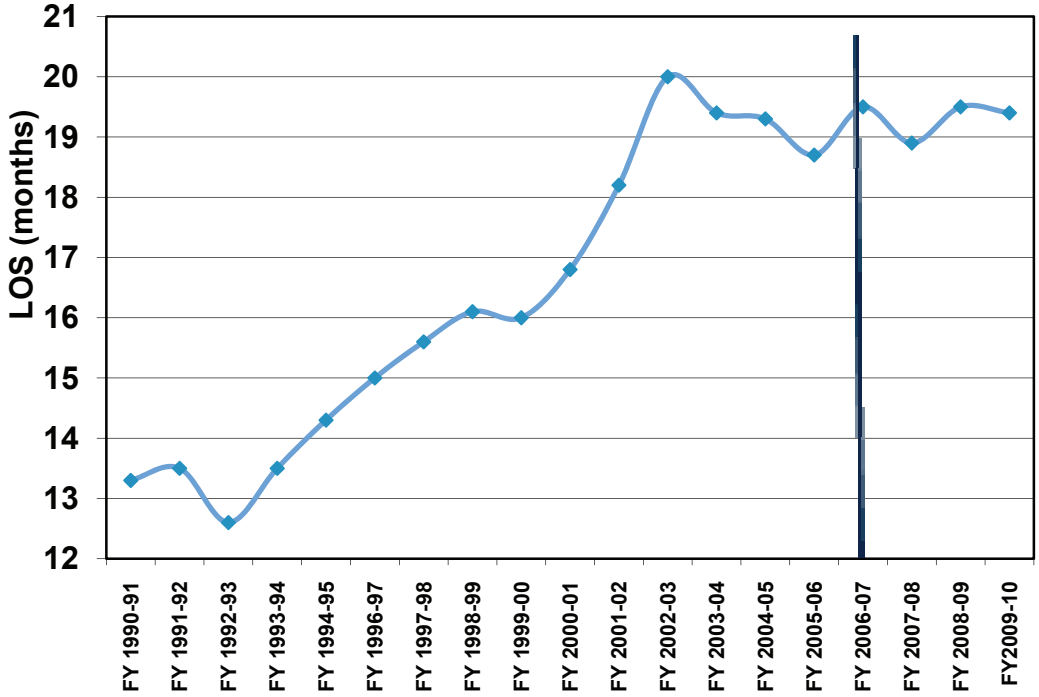
As the Continuum of Care concept has evolved during the past five years, DYC has significantly focused its efforts on delivering high quality, targeted services matched to each youth's criminogenic risk factors. These efforts are reflected in significant, meaningful and sustained reductions in the risk of re-offending. Further, reductions in both the number and the rate of recommitments indicates that matching services to risk and need, and supporting youth during their transitions back into the community, are having a positive effect.

Sustained rates of recidivism and LOS have not seen the same positive impacts. However, as discussed earlier, over the five-year implementation of the Continuum of Care, youth problems have become increasingly severe, and yet there has not been a corresponding increase in recidivism or LOS. Over time, continued system improvements, in conjunction with a greater understanding of the underlying complexities associated with residential LOS and recidivism rates, will likely assist DYC in improving these outcomes.

The Continuum of Care strategies of using assessment to match services to risk and need, and supporting youth transitions back to the community, appear to be having the desired effect as Colorado boasts a relatively low recidivism rate in comparison to other states.

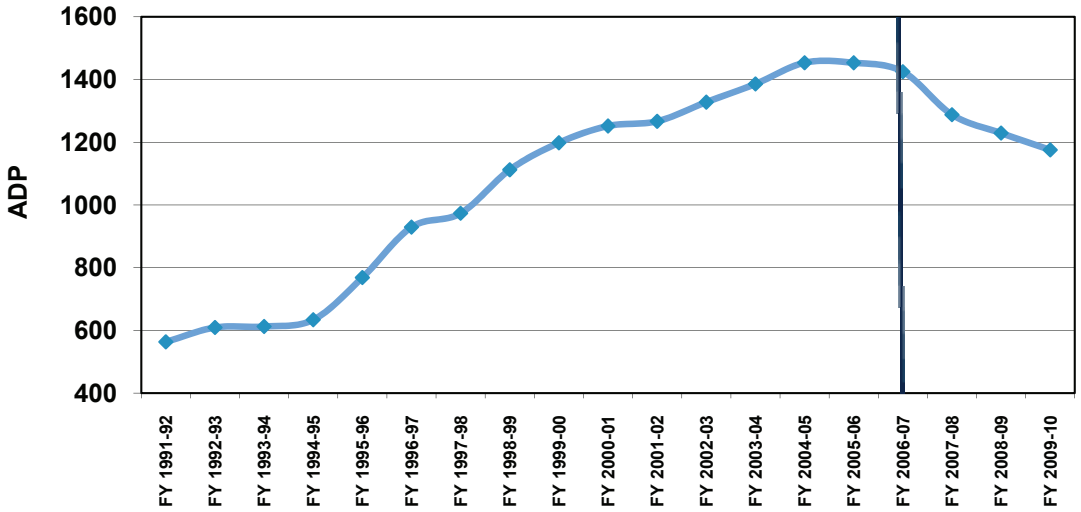
The Continuum of Care has sought to support the transition of youth from residential placement into the community while maintaining public safety and maximizing youths' chance of success. While Continuum of Care efforts have not yet demonstrated clear reductions in residential LOS, they appear to have stabilized a trend of dramatic increases in LOS over the past decade. In the face of clear increases in the severity of criminogenic risk factors in youth served, as documented through the CJRA and observed by DYC (specifically in increases of youth with mental health and/or substance abuse needs), Continuum of Care efforts seem to have met the need and averted a continuous rise in LOS.

Figure 7: Trends in LOS



Since DYC began its Continuum of Care efforts, the average daily population (ADP) of youth in commitment has declined, as shown in the figure below. The vertical line marks the beginning of the Continuum of Care.

Figure 8: Trends in ADP



The observed decline in ADP reflects a complex interplay of DYC efforts, local practices and a decrease in the overall rate of new commitments. While DYC's engagement in the SB94 program and participation in statewide HB1451 may ameliorate the number of new commitments by helping to provide communities with the resources to improve services to youth before further penetration of the juvenile justice system, the over-arching trends are too interwoven to attribute reductions to any single effort or policy.

Table 8: Trends in Commitment LOS

Length of service (in days)	Fiscal Year							
	2003-04	2004-05	Continuum of Care Implemented	2005-06	2006-07	2007-08	2008-09	2009-10
Parole LOS	8.0	7.1		6.4	6.8	6.7	6.6	6.7
Residential LOS	18.9	18.8		18.2	19.0	18.5	19.0	18.9
Total Commitment LOS	26.9	26.0		25.1	25.9	25.2	24.5	25.8

Residential length of service (or length of stay as more commonly referred to in the literature) poses great complexity to researchers, policy makers and administrators. While there is a growing belief and emerging body of literature suggesting that long out-of-community placements can be counter-productive and even harmful as youth are disconnected from family, school and community, the research base is inconclusive. However, a recent study (Winoker, et al., 2008) conducted in Florida with a sample of 16,779 juveniles released from commitment programs to the community or aftercare found no relationship between length of confinement and recidivism. Based on these findings, the authors point to the need for further research but suggest that juvenile justice systems work towards reducing lengths of service. This conclusion is in keeping with the best practice literature and with common sense; if longer LOS does not predict better outcomes, youth are better served by moving them as quickly as possible from restrictive placement back to their communities.

Transition and Non-Residential Services Expenditures

The transitional and non-residential services that are provided as part of the Continuum of Care are funded through two appropriations. The 2009 Long Bill (SB09-259) line item 11(C): Community Programs: Parole Program Services provides funding to assist in successful transition from commitment to parole. Services provided in this appropriation may include Wraparound services, Tracking, Day Treatment, and other Community-Based services. The second appropriation capturing Continuum of Care expenses is the 2009 Long Bill (SB09-259) line item 11(B): Institutional Programs Personal Services. This appropriation captures salaries and personal services costs for program, supervisory and support staff at DYC institutions, including those costs that are related to delivering transition services in the Continuum of Care.

The total FY 2009-10 appropriation for Parole Program Services is $5,983,518. Of this, $5,880,540.87 was spent directly on parole and transition services for the youth DYC serves. A minimal amount of expense ($15,558.95) was over-accrued as an expense in the appropriation and was reverted back to the general fund in FY 2010-11.

Table 9 on the following page shows the breakdown of spending in the Parole Programs appropriation.

Table 9: FY 2009-10 Expenditures	
Expenditure Description	**Amount**
Direct services paid through Savio Parole Program Services line item (480)	$5,334,249.17
Other direct services not paid through Savio	$3,879.74
Child placement agencies[26]	$103,157.28
Behavioral health concepts[27]	$439,254.68
Authorizations (payables) not expended	$15,558.95
Total	**$5,896,099.82**
Funds not expended	$87,418.18
Total Appropriation	**$5,983,518.00**
ARRA credits	$199,839.82
Funds not expended	$87,418.18
Total FY 2009-10 funds reverted to General Fund	$287,258.00

This year, the Division received credits in this appropriation to record an increase in FMAP[28]. This was an American Recovery and Reinvestment Act (ARRA) provision. The increase was 6.2% and equated to credits in the amount of $199,839.82. Receiving these credits contributed to the Division reverting $287,258 in the appropriation at year-end.

In addition to the services paid through Savio that were provided through the Parole Program Services line item (480), expenses were incurred in the Institutional Personal Services (104) line item in the amount of $237,603.57. Of this total, $121,854.27 was spent on offense specific services for youth transitioning back into the community. The remaining $115,749.30 was spent on transition services specific to youth transitioning out of Lookout Mountain Youth Services Center.

[26] Child Placement Agencies provide foster care placements for youth in the community. These are community-based placements (homes) that support youth who may not have a viable family to return to.
[27] Behavioral Health Concepts refer to funds that support treatment services at the Treatment Program at Mount View – part of the residential component of the Continuum of Care.
[28] Medicaid is a joint federal-state program that finances health care for certain categories of low-income individuals, including children, families, persons with disabilities, and persons who are elderly. The federal government matches state spending for Medicaid services according to a formula based on each state's per capita income in relation to the national average per capita income. The rate at which states are reimbursed for Medicaid service expenditures is known as the FMAP, which may range from 50 percent to no more than 83 percent.

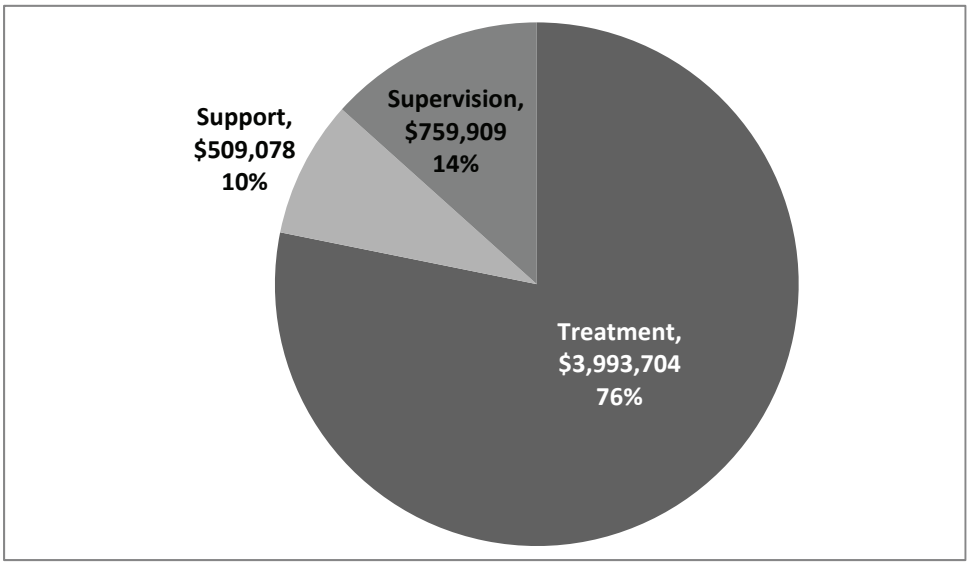
Table 10: FY 20009-10 Continuum of Care Expenditures Reported	
Expenditure Description	**Amount**
Direct services paid through Savio Parole Program Services line item (480)	$ 5,334,249
Direct services paid through Savio Institutional Personal Services line item (104)	$ 237,604
Total Services Paid Through Savio	**$ 5,571,853**
Description of Reported Expenditures	
Direct Expenditures Linked to Individual Youth	$ 5,262,691
Provider Network Management costs	$ 45,135
Savio Administrative Fees	$ 297,529
Total Expenditures Reported	**$ 5,605,355**
Difference	**+ $ 33,502**

The table above shows the expenditures extracted from the Savio database for this report, compared with the expenditures paid through Savio that cleared the Colorado Financial Reporting System (COFRS). The $33,502 difference between the cleared and reported amounts equals less than one percent (0.6%) of expenditures and is the result of data entry errors in the Savio database, either in the form of duplication of entries or the presence of some service authorizations not paid (because services were not utilized) that should have been deleted from the database but were not.

Table 11 on the following page shows expenditures by region. The Southern and Western regions accounted for a slightly larger percentage of Continuum of Care expenditures than their percentage of committed youth served. Although the Central and Northeast regions served more youth, their percentages of expenditures were somewhat lower. None of these differences, however, was statistically significant.

Table 11: FY 20009-10 Expenditures by Region			
Region	**Expenditures**	**Percent of Total**	**Percent of Overall Committed Youth**
Central	$2,177,015	41.4%	43.1%
Northeast	$1,051,359	20.0%	25.2%
Southern	$1,176,237	22.4%	20.4%
Western	$858,080	16.3%	11.3%
Total	**$5,262,691**	**100%**	**100%**

Figure 9: FY 2009-10 Continuum of Care Expenditures by General Category Direct Service Dollars Associated with Individual Youth



The vast majority (76%) of expenditures was dedicated to treatment and treatment-related services (see below for details on treatment expenditures). This percentage was consistent across each of the management regions. Another 10 percent of expenditures were for support-related services that help to provide youth with tangible goods and services (e.g., clothing, transportation and housing) needed to establish independent living. The remaining 14 percent went to the purchase of surveillance-based supervision services, primarily electronic home monitoring (EHM) and substance use monitoring (urinalysis, etc.).

Expenditure breakdowns were slightly different from last fiscal year: 84% of last year's expenditures were dedicated to treatment services, compared with 78% this year. The proportion of expenditures dedicated to support services was unchanged at 10%, while the proportion spent on supervision more than doubled (6% last year vs. 14% spent this fiscal year).

When considering overall expenditures, as well as average expenditures across youth served, it is important to note that these funds encompass all non-residential and transition services, including those that may have been received during the time a youth was in residential placement. The bulk of this report only accounts for expenditures in the just completed (FY 2009-10) fiscal year. When examining all of the services provided to youth served during this fiscal year (including not only services paid during this fiscal year, but also including services from the last fiscal year), it is apparent that, in keeping with the Continuum of Care model, youth begin to receive transition services well before their parole period. For youth served in this fiscal year who were matched to services from the last two years, transition services began on average 4.5 months prior to a youth's actual parole date.

The importance of early transition (referred to as "backing services in"), where services that will be delivered while a youth is in the community are carefully planned and actually begin a few months prior to their release from residential placement, is a primary component of the Continuum of Care and is evidenced by the timing of services that allow youth to receive needed resources beyond the constraints of the Residential Services line item, or other budget rigors. Most importantly, these expenditures allow DYC to ensure continuity of care.

DYC's foundational strategy of providing individualized and targeted services to each youth means that there is no ideal average cost per youth over the course of commitment.

Table 12 (below) shows the distribution of the average expenditures per youth across DYC's four management regions. Averages are based on direct expenditures tied specifically to individual youth.

Table 12: FY 2009-10
Monthly Average Expenditures per Youth

Region	Youth Served	Average Expenditures
Central	674	$ 547
Northeast	341	$ 600
Southern	309	$ 521
Western	178	$ 515
Statewide	**1,502**	**$ 550**

Average monthly expenditures per youth were somewhat higher for the Northeast and Central regions than for the Southern and Western regions. However, the Southern and Western regions had longer

lengths of service, leading to overall higher costs per youth over the fiscal year.[29] While further study is necessary to draw any conclusions, this pattern of higher monthly expenditures and shorter lengths of service corresponds with evidence from other studies that targeted intensive services, while expensive in the short term, can bring about better outcomes sooner.

It is important to note that these are only averages across all youth. As mentioned previously, an overall average cost per youth does little to account for differences and patterns in service needs for individual youth, the amount and intensity of the services delivered, and the associated costs. Youth with greater and more complex needs are likely to drive both longer length of service and higher expenditures on more intensive services.

Treatment Expenditures

The total of $3,993,704 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 (44.1%) was spent on community transition service packages. These "packaged services" contain a combination of treatment (generally skill building), supervision, support (via resources/referrals) and advocacy for families and youth transitioning out of residential placement. These services are purchased as a package and generally cannot be broken into amounts based on individual service types. Packages are generally offered in a low/high or a low/medium/high level of intensity with corresponding differences in the types, amounts, frequencies, and durations, and costs of services.

Job and skills training represented 14.9 percent of treatment expenditures. The expenditures were used for vocational or life skills training (often including social skill building). Another 12.6 percent of services were expended on family treatment programs; either evidence-based family therapy programs (specifically FFT and MST), or other family preservation and training services.

Bundled, or packaged, services decrease DYC's capacity to ensure that youth receive targeted care matched to their criminogenic risk and protective factors.

Treatment expenditures for Independent Living Skills programs (6.9%) primarily targeted the provision of skill training in general life skills and social skills to youth who are either emancipating legally or who will otherwise be living on their own when they return to the community. Experiential therapy and traditional individual therapy each made up approximately five (5) percent of expenditures. Experiential therapy programs are those that include artistic expression, recreation or animal assisted therapy in their treatment models.

[29] F=8.35; p<.000

Offense-based treatment (for youth committed for a sexually-based offense) made up 3.8 percent of expenditures. This expenditure almost exclusively represents offenders convicted of an offense featuring sexually abusive behavior. However, there are some domestic violence offenders included in this category.

Advocacy and Case Management made up two (2) percent of all treatment expenditures. This includes treatment program-specific case management (including providing DYC client managers with case notes and summary reports) as well as general advocacy work to help link family and children to community resources.

The remaining expenditures were spread among six different services types, each of which represented less than two (2) percent of expenditures: Specialized Assessment and Evaluations (offender specific, neurological, substance abuse, etc.), Evidence-Based Treatment (based on cognitive-behavioral treatment models), Day Treatment, Substance Abuse, and Group Therapy.

Table 13 shows the distribution of treatment expenditures.

Table 13: FY 2009-10 Treatment Expenditures by Type of Service

Service Type	Expenditures	Percent of Total
Community Transition	$ 1,760,724	44.1%
Job/Skills Training	$ 593,082	14.9%
Family Services	$ 294,707	7.4%
Independent Living	$ 274,368	6.9%
Family Therapy (FFT & MST)	$ 207,499	5.2%
Experiential Therapy	$ 196,743	4.9%
Individual therapy	$ 173,915	4.4%
Offense Specific Treatment	$ 150,036	3.8%
Advocacy and Case Management	$ 80,241	2.0%
Restorative Justice	$ 73,541	1.8%
Specialized Assessment and Evaluation	$ 55,203	1.4%
Evidence-based Behavior Training	$ 43,250	1.1%
Day Treatment	$ 42,783	1.1%
Substance Abuse Treatment	$ 43,404	1.1%
Group therapy	$ 4,208	0.1%
Total	**$ 3,993,704**	**100%**

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 14: FY 2009-10 Support Expenditures by Type of Service

Service Type	Expenditures	Percent of Total
General Living Expenses	$ 134,108	26.3%
Professional Services	$ 125,463	24.6%
Education	$ 96,211	18.9%
Transportation	$ 76,746	15.1%
Pro-social Engagement	$ 46,782	9.2%
Cultural & Communication Support	$ 15,739	3.1%
Medical	$ 14,018	2.8%
Total	**$ 509,078**	**100.0%**

More than one-quarter (26.3%) of support-related expenditures were dedicated to assisting youth in transition with general living expenses. 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). This service type also includes help in securing identification (e.g. birth certificates) needed to pursue employment in the community.

Another quarter of support dollars (24.6%) were used for professional services, which include testimony, staffing, administrative support costs, hourly consultation fees, presentations at parole board, and other related activities. This includes mileage reimbursements for treatment staff to attend meetings, etc. Fifteen (15) percent of support expenditures were used for transportation needs of youth and families, primarily for youth to attend employment interviews, and transportation to work and school.

A signification portion of funds was used to assist youth with ongoing educational expenses (18.9%). This included tuition payments, the purchase of books and other educational supplies, and GED or other testing fees. Funds that were used to engage youth in pro-social activities in the community made up nine (9) percent of expenditures. The remaining expenditures were divided among cultural communication and support (primarily translation services) and medical expenditures, generally used to purchase medications for youth.

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 15: FY 2009-10 Supervision Expenditures by Type of Service		
Service Type	**Expenditures**	**Percent of Total**
Tracking and Day Reporting	$ 672,157	88.5%
Electronic Home Monitoring (EHM)	$ 50,018	6.6%
Substance use Screening (monitoring)	$ 37,734	5.0%
Total	**$ 759,909**	**100.0%**

Most (88.5%) of all supervision expenditures were spent for tracking and day reporting services for youth. Tracking 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. This category also includes the monitoring of sex offenders through the use of polygraphs, etc.

The remaining expenditures included electronic home monitoring (6.6%) and substance abuse screening (5.0%), generally in the form of urine analysis for illegal substances.

Continuum of Care Quality Initiatives

The Leadership Team of the Division of Youth Corrections has established a well-specified structure of responsibility and leadership for the ongoing implementation of the Continuum of Care. Anchored by the Continuum of Care Implementation Oversight Committee, a group of DYC leaders and representatives of all phases of the Continuum, DYC has put in place a set of goals, objectives and action steps. While the Oversight Committee meets at least monthly to establish priorities and review progress, sub-committees work on an ongoing basis to implement local and statewide initiatives. These sub-committees and their focus are briefly presented below.

Continuum of Care Implementation Oversight Committee – This committee features representation from the major organizational areas, including Assessment staff, Clinical Staff, Client Management and Client Management Supervisors, Central Office Managers, and selected facility and research staff. The Oversight Committee works to:

- Create a common definition of the Continuum of Care
- Create and continually update a Continuum of Care Roadmap
- Create a 3-5 year strategic Continuum of Care Plan
- Develop and measure Continuum of Care Outcomes
- Create and implement a comprehensive quality assurance process
- Utilize a change management process
- Develop and implement a Communication Plan for the Oversight Committee for internal and external stakeholders

Evidence Based Practices (EBP) Committee – This committee was created in collaboration with the Division's Provider Council to support the implementation of research-proven methods that reduce recidivism and increase the likelihood that youth will be successful when they have completed their commitment or detention time. The committee develops standards and recommends policies for DYC's adoption of evidence-based practice. Over the past year, the committee has developed and begun implementation of an evaluation protocol to assess current practices in the state-operated, private provider, and Senate Bill 94 system to determine alignment of evidence-based principles, and recommends changes at the program and system level to enhance their ability to produce positive outcomes. The Division of Youth Corrections' EBP Committee emphasizes *process* rather than promoting rigid adoption of discrete, evidence-based *programs*. Reflecting this stance, the committee began its work by developing a set of guiding principles that serve as the framework for understanding the use of EBPs across the Division's detention and commitment continuums.

Motivational Interviewing Oversight Sub-Committee – This sub-committee is charged with strengthening the fidelity of DYC's use of Motivational Interviewing (MI). Sub-committee objectives include:

- Implement MI across the Continuum of Care
- Identify MI fidelity and training needs
- Develop plans to address MI fidelity and training needs
- Develop a system to assess MI fidelity and staff participation (engagement)
- Develop a Statewide MI Sustainability Plan
- Provide oversight to ensure effective and efficient use of resources
- Implement an MI Communication Plan

CJRA Oversight Sub-Committee – This sub-committee is charged with overseeing and directing the ongoing CJRA implementation process. Sub-committee objectives include:

- Lead development of a CJRA Fidelity Improvement Plan
- Establish CJRA Quality Assurance Practices
- Create a CJRA Master Training Plan
- Direct CJRA Sustainability Model
- Validate the CJRA for Colorado
- Implement a CJRA Communication Plan

Multi-Disciplinary Team (MDT) Steering Committee – This committee was formed to guide adoption of a Multi-Disciplinary Team decision-making model across the Continuum of Care. The Steering Committee's purpose is to develop project and change management plans, implement them and provide for sustainability. Goals include:

- Develop a project plan for MDT decision making
- Develop a change management plan for MDT decision making
- Implement MDT decision making model

In addition to these active Continuum of Care sub-committees, two additional work groups coordinate their work with the Continuum. These include the (1) **Communications Group**, tasked with ensuring optimal communication across the organization regarding system initiatives and priorities, and the **Restorative Community Justice (RCJ) Committee** that is developing an implementation model to integrate RCJ into the Continuum of Care.

Observations and Recommendations

The Colorado Division of Youth Corrections is in the fifth year of a comprehensive systems improvement effort – the Continuum of Care. The Continuum of Care 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. A best practice model, the Continuum promotes a full array of assessment, case planning and interventions that reduce risk and ultimately reduce the likelihood of re-offending behavior. Most notably, the Division of Youth Corrections continues to prioritize and move forward with an evidence-based approach to management and implementation. Led by the Continuum of Care Oversight Committee, DYC leadership is putting in place an integrated set of structures to support high quality implementation across the entire organization.

As an external review of the Initiative based on available data, this evaluation continues to point to positive progress in this system change effort.

A system change effort like the Continuum of Care 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 as discussed in prior reports, necessitates that the desired change will not be immediate, but will unfold in a developmental way over time.

Observations

Criminogenic risk decreases for youth receiving Continuum of Care services. CJRA data demonstrates that dynamic risk scores decrease significantly for youth receiving services. Through Continuum of Care strategies, DYC is significantly reducing risk from the time a youth is committed to the time a youth goes on parole, and is maintaining those gains when the youth enters the community.

Treatment continues to represent the majority of expenditures, but a growing proportion of funds being spent on surveillance (Supervision) suggests a trend that should be monitored and addressed by DYC leadership.

Data-driven decision making. The monitoring (tracking) of services provided through the Continuum of Care has improved immensely over the past five years. However, the use of bundled or "packaged" non-residential services reduces DYC's capacity to examine and control the specific services a youth is receiving.

The Continuum of Care has evolved from a discrete initiative to a holistic system improvement process. The Continuum of Care has become a cornerstone of DYC's philosophy and systems improvement efforts. This success demonstrates the potential for positive change when an organization is given the flexibility to innovate and become more nimble in providing optimal services.

The Continuum of Care continues to identify and serve youth who enter the system at a high risk for re-offending. CJRA risk and needs data demonstrates 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 or adult justice system.

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 service 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. The CJRA Oversight Committee is developing and implementing quality assurance protocols necessary to support quality practice throughout the system.

In the context of a population that grows more complex and requires greater intervention, the stability in recidivism and recommitment represents a meaningful success for the Continuum of Care.

Recidivism and recommitment rates remain flat. Pre-discharge recidivism (34.6%) remains stable and is significantly lower than the baseline year's rate of 39.1 percent. The percentage of committed youth being recommitted has decreased in the past five years. In the context of a population that appears to bring greater complexity and multiple risk areas requiring intervention, these relatively positive, stable trends in recidivism and recommitment represent meaningful successes for the Continuum of Care.

Ongoing system improvement. The Division of Youth Corrections is engaged in systematic efforts to implement the integrated strategies of the Continuum of Care. Strategies to bolster the service array of evidence-based services continue, along with data-driven quality assurance efforts. These efforts are exemplified by the Continuum of Care Oversight Committee and related sub-committees.

Recommendations 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 promote a better understanding of 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 still does not allow us to track how well actual services are targeted to match the youth's criminogenic needs. 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. 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.

Unbundle packaged services so that Client Managers can ensure that youth receive targeted services matching their risk and needs. While tracking of expenditures has improved greatly in the past year, this area still demands attention. Closely related to the issues addressed directly above, the packaging of services, while convenient for the provider and billing systems, masks the actual services received by youth and challenges the Continuum of Care in living up to "the right services at the right time" by creating a black box of services in which targeting services to individual needs is difficult and linking outcomes to services is impossible.

Need to understand drivers for youth lengths of stay. As was noted last year, 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.

Continue to encourage and support the use of evidence-based practices across all state-operated and contracted programs. The work of the Evidence Based Practices Committee represents an important step forward. It is important that these efforts continue.

Continue to promote Multi-Disciplinary Teams (MDTs) to carefully map out and coordinate transition services prior to youth release on parole. MDTs represent the vital link between assessing a youth's criminogenic risks and needs and ensuring that services provided to the youth directly respond to those needs. MDTs support an efficient use of resources through the purposeful selection of treatment services, thus avoiding the problem of over-serving youth with multiple services in the hope that something may have a positive effect. MDTs are also an important part of monitoring treatment progress to ensure that risks are being reduced and protective factors enhanced during the youth's commitment.

Continue focusing efforts on increasing youth engagement in the community as part of the transition effort. The primary focus during residential treatment is immediate youth behavior correction, sometimes changing problematic thinking patterns that lead to delinquent behavior, and providing youth with knowledge and skills needed to avoid that behavior in the future. The data reported in this report shows a marked reduction of risk at the time youth leave secure residential environments. Without engagement and support in the community at the time a youth transitions from placement and completes parole, these gains can quickly be lost. While a residential environment may provide a forum for instruction, until the youth can apply new skills in his or her own environment, with continued reinforcement and support, they are not likely to be sustained in a less rigorous environment filled with opportunities for youth to make the same mistakes and engage in the same behaviors that led to their original commitment.

Continue training efforts to assure staff have the knowledge and competencies to deliver effective interventions. Now that the CJRA has been implemented across the system, it is important that DYC staff have the ongoing training and support to link assessment results to those interventions that hold the most promise for changing each specific youth's delinquent behavior. This means understanding the intervention services being provided, including the risk and protective factors in which they are most likely to effect change, their use of evidence-based practices, and being able to link those services to specific needs outlined in the CJRA.

Develop greater capacity for evidence-based family interventions for youth returning to family homes, as well as independent living services for older youth. A significant portion of expenditures are for some form of family treatment and/or services (12.6 % of treatment spending) or support related to independent living (6.9% of treatment spending and 26.3% of support spending). These services can have a significant impact on a youth's successful return to the community, but only if interventions are delivered with fidelity to evidence-based practice, meaning that they adhere to the principles of high-quality intervention services that have demonstrated effectiveness in the past.

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Appendix

Colorado Juvenile Risk Assessment

DOMAIN 1: 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 ☐ Dependency and Neglect
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	
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 the 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:	O Alcohol/drug treatment not warranted O Not currently attending needed alcohol/drug treatment program O Currently attending alcohol/drug treatment program O Successfully completed alcohol/drug treatment program

DOMAIN 9A: Mental Health History	
1. 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.	
2. 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
3. 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
4. History of being a victim of neglect:	O Not a victim of neglect O Victim of neglect
5. 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
6. 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
7. Currently has health insurance:	O No health insurance O Public insurance (Medicaid) O Private insurance
8. 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
2. Currently diagnosed with ADD/ADHD: *Confirmed by a professional in the social service/healthcare field.* 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
3. 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
4. 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
5. 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, relapse prevention.*	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