Evaluation of the Continuum of Care Program

Annual Report: Fiscal Year 2010 – 2011

Prepared for:
Colorado Department of Human Services
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By: The Center for Research Strategies
and the Aurora Research Institute

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Submitted to:
The Colorado Department of Human Services Office of Children, Youth and Families
The Division of Youth Corrections

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List of Acronyms

CAC	Certified Addiction Counselor
CCAR	Colorado Client Assessment Record
CJRA	Colorado Juvenile Risk Assessment
CofC	Continuum of Care
DCP	Discrete Case Plan
DYC	Division of Youth Corrections
EBP	Evidence-Based Principles
FY	Fiscal Year
LOS	Length of Service (Stay)
MDT	Multi-Disciplinary Team
RCJ	Restorative Community Justice
SB 94	Senate Bill 94
TRAILS	Automated data system used by DYC

Executive Summary

This report is in response to the request for information sent to the Department of Human Services pursuant to item 13 included in Appendix I of the Long Bill narrative (S.B. 11-209). Item 13 in that list was specific to Continuum of Care and is shown below.

Department of Human Services, Division of Youth Corrections, Community Programs, S.B. 91-94 Programs and Parole Program Services -- The Division is requested to provide a report to the Joint Budget Committee by November 1 of each year concerning the continuum of care initiative and the impact of budgetary flexibility. This report should include the following information: (1) the amount of funds transferred to these line items in the prior actual fiscal year based on flexibility provided in the Youth Corrections budget; (2) the type of services purchased with funds transferred; and (3) the number of youth served with such expenditures.

In FY 2004 – 05, the Colorado General Assembly granted the Division of Youth Corrections (DYC) the budgetary authority to spend up to 10% of the General Fund appropriation for the Purchase of Contract Placements to provide treatment, transition, and wrap-around services to youth in DYC residential and non-residential settings. ***For the second year in a row, DYC was unable to take advantage of this budgetary flexibility opportunity.*** Due to budget shortfalls that strained DYC's ability to adequately fund Contract Placements, there were no funds shifted from Contract Placements to Parole Program and Transition Services. Consequently, this year's report will focus on DYC's continued efforts to reduce reliance on secure commitment and detention placements and increase evidence-based care to Colorado's youth, in accordance with empirically supported juvenile justice best practices.

DYC'S CONTINUUM OF CARE PROGRAM IMPLEMENTS BEST PRACTICE RECOMMENDATIONS

DYC's progressive transformation of the juvenile justice system in Colorado utilizes five key strategies to achieve success: *Providing the Right Services at the Right Time* delivered by *Quality Staff* using *Proven Practices* in *Safe Environments* while embracing *Restorative Community Justice Principles*. The most recent recommendation for juvenile justice systems highlighted the need to align services along a **continuum of care** and to match services to

youth risk and need which mirrors DYC's strategy of "providing the right services at the right time".

DYC has an established assessment process that is utilized at intake, parole, and discharge from parole and at other points along the continuum of care as needed. A comprehensive picture of youth needs and risks is obtained through assessments in five key disciplines: criminogenic risk, mental health, alcohol and drug use/abuse, medical and dental, and education. Knowledge obtained through these assessments provides the foundation for providing the right services at the right time and can influence decisions about the appropriate duration and level of restriction, the type and intensity of therapeutic interventions and the level of supervision required to maintain public safety.

COMMITTED YOUTH NEEDS ARE INCREASING IN COMPLEXITY AND SEVERITY

Assessment data from five successive cohorts of newly committed youth were examined to determine whether the population of commitment youth was stable over time or exhibited changes with ramifications for services and funding. Data examined presented a consistent picture of increasing severity and complexity of need and or risk in newly committed cohorts of youth.

- Youth criminogenic protective factors, which decrease the likelihood of reoffending, declined across cohorts in three areas: attitudes and behaviors, current relationships, and aggression.

- Youth criminogenic risk factors, which increase the likelihood of reoffending, increased across cohorts in four areas: attitudes and behaviors, substance abuse, family living arrangement, and school.

- The percentage of newly committed youth requiring formal, professional mental health intervention steadily increased across cohorts from 43.0% in FY 2006 – 07 to 56.3% in FY 2010 – 11, using the domain score for overall symptom severity from the Colorado Client Assessment Record (CCAR).

- The percentage of newly committed youth requiring treatment for substance abuse increased from 59.5% in FY 2006 – 07 to 68.8% in FY 2010 – 11. When youth requiring intervention are included, 86.7% of newly committed youth in FY 2010 – 11 required substance abuse services.

YOUTH CRIMINOGENIC RISK AND PROTECTIVE FACTORS EXHIBIT POSITIVE CHANGE AS THEY PROGRESS THROUGH THE CONTINUUM OF CARE

Criminogenic assessment data for youth newly discharged from parole during FY 2010 – 11 were examined to determine whether risk and protective factors that influence the likelihood of reoffending changed from intake to parole and from intake to discharge from parole. Increases in protective factors and decreases in risk factors achieved by the time of parole and maintained through discharge would provide evidence that supervision, support, and treatment services provided by DYC were associated with a reduced risk in youth reoffending.

- The 625 youth newly discharged from parole who had three valid CJRA assessments aligning with intake, parole board referral, and parole discharged contributed data for the analysis.

- Both risk and protective factors improved over time for youth newly discharged from DYC.

    - From intake to parole, youth protective factors increased in six areas: school, current relationships, family living arrangement, attitudes and behaviors, aggression and skills.

    - From intake to parole, youth risk factors decreased in seven areas: school, current relationships, family living arrangement, substance abuse, attitudes and behaviors, aggression and skills.

    - Improvements were largely maintained through discharge from DYC for all risk and protective factors with the exception of the school protective factor.

- Some loss of improvements between parole and discharge from DYC are expected as youth leave the structured and predictable setting of residential commitment and return to their community, which provides opportunities for engaging in illegal or anti-social behavior and likely offers diminished scaffolding for pro-social behavior.

INABILITY TO FLEXIBLY SHIFT FUNDS IMPACTS SERVICE FUNDING DECISIONS

Decades of research now consistently show that evidence-based treatment options are associated with positive youth outcomes and lifetime savings to social systems, while supervision is associated with worsening youth outcomes and lifetime costs to youth and social systems (Drake, 2007[1]). DYC must successfully balance the utilization of less expensive supervision and support with more expensive treatment to effectively protect public safety while building youth skills and competencies that will enable them to become responsible, productive citizens of Colorado.

- Consistent with what the literature has suggested as best practice, the majority of transition and parole program services funding was spent on treatment during FY 2010 – 11.

- The percentage of the budget spent on treatment declined 12% from FY 2008 – 09 to FY 2009 – 10. This drop coincides with budget cuts that made taking advantage of the ability to shift funding from contract placements to transition and parole services impossible.

- As the proportion of the budget dedicated to treatment decreased, supervision's proportion increased.

- Despite, these fiscal trends, DYC appears to be utilizing assessment data to allocate treatment funds. Specifically, DYC treatment spending for youth whose assessment data indicated a need for mental health intervention consistently exceeded treatment spending for youth whose scores did not indicate a need for mental health intervention.

[1] Drake, E. (2007). Evidence-based juvenile offender programs: Program description, quality assurance, and cost. Washington Institute for Public Policy. Document No. 07-06-1201 Accessed at www.wsipp.wa.gov, September15, 2011

CONCLUSIONS AND RECOMMENDATIONS

This year's report focuses on the beginning of the continuum of care, the assessment processes and what these assessment data reveal about the youth in commitment. The analysis of assessment data from five successive cohorts indicates that youth have fairly severe needs when entering commitment. It is encouraging, however, that measures of dynamic risk and protective factors that are linked to future criminal justice involvement are reduced over the course of youths' commitment.

Future years' evaluations need to look at the implementation of evidence-based principles farther downstream in the commitment episode. They should also address the level of adherence to these principles across the continuum of care. Specific recommendations include:

- Examining the impact of Multi-Disciplinary Teams on service provision as it relates to matching services to needs and the impact of service provision on youth outcomes should be explored in depth in future years.
- Examining the match between youth risk/needs and youth stays in various security level placements to determine the extent to which DYC is utilizing the least restrictive environments possible when providing services to youth.
- Improving the data extraction process so a more direct link between youths' assessment data, service delivery and outcomes can be established.
- Conducting a thorough process evaluation to determine the level and success of implementation of each component of the continuum of care.
- Examining the extent of DYC staff understanding and implementation of Continuum of Care's evidence-based principles and philosophies.

Introduction

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 (DYC). The Continuum of Care 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. Upon commitment, youth undergo a thorough assessment process in which their needs are evaluated. Findings from the assessment process are utilized by a multi-disciplinary team (MDT) of professionals to develop a discrete case plan (DCP) that guides the process of matching individualized treatment to each youth's unique pattern of criminogenic risk and needs. Transition planning for the youth's re-entry into the community is a component of the DCP from very early in a youth's commitment. As the youth and family progress through the Continuum of Care, re-assessment occurs and the DCP is revised accordingly to meet the changing needs of the youth and family. This cycle of assessment, case planning and treatment is repeated periodically until discharge from parole. The DCP is 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.

In FY 2004 – 05, the Colorado General Assembly granted DYC the budgetary authority to spend up to 10% of the General Fund appropriation for the Purchase of Contract Placements to provide treatment, transition, and wrap-around services to youth in DYC residential and non-residential settings. Since that year, the General Assembly has continued to allow DYC some flexibility to use a percentage (from 5% to 20% depending on the Fiscal Year) of Contract Placement funds to enhance Parole Program Services. This funding flexibility reflects DYC's request to move away from a more traditional "stove pipe" funding and service structure to a more dynamic structure consistent with the process by which a youth progresses through the commitment continuum.

DYC is required to evaluate the Continuum of Care program per item 13 included in Appendix I of the Long Bill narrative (S.B. 11-209). Item 13 specifically requests an annual report "…concerning the continuum of care initiative and the impact of budgetary flexibility". The request includes three specific report components regarding *the funds transferred* from Contract Placements to Parole Program Services: (1) the amount of funds transferred, (2) the type of services purchased with transferred funds, and (3) the number of youth served with such expenditures.

For the second year in a row, DYC was unable to take advantage of this budgetary flexibility opportunity. Because of budget shortfalls that strained DYC's ability to adequately fund Contract Placements, there were (1) no funds shifted from Contract Placements to Parole Program Services. Consequently, there were (2) no services purchased and (3) no youth served or impacted with budgetary flexibility in FY 2010 – 11. This year's report will focus on DYC's continued efforts to reduce reliance on secure commitment placements and increase evidence-based care to Colorado's youth, in accordance with empirically supported juvenile justice best practices.

Framework of an Evidence-Based Juvenile Justice Model

While juvenile justice systems nation-wide face a myriad of challenges in their efforts to provide effective services to juvenile justice involved youth, knowing what to do is no longer one of these challenges (Lipsey, Howell, Kelly, Chapman, & Carver, 2010[2]). As described in a 2006 Justice Policy Institute Report, the "Get Tough" policies of the early 1990s were not only ineffective, but actually negatively impacted efforts to increase public safety, reduce crime, and increase the likelihood that at-risk youth will eventually become contributing members of society. Decades of research on criminogenic risk and protective factors and the development of validated risk and needs instruments have produced a clear picture of the factors that put youth at risk for original and repeated juvenile justice involvement. Further, applied research on juvenile justice policy efforts designed to

[2] Lipsey, M.W., Howell, J.C., Kelly, M.R., Chapman, G.C., and Carver, D. (2010). Improving the effectiveness of juvenile justice programs: A new perspective on evidence-based practice. Center for Juvenile Justice Reform Report. Accessed online at www.cjjr.georgetown.edu on September 10, 2011.

address risk and protective factors have enabled experts to identify a concrete array of programs with demonstrated efficacy in real-world settings (Lipsey et al., 2010[1]).

The Center for Juvenile Justice Reform (CJJR) compiled a nation-wide body of research sponsored by OJJDP, NIJ, BJS, and the US Department of Health and Human Services. From this literature base, CJJR developed a recommended framework to help juvenile justice systems address the true remaining challenge: transforming juvenile justice systems by translating research into practice. "The overarching frame for this approach is to construct juvenile justice systems that are aligned along a **continuum of care**, from prevention to early intervention and then to more significant system involvement as needed. Incorporated into that continuum are the fundamental elements of:

- valid risk and needs assessments,
- the matching of the level of risk and need to the appropriate service, and then
- ensuring that the services provided are effective at improving outcomes for the children and youth placed in them." (Lipsey et al., 2010[3])

STRUCTURE OF THE CONTINUUM OF CARE REPORT

This Continuum of Care evaluation report is comprised of the following elements:

- An examination of the core principles and practices of Colorado's Continuum of Care program and the extent to which Colorado's model is consistent with the framework recommended by CJJR.

- An explanation of the extensive assessment process utilized in the Continuum of Care to identify youth criminogenic risks, youth needs, and the appropriate treatments over time for youth served by the Continuum of Care.

- An examination of the youth served by the Continuum of Care during FY 2010 – 11 and critical changes in the Continuum of Care youth since FY 2006 – 07 and

[3] Lipsey, M.W., Howell, J.C., Kelly, M.R., Chapman, G.C., and Carver, D. (2010). Improving the effectiveness of juvenile justice programs: A new perspective on evidence-based practice. Center for Juvenile Justice Reform Report. Accessed online at www.cjjr.georgetown.edu on September 10, 2011.

- An exploration of the relation between flexible funding availability and the full implementation of evidence-based practices at the core of the Continuum of Care model.

Colorado's Adoption of a Best-Practice Juvenile Justice Model

The majority of juvenile justice systems in the United States are county-operated. However, evidence demonstrates that coordination at the state level is a more effective way to build positive cultures and implement consistent evidence-based policy (Ziedenberg, 2006[4]). The fact that DYC has been operating at a state level for decades facilitated their ability to implement a Continuum of Care model. Initiated in FY 2005 – 06 as a fundamental system transformation, DYC's Continuum of Care is an integrated system of programs and services that provide youth and their families with individually determined levels of support, supervision, and treatment as they move through the juvenile justice continuum from initial commitment to parole and finally discharge. The remainder of the continuum described by CJJR is comprised of Senate Bill 94 and detention services described in a separate report.

As part of the system transformation process, DYC developed five key strategies that align with CJJR's remaining fundamental elements: valid risk and needs assessments, matching risk to services, and ensuring provided services are effective at improving outcomes.

DYC's Key Strategies

Figure 1. DYC's Five Key Strategies

[4] Ziedenberg, J. (2006). Models for change: Building momentum for juvenile justice reform. A Justice Policy Institute Report. Accessed online at www.justicepolicy.org on September 10, 2011.

The Five Key Strategies are not independent constructs. There is a great deal of overlap and interplay between each of the strategies. Therefore, they will be discussed in relation to a variety of topics throughout this report and will not necessarily be presented in the order in which they were originally depicted in Figure 1.

PROVIDING THE RIGHT SERVICES AT THE RIGHT TIME

Implementing the right services at the right time requires an understanding of 1) individual youth needs and how those needs change over time, 2) the risk that a youth poses to the community and how that risk changes over time, and the 3) resources available within the youth's family and community that can be that leveraged to assist in a successful transition back to the community. DYC utilizes actuarial risk assessment tools to identify criminogenic risk, needs and protective factors and estimate the risk posed by the youth to the community. These assessments are administered at multiple time points and incorporated into the ongoing reviews of youth progress that enable DYC staff to develop individualized, targeted case management, treatment, milieu, and transition services. In addition, youth client managers across the state engage with youth and their families in their home communities to determine family and community resources that will facilitate a successful transition back to the family and community.

Planning processes completed during FY 2010 – 11 will enable MDTs to be implemented across the system to match assessment results to treatment plans during the next FY. A case conceptualization model will also be implemented to match elevated CJRA domains to interventions that target criminogenic risk. The utilization of a process to link treatment to the specific needs of the youth further demonstrates DYC's commitment to provide youth with the right services at the right time.

PROVEN PRACTICES

DYC is committed to utilizing practices proven to improve outcomes among juvenile justice involved youth. Within DYC, an Evidence-Based Practices (EBP) committee develops standards and recommends policies for the adoption of EBPs. The inventory of EBPs developed by this committee assists providers in determining the extent to which their

practices are evidence-based. DYC also utilizes an extensive battery of research supported assessment tools to drive their decision making. Many of these tools allow for a measurement of youth change over time and several will be discussed throughout the report.

Another proven practice that DYC has instituted system-wide is motivational interviewing which is a client-centered, goal oriented approach to communication. The primary objective of motivational interviewing is to increase the youths' intrinsic motivation for behavior change through the exploration and resolution of ambivalence[5]. Staff members are expected to use this form of communication every time they interact with youth.

QUALITY STAFF

DYC is committed to hiring qualified, licensed and certified personnel who demonstrate knowledge of evidence-based principles. An example of this commitment is evident in the qualifications required of the assessment personnel. Assessment specialists must have a bachelor's degree, be at least a level II Certified Addiction Counselor (CAC II or CAC III), and be certified to administer an assessment of criminogenic risk. Mental Health Assessment specialists must have at least a master's degree and either be a licensed mental health clinician or be supervised by one. Psychological assessments are conducted by licensed psychologists or psychology interns who are supervised by a licensed psychologist.

Additionally, DYC devotes substantial resources to the initial and continued training of their staff. Assessment staff members who administer the CJRA are required to recertify on its administration every year. During FY 2011 – 12, new staff will be required to attend eight days of training, up from the five day training required in previous years. All staff members, from DYC management to line and kitchen staff, are trained in motivational interviewing so that communication methods are consistent across every interaction a youth has with staff members. During FY 2010 – 11, MDT members were extensively trained on how to make decisions as a team and how to use assessment data to drive

[5] Motivational Interviewing. Report accessed online at www.gainscenter.samhsa.gov on October 13, 2011.

treatment decisions. During the next fiscal year the case conceptualization process will be trained on how to use decision trees to make treatment decisions by client manager supervisors utilizing a train-the-trainer model.

SAFE ENVIRONMENTS

DYC has multiple policies and practices in place to ensure a safe environment for youth within their care. DYC provides staff with initial and ongoing safety training, support and technical assistance to assist staff in maintaining their safety and the safety of the youth to whom they provide services. Safe environments are also promoted by utilizing empirically supported classification, placement and service decisions which help to ensure that youth receive the lowest level of intervention necessary to maintain youth and staff safety.

RESTORATIVE JUSTICE PRINCIPLES

DYC integrates Restorative Community Justice (RCJ) principles throughout the Continuum of Care. Youth are expected to take responsibility for repairing relational disharmony, impact, and harm. Staff members are extensively trained on RCJ philosophy, practices and activities. DYC employs a Restorative Justice Coordinator who has implemented a restorative justice curriculum that all youth must complete prior to parole. A restorative justice oversight committee has been formed and regional work groups will conduct restorative justice inventories during future FYs to determine the level at which each region integrates RCJ principles into their practice. The ultimate goal is to have staff at all levels trained and implementing RCJ principles when interacting with youth.

Implementation of the DYC Continuum of Care Model

A critical element of an evidence-based juvenile justice model is knowledge about the youth served. Understanding the needs of and risks posed by youth served provides a base from which decisions can be made about the appropriate duration and level of restriction, the type and intensity of therapeutic interventions, the level of supervision required to maintain public safety, as well as other decisions made as each youth progresses through the continuum of care. In essence, knowledge about the youth served provides the foundation for providing the right services at the right time that can affect positive

outcomes in youth. Consistent with evidence-based practices, DYC utilizes a battery of validated instruments to assess each youth and inform decision-making around placement, transition services, treatment, supervision and support. The following sections describe the assessment process in the Continuum of Care.

Evidenced-Based Assessment Practices

Upon being committed to DYC, all youth spend a maximum of 30 days in assessment. At this time, assessment specialists compile collateral background data and conduct the extensive DYC initial assessment (see Table 1). The initial assessment targets five vital disciplines utilizing multiple, evidence-based methods to collect comprehensive data on each youth.

Table 1. Five Vital Disciplines Assessed and Methods Utilized during the Initial Assessment

DYC Initial Assessment	
Five Vital Disciplines Assessed	*Assessment Methods*
Criminogenic Risk Mental Health Alcohol and Drug Use/Abuse Medical and Dental Education	Clinical Assessment Motivational Interviewing Psychological Evaluation (as-needed) Validated Instruments

The assessment specialist uses all the information to prepare an assessment report that is used to formulate goals within the DCP. The DCP is used by DYC state operated and contract facilities, as well as the youth's client manager and MDT, to develop treatment and transition plans. Youth may be referred for further psychological evaluations, neuropsychological evaluations, and sex-offense specific evaluations if there are clinical indications to do so.

Assessment Tools

DYC has at its disposal a diverse set of assessment tools. Many of the instruments are used only when clinically indicated, but a subset is used for all youth entering commitment. Table 2 describes the number of tools available in each category of assessment. A list of the assessments, their uses, and validation information is included in the Appendix.

Table 2: Assessment Tool Availability across Categories

Categories of Assessment Tools	Number of Instruments
Universally Applied Instruments	9
Discretionary Psychological Instruments	19
Other Discretionary Instruments	9
Neuropsychological Instruments	24
Total	**58**

Throughout commitment, a youth may be reassessed on a number of these instruments to determine their current treatment needs. A criminogenic risk assessment and mental health assessment is completed with all youth at intake and at discharge from commitment. The criminogenic risk assessment is also administered at the time of parole for all youth, at discharge from DYC, and on an as needed basis when there is a change in placement or clinical status. Other assessments are also completed on an as needed basis when there is a change in placement or clinical status. The instruments utilized to assess criminogenic risk and mental health issues are described further below because data from these assessment tools will be examined in detail later in the report.

Criminogenic Risk. The Colorado Juvenile Risk Assessment (CJRA[6]) assesses youths' risk of reoffending. The CJRA is an empirically validated assessment tool that measures risk and protective factors across the twelve domains listed in Table 3.

Table 3. Domains Assessed in the CJRA

CJRA Risk and Protective Factor Domains		
Criminal History	Demographics	School
Use of Free Time	Employment	Relationships
Family	Substance Abuse	Mental Health
Attitudes & Behaviors	Aggression	Social Skills

"Protective factors are events or circumstances in the youth's life that reduce the likelihood of the youth committing a crime. An example is having a good relationship with a positive adult role model. Risk factors are circumstances or events in the youth's life that increase the likelihood that the youth will start or continue criminal activities. Two empirically

[6] The CJRA can be accessed online at http://www.colorado.gov/cdhsdyc/Resources-Publications/Assess_CJRA.pdf

derived risk factors that are included in nearly all juvenile risk assessments are age at first offense and number of prior adjudications.

Risk and protective factors can be static or dynamic. Dynamic factors are circumstances or conditions in a youth's life that can potentially be changed, such as the youth's friends or school performance. Static factors are events in a youth's life that are historic and cannot be changed, such as the youth being physically abused (pgs 7 – 8)."[7]

The remainder of this report will focus on dynamic factors for seven select domains. Dynamic factors were selected because they are more likely to be impacted by services the youth receive. The seven domains were selected because they had a sufficient number of items and variability to differentiate between youth. A period of the last six months is the criteria used on the domains referring to current risk and protective factors. Table 4 contains the domains that were used and a description of the content of each.

Table 4: Risk and Protective Factor Content by CJRA Domain

Domain	Content Examples	
Current School Status	• School Attendance – most recent term • Teacher, staff, coach youth likes	• Behavior (suspension, expulsion etc.) • Attitudes about education
Current Relationships	• Pro- social relationships • Antisocial relationships • Romantic Relationship	• Positive relationship with non-family adult • Community Ties
Family Living Arrangement	• Individual who live with youth(prior to commitment) • Household income • Prior history of confinement for both youth and family members	• Family's appropriate use of punishment and rewards • Rule adherence • Level of family conflict • Family involvement
Current Substance Abuse	• Alcohol and drug use during the last six months	
Attitudes/Behaviors	• Antisocial attitudes • Respect for others	• Willingness to change • Empathy for others
Aggression	• Attitude toward aggression	• Use of aggression for problem solving
Skills	• Appropriate behavior management • Goal setting • Ability to appropriately deal with emotions	• Problem solving • Ability to deal with difficult situations

[7] CJRA Manual, (2007). Colorado Division of Youth Corrections.

Mental Health Functioning. The Colorado Client Assessment Record (CCAR)[8] is an instrument utilized by the Division of Youth Corrections to assess and identify current conditional mental health status as well as possible treatment needs of the committed juvenile population. The 25 CCAR domains primarily focus on mental health functioning. An overall symptom severity score, rated on a scale of 1 – 9, incorporates information about anxiety, depression, thought disturbances, attention, and manic issues captured on other domains. An overall symptom severity score of five or higher indicates that the individual needs professional mental health intervention, likely in the form of therapy or medication.

Substance Abuse Risk. The SUS-1a, a brief screener, and the ASAP-II are jointly utilized to determine the level of substance abuse services needed by the youth. If there are no clinical indicators of substance abuse on the SUS-1a, the youth is classified at the "prevention" level. The ASAP-II, a comprehensive assessment of substance abuse history, determines treatment needs of youth with clinical indicators on the SUS-1a. These youth are classified as needing "intervention" or "treatment" depending on the severity of their substance abuse.

[8] The complete CCAR tool and manual can be accessed online at http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251581450335

Understanding Youth within the Continuum of Care

Juvenile justice studies typically find that 50 to 70% of committed youth meet criteria for at least one mental health disorder. In a three-state study, 79% of youth with mental health symptoms met the criteria for at least two disorders, and 60% of these youth with mental illness also met criteria for a substance use disorder. These findings indicate a high level of co-occurring disorders in this population[9]. Research also finds that the prevalence of mental illness and substance use disorders increases as youth move further along the juvenile justice continuum. Educational complications are frequently present as well. The National Re-entry Resource Center reported findings from one study that identified 48% of youth as performing below grade level. They also reported that many delinquent youth are developmentally behind their peers, and they more likely to have diagnosed learning disabilities. It is estimated that 30 to 70% of youth involved in the juvenile justice system have learning disabilities[10].

It is clear from the literature that in addition to anti-social and criminal behavior and difficult family and peer influences, the juvenile justice youth population presents with a complex profile of severe and often co-occurring mental health, substance abuse, educational, and developmental challenges. Juvenile justice systems must be prepared to address a complex array of youth risk factors and alarming absence of protective factors.

Colorado's committed youth present with similar profiles to those described in the literature. The percent of newly committed youth who required **no** mental health treatment AND required **no** substance abuse treatment or intervention declined from 7.4% in FY 2006 - 07 to 5.3 percent in FY 2010 - 11. During the same time period, the percent of youth with co-occurring substance abuse and mental health treatment needs increased

[9] Shufelt, J. & Cocozza, J. (2006). *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study*. Delmar, NY: National Center for Mental Health and Juvenile Justice. Accessed online at http://ncmhjj.com/pdfs/publications/PrevalenceRPB.pdf on October 12, 2011.

[10] Altschuler, D. & Kane, L. Frequently Asked Questions: Juvenile Justice. National Reentry Resource Center's Committee on Juvenile Justice. Accessed online at http://www.nationalreentryresourcecenter.org/faqs/juvenile#Q3 October 12, 2011.

dramatically from 35.7% to 48.3%. In addition to those with co-occurring needs, an additional 46% - 57% of youth needed either substance abuse treatment/intervention OR mental health treatment. ***In other words, more than 90% of newly committed youth required substance abuse and/or mental health treatment, with almost 50% of newly committed youth in FY 2010 – 11 requiring treatment for both.***

Historical Change in the Severity and Complexity of Youth Needs

Prior Continuum of Care evaluations attempted to examine changes in the committed youth population over time. However, those comparisons examined the entire population served during a FY. Most youth progress through the continuum of care over a multi-year time span. Consequently, any analysis that compares the entire population during each FY will include many of the same youth across successive years making it impossible to determine whether the population of youth is changing over time.

A different approach involves identifying cohorts of youth and examining them at a single point in time or across successive time points. In the current analysis, we defined cohorts of youth according to the FY in which they were committed utilizing data from FY 2006 – 07 through FY 2010 – 11[11]. Initial criminogenic risk, substance abuse treatment needs, and mental health treatment needs were examined across successive cohorts to examine whether characteristics of the commitment population changed over time. ***An examination of the initial criminogenic risk, mental health treatment needs, and substance abuse across cohorts produced a consistent pattern of increasingly severe and complex needs over the five year time span.***

CRIMINOGENIC RISK

Delinquency is typically defined by both negative and positive behavioral influences. The influences that have the strongest known association with delinquency outcomes are typically categorized into risk and protective factors.

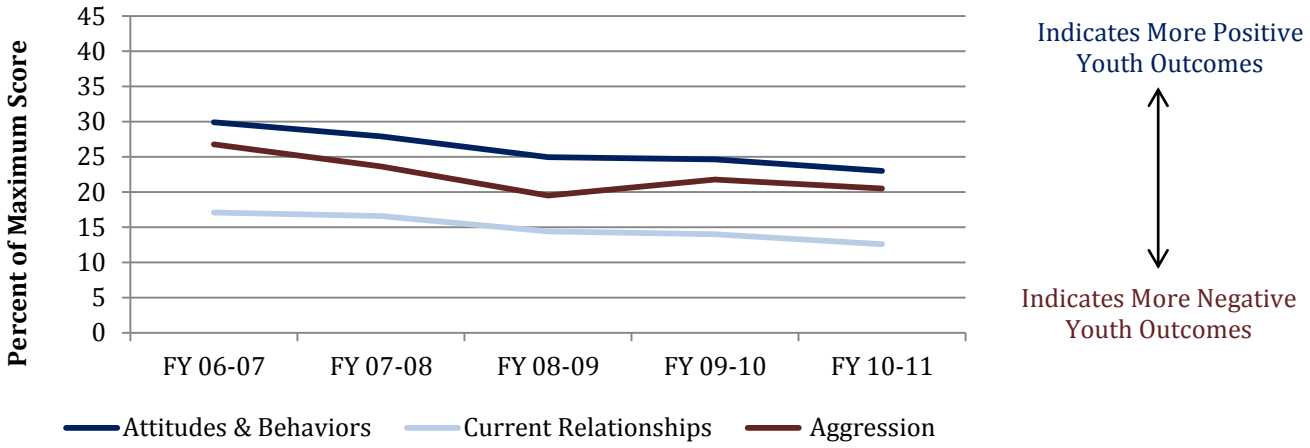
[11] Across the five years included in the analyses, a total of 95 youth were committed during more than one FY. Consequently these youth are included in multiple cohorts.

*"**Risk factors** are conditions or variables associated with a lower likelihood of positive outcomes and a higher likelihood of negative or socially undesirable outcomes. **Protective factors** have the reverse effect: they enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences from exposure to risk."*

-Jessor, Turbin, and Costa, 1998[12]

Figures 2 and 3 display CJRA criminogenic protective and risk factors plotted as a percentage of the maximum possible score. Each protective and risk factor has a different number of items and therefore a different range of possible scores. Converting raw scores into a percentage of the maximum possible score enables the reader to easily compare scores across domains.

Figure 2. Mean Initial CJRA Protective Scores across Cohorts



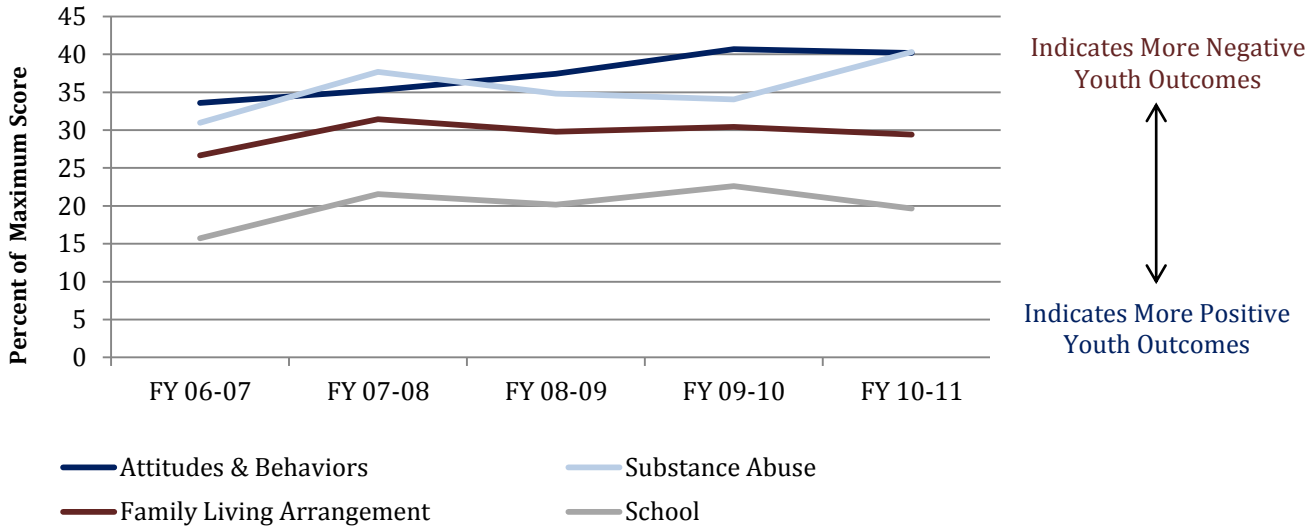
Across successive cohorts, there was a gradual decline in three protective factors: attitudes & behaviors, current relationships, and aggression. Protective factors, when present, reduce the likelihood of reoffending. Consequently, a decline in protective factors indicates that on average, successive cohorts possessed fewer self, family, and peer factors that would reduce the likelihood of reoffending. Scores for Attitudes & Behaviors, Current Relationships and Aggression declined 6.8% 4.5 %, and 6.3% respectively since FY 2006 –

[12] Jessor, Turbin and Costa. (1998) Risk and protection in successful outcomes among disadvantaged adolescents. Accessed online at http://www.who.int/hiv/pub/me/en/me_prev_ch4.pdf on October 13, 2011

07. This trend indicates youth are entering commitment with a higher likelihood of reoffending.

While protective factors declined over time, risk factors across four domains increased: attitudes & behaviors, substance abuse, family living arrangement, and school (see Figure 3). Risk factors, when present, increase the likelihood of youth reoffending. Thus, the increase in risk factors across successive cohorts indicates that the likelihood of reoffending has increased over the five cohorts examined. The largest observed change is risk was for the substance abuse domain which increased 9.3% between FY 2006 – 07 and FY 2010 – 11. Overall, Risk and protective factors show a concerning trend of a youth population with increasing criminogenic treatment needs.

Figure 3. Mean Initial CJRA Risk Scores across Cohorts



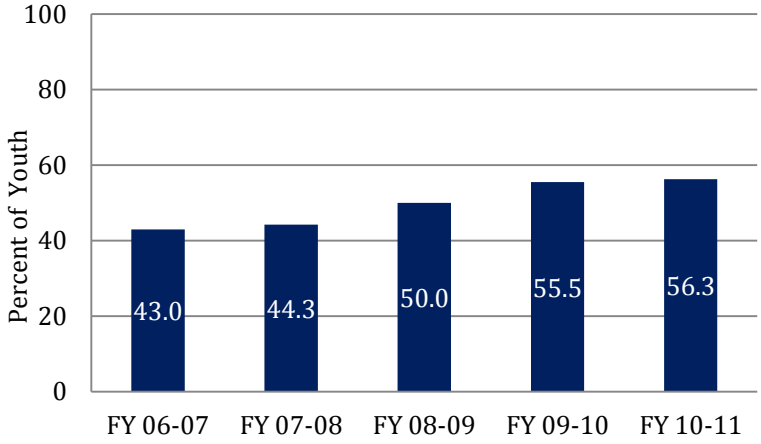
NEED FOR PROFESSIONAL MENTAL HEALTH INTERVENTION

Initial mental health assessment data were also examined across successive cohorts. Mental health assessment data were available from two assessment tools: the CJRA and the CCAR. The CCAR data presented in this year's report may be new to some readers and was included to depict mental health symptoms in this report for the following reasons: 1) the CJRA current mental health domain includes a limited number of mental health items that relate specifically to risk of reoffending, but 2) the CJRA mental health domain does not

indicate whether mental health treatment services are required[13]. In contrast to the CJRA, the CCAR was designed to measure mental health functioning independent of an individual's criminogenic risk and is used across the state of Colorado. Further, the overall symptom severity score is clinically derived. Overall symptom severity scores of 5 or higher indicate "*Symptoms are present which require formal, professional mental health intervention"*.

Figure 4 depicts the percent of newly committed youth whose initial CCAR score on the overall symptom severity domain was a five or higher. The percent of youth who met or exceeded this mental health need level at the time of their initial commitment assessment increased across the five successive cohorts between FY 2006 – 07 and FY 2010 – 11.

Figure 4. Percent of Youth in Need of Mental Health Intervention across Cohorts



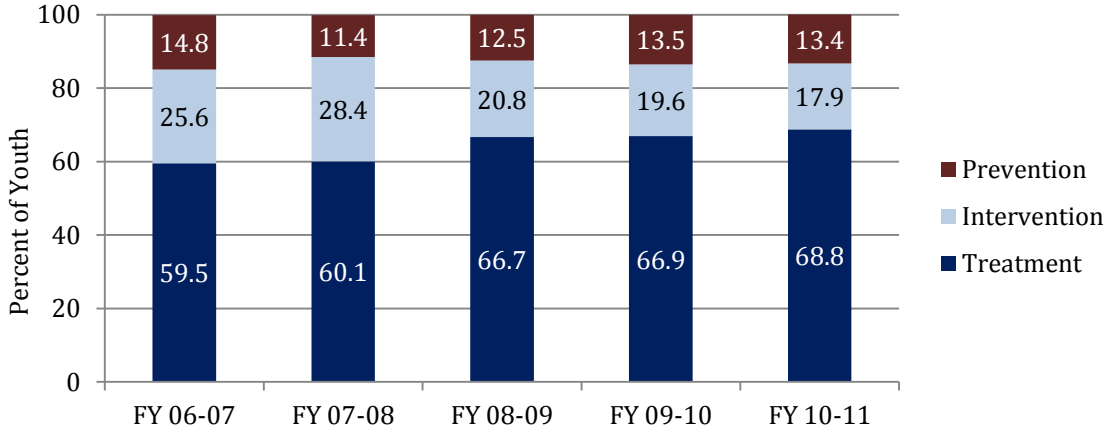
This figure also depicts the startling statistic that for the past three fiscal years, at least *half* of the newly committed population had mental health needs that required professional intervention. It is important to note that while the mental health needs exhibited by the youth may not directly affect their risk for reoffending, treatment of those needs requires considerable DYC fiscal and personnel resources.

[13] Current mental health domain scores have a maximum value of 4 for risk factors and 3 for protective factors. This small range of possible values limits its utility for discriminating between youth with high and low mental health needs. Further, the distributions of scores are skewed making them undesirable for analysis.

NEED FOR SUBSTANCE ABUSE TREATMENT

While mental health needs are significant, treatment needs are even higher for substance abuse. Figure 5 below depicts the substance abuse treatment needs of newly committed youth. All youth are categorized as needing "Treatment", "Intervention", or "Prevention" services. Over the past five years, the majority of newly committed youth required treatment services for substance abuse. During FY 2010 – 11, 68.8% of newly committed youth had Treatment level needs. The increase reflects a shift over time in the percentage of youth requiring intervention or treatment needs since the percentage of youth needing prevention services did not change substantially. Thus, *most* newly committed youth require services to treat substance abuse. Less than 15 percent of youth committed each year require only prevention services.

Figure 5. Percent of Youth in Need of Substance Abuse Treatment by Cohort

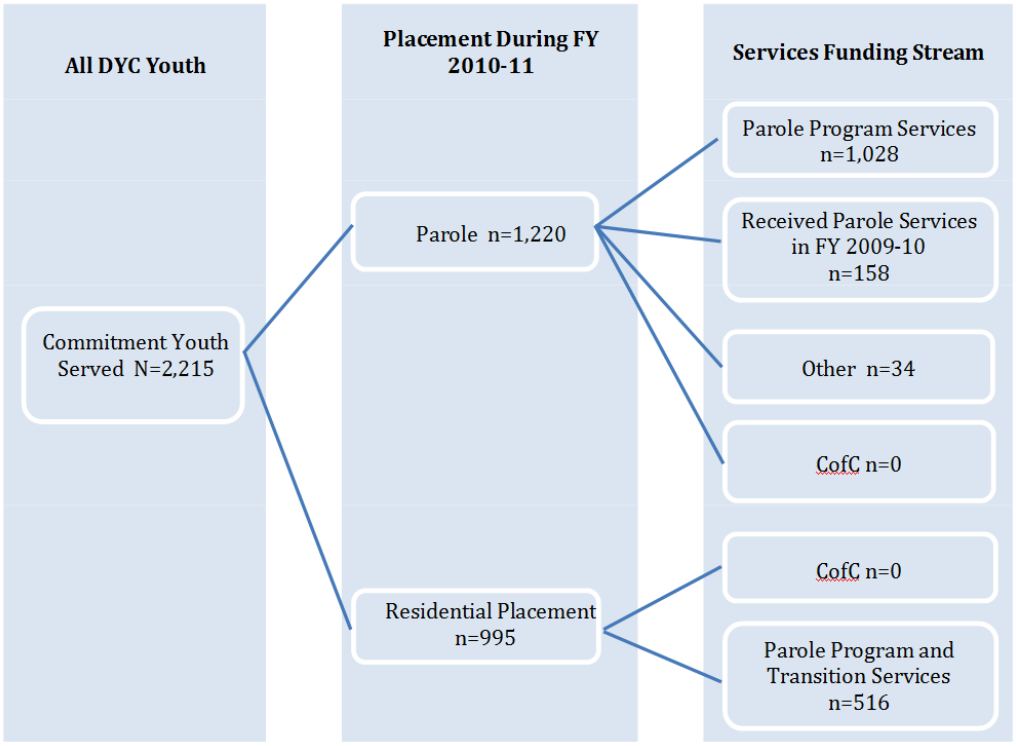


Continuum of Care Youth Served during FY 2010 – 11

During FY 2010 – 11, DYC served 2,215 unique youth in commitment (see Figure 6). More than half of these youth (n=1,220) spent some portion of the fiscal year on parole. The remaining 995 youth spent the entire fiscal year in residential placement. It is important to note that while a youth is committed, all placements including those in the community are considered residential placements. Of the youth that spent time on parole 84.3% (n = 1,028) received transition and parole services paid for by the parole programs services line item in the budget. Of the 192 youth on parole who did not receive services in this fiscal year, 158 received services during the prior FY. The remaining 34 youth, like all committed

youth, received services provided by their DYC client manager /parole officer. Client manager salaries are funded through a different budget line item and not included in parole program services.

Figure 6. Funding for Parole and Transition Services during FY 2010 – 11



In addition to youth on parole, more than half (n = 516) of youth who spent the entire year in residential placements also received transition services. Evidence-based models of re-entry identify transitional services in a residential setting as key to successful community re-integration. Transition services that begin while the youth is still in a residential setting could include: identifying the appropriate community-based programs and supports for individually varying needs, establishing payment plans, and taking the steps needed to register the youth for enrollment in these programs.

YOUTH DEMOGRAPHICS

The following two figures (7 and 8) depict the demographic distributions of the entire commitment population as well as youth newly committed this year. Tables 5 and 6 follow

the same format and display offense and age information. They are presented this way to illustrate that while newly committed youth have increased in their clinical severity there is very little difference between those youth committed this year and those already in commitment on demographic variables or offense variables.

Figure 7. Ethnicity of Committed Youth

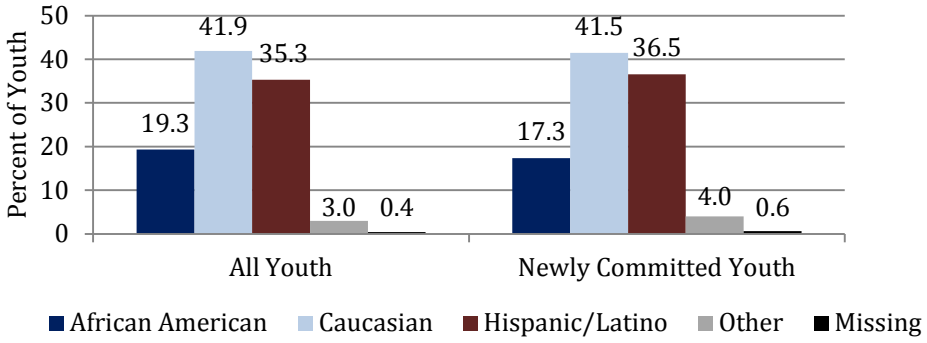


Figure 8. Gender of Committed Youth

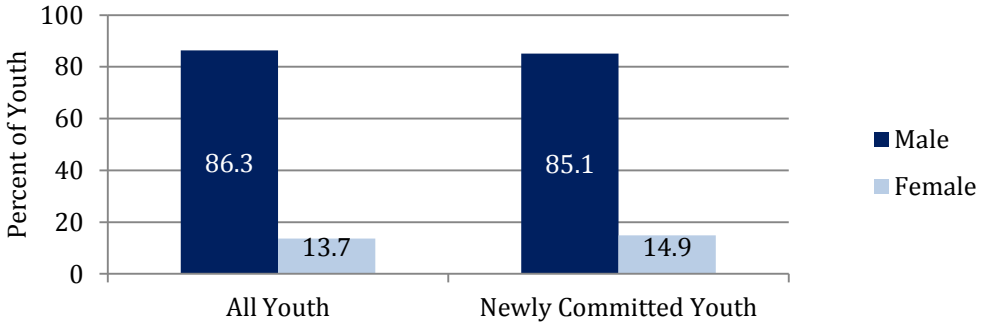


Table 5. Original Commitment and Offense Types

Variable	All Youth	Newly Committed Youth
	n = 2215	n = 646
Original Commitment Type	**Percent**	**Percent**
Non-Mandatory	69.8	69.0
Mandatory	20.4	18.3
Repeat	7.0	9.6
Violent	0.9	0.6
Aggravated	1.8	2.3
Missing	0.1	0.2
Original Commitment Charge	**Percent**	**Percent**
Felony	58.5	60.5
Misdemeanor	36.4	35.6
Petty	0.1	0.0
Missing	5.1	3.9

*For the 24 youth with two commitments, the most recent commitment record was utilized for computations.

Table 6. Mean age at Commitment

	All Youth	Newly Committed Youth
	n = 2215	n = 646
Age at Commitment	**16.7**	**16.8**

EFFECTS OF TREATMENT ON YOUTH DISCHARGED IN FY 2010 – 11

The previous section described the trend that the population of youth admitted to commitment is presenting at initial assessment with greater needs each year. ***While this clinical presentation is alarming, an analysis of the change in raw CJRA scores from initial commitment to parole and discharge reveals a positive outcome picture.*** To assess change in criminogenic risk, only youth who were discharged in FY 2010 – 11 and had three CJRA assessments (at initial commitment, at the time of their parole hearing, and at discharge) were included. Change scores, for the CJRA dynamic domains, were calculated between the CJRA conducted at initial assessment and those done at parole and discharge using raw domain scores. *Increases* in dynamic *protective* factors and *decreases* in dynamic *risk* factors would both be indications of positive youth change.

The most dramatic gains are seen between youths' initial assessment and the CJRA administered at the time of their parole hearing. When reassessed at discharge the magnitude of the change from initial assessment is slightly less. It is not surprising that when youth leave the structured and predictable setting of residential commitment and return to their community some portion of the gains achieved is not maintained. The discharge CJRA scores still show a reduction in risk factors and an increase in protective factors from those measured at admission. Figure 9 depicts the gains in protective factors.

Figure 9. Improvement in Mean CJRA Dynamic Protective Factors from Intake to Parole and from Intake to Discharge

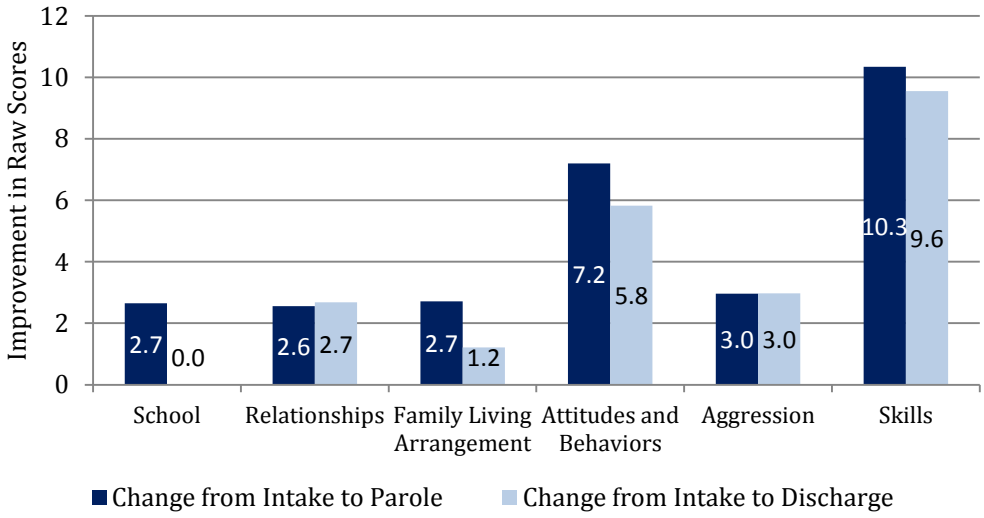
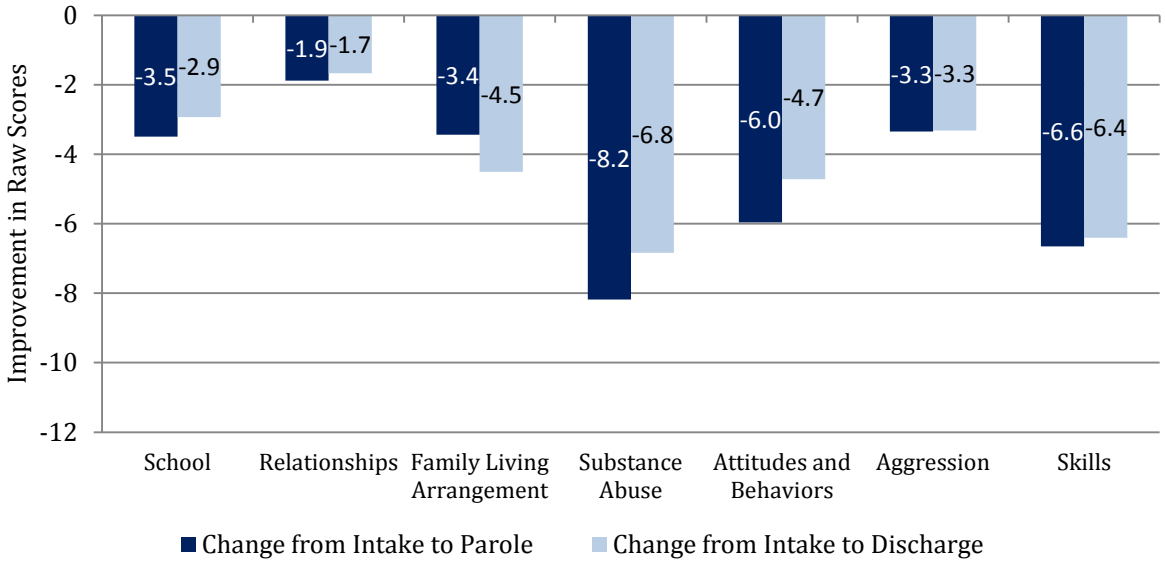


Figure 10 depicts the reduction of risk that occurred as youth progressed through the Continuum of Care. The bars are oriented in a downward direction, illustrating the decrease in risk factors.

Figure 10. Improvement in Mean CJRA Dynamic Risk Factors from Intake to Parole and from Intake to Discharge



Balancing Security and Treatment Needs

DYC parole program and transition expenditures[14] on individual youth fit into one of three major categories: treatment, supervision, or support. Services across these categories vary widely in cost. ***Decades of research now consistently show that evidence-based treatment options are associated with positive youth outcomes and lifetime savings to social systems, while supervision alone is associated with worsening youth outcomes and lifetime costs to youth and social systems (Drake, 2007[15])***. Through changing economic environments, DYC must successfully balance the utilization of less expensive supervision and support with more expensive treatment to effectively protect public safety while building youth skills and competencies that will enable them to become responsible, productive citizens of Colorado.

Supervision is designed to temporarily constrain/monitor youth behavior. Residential confinement is the most extreme form supervision, and is designed to protect the public from perceived immediate threats to both persons and property. As youth move through the commitment continuum, the level of supervision required typically decreases from a secure facility with 24 hour supervision at initial commitment to parole in the community with tracking and day reporting with a parole officer, electronic monitoring, and substance use testing as needed.

Support expenditures provide temporary tangible assistance to facilitate independent living in the community. Included in support expenditures are cultural and communication support, educational expenses, general living expenses, medical expenses, professional services, and pro-social engagement. Support expenditures are particularly important for youth with minimal or no family support to ease their transition back to the community. These expenditures are designed to be short-term and therefore limited in quantity.

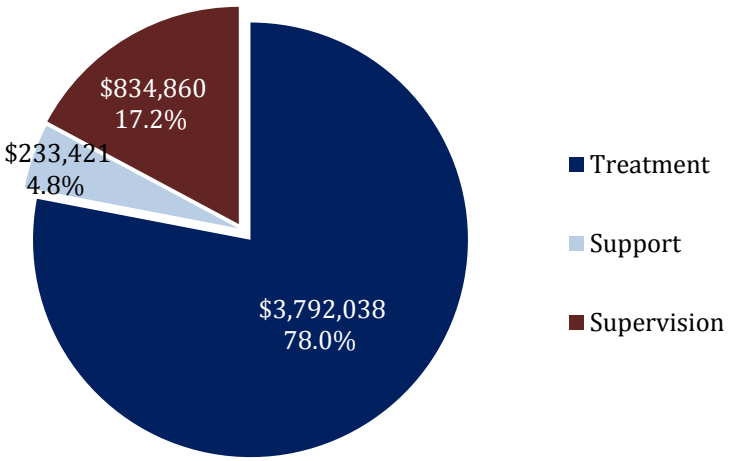
[14] It is important to note that the varying ability to utilize the funding flexibility has *not* affected the provision of treatment services within DYC's residential commitment facilities but *has* affected the provision of treatment within parole and transitional services.

[15] Drake, E. (2007). Evidence-based juvenile offender programs: Program description, quality assurance, and cost. Washington Institute for Public Policy. Document No. 07-06-1201 Accessed at www.wsipp.wa.gov, September15, 2011

Juvenile justice *treatment* consists of services designed to positively change youths' current and future behavior with the goal of youth becoming productive and responsible citizens. Treatment plans are tailored to the individual strengths and needs of each youth but include a broad array of treatments including community transition services, jobs and skills training, individual and family therapy, mental health treatment, offense specific treatment and substance abuse treatment. The cost of treatment varies depending upon type, duration and intensity.

Consistent with best practices described in the juvenile justice literature, the majority of transition and parole program services funding was spent on treatment during FY 2010 – 11 (see Figure 11). Supervision occupies the second greatest proportion of spending followed by support.

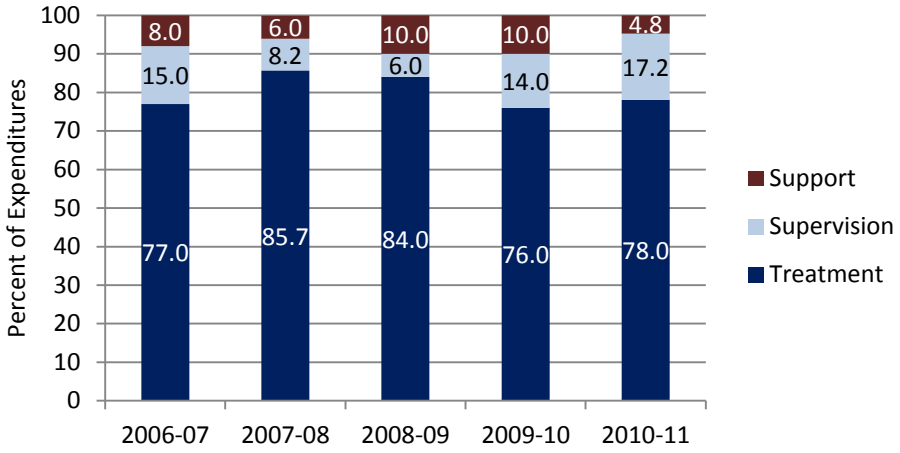
Figure 11. Expenditures by General Category Direct Service Dollars



For the past five years, treatment spending has encompassed the greatest proportion of the budget. The relative percentage spent on treatment has, however, changed fairly substantially. ***The percentage of the budget spent on treatment declined 12% from FY 2008 – 09 to FY 2009 – 10. This drop coincides with budget cuts that made taking advantage of the ability to shift funding from contract placements to transition and parole services impossible.*** As the proportion of the budget dedicated to treatment decreased, supervision's proportion increased. Figure 12 clearly depicts the shift in funding from treatment to supervision that has occurred in the last two years. Typically supervision

is a less costly solution to the problem of criminal behavior (Drake, 2007[15]), and it gives the perception of increasing public safety. But while supervision may increase public safety temporarily, if it is not complemented by an appropriate level of treatment for each youth, the long-term costs can be greater in the form of increased recidivism and unreached potential of becoming a contributing member of society.

Figure 12. Expenditures by Category over the Past Five Years

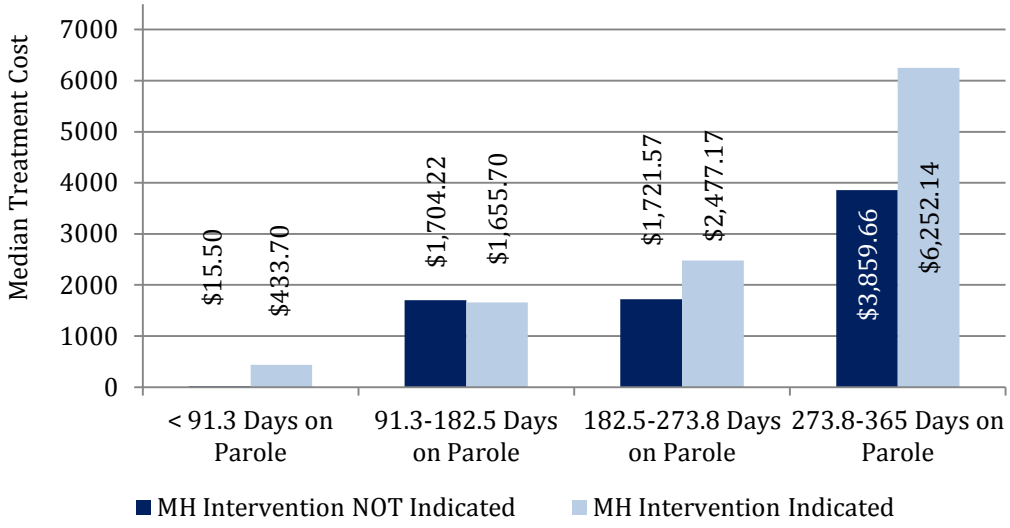


Even given these tough economic circumstances, DYC has implemented policies to match treatment to the needs of the youth. As described above, DYC has an extensive assessment protocol for all youth that leads to treatment decisions. One indicator of high youth treatment need is Overall Symptom Severity on the CCAR. An elevated domain score (five and higher) indicates the need for professional mental health intervention. One would expect that treatment expenditures would be higher for youth with mental health treatment needs than for those youth without mental health treatment needs. Expenditures vary by the length of time a youth spends on parole. The more days a youth spends on parole the more opportunity there is to receive treatment and in turn accrue costs. Therefore, the length of service (LOS) must be controlled for in order to compare expenditures.

Figure 13 compares youth with mental health needs (as defined by their CCAR Overall Symptom Severity domain score) versus those whose CCAR scores do not indicate a need for mental health intervention. For this analysis, the year was divided into four equal

quartiles of days and youth were placed into a quartile depending upon the number of days they were on parole during FY 2010 – 11. For example, a youth who spent 30 days on parole in the FY year would be in the first group, while a youth who spent 190 days on parole would be in the third group.

Figure 13. Median Parole/Transition Treatment Dollars Spent: Mental Health Intervention Need by FY time on Parole



In Figure 13 above, the spending on those with MH needs greatly surpassed the spending on those without mental health needs indicating that DYC personnel recognized the need for additional treatment and were able to obtain it for these youth.

Summary & Recommendations

The Juvenile Justice literature clearly identifies what works to improve youth outcomes in a juvenile justice population. The first step is to train staff to administer validated assessments to identify the risk and needs of the youth in the system. This assessment information must then be directly linked to treatment decisions so that the provision of evidence-based treatment is specific to the youth's needs. The overall model must be one that provides the right service at the right time in the least restrictive environment. Transition services to aid in successful re-entry into the community are another critical component. Finally, to ensure that the local continuum of care implementation obtains the rates of success associated with the evidence-based model, it is essential that all aspects of the system maintain a high level of fidelity to original design.

This report focuses on the implementation of a comprehensive assessment process and the resulting data. DYC employs qualified staff as assessment specialists at each of its assessment facilities. These staff members are qualified to administer the battery of empirically validated tools that DYC has selected as part of the assessment protocol. When a higher level of expertise is clinically indicated, the assessment specialists are able to make referrals to other specialized staff or contract personnel. DYC assessment staff members have at their disposal a broad array of instruments designed to assess youth on five vital disciplines: criminogenic risk, mental health issues, substance abuse needs, medical/dental status, and educational/vocational needs.

The analysis of assessment data from five successive cohorts indicates that youth have a variety of elevated needs at the start of their commitment sentences. Criminogenic risk, mental health intervention needs, and substance abuse needs have all increased over the past five years with each subsequent cohort of newly committed youth. It is encouraging, however, that measures of dynamic risk and protective factors that are linked to future criminal justice involvement are reduced over the course of youths' commitment. These improvements are most marked during the period from initial commitment to parole but are maintained to a large extent through discharge from parole.

While improving youth outcomes is an important goal, it must be balanced with the need to preserve public safety. Parole and transition services funding pay for three general types of service: supervision, support and treatment. Treatment is often the most costly of the service types. It is clear that when comparing the relative proportion of the parole and transition services budget spent on each category of service, treatment is the service type that is reduced when budgetary flexibility to shift funding from contract placements to parole and transition services is eliminated. The reduction in the proportion of the budget spent on treatment results in a greater proportion being spent on supervision. While this may have a short term impact on perceived public safety, the long term costs to society may be substantial. The literature consistently suggests that supervision-only models lead to greater recidivism and other public system involvement, whereas treatment models significantly reduce recidivism and increase youths' potential to become contributing members of society. Given the clear and consistent research indicating that treatment models are preferable to primarily supervision models, it is critical that funding is maintained at levels adequate to provide for the increasing treatment needs of Colorado's committed youth.

RECOMMENDATIONS

This year's report focuses on the beginning of the continuum of care, the assessment processes and what these assessment data reveal about the youth in commitment. Future years' evaluations need to look at the implementation of evidence-based principles farther downstream in the commitment episode. They should also address the level of adherence to these principles across the continuum of care.

In the upcoming FY (2011 – 12) Multi Disciplinary Teams (MDTs) will be fully implemented to review youths' assessment reports and case histories to create Discrete Case Plans. The implementation of this process models evidence-based systems. The MDTs have been tasked with closely matching service provision to the risks and needs quantified in the assessment process. It is likely that the shift from a model where individuals (e.g. client managers or facility staff) make many of the treatment decisions to the MDT model will result changes in service provision. These changes should be objectively evaluated to

determine the level to which needs are matched to services and the impact this has on youth outcomes.

Another evidence-based philosophy that DYC has embraced is the concept of utilizing the least restrictive environment possible to provide services to youth. Determining the level of placement is a balancing act between preserving public safety and placing youth in less secure settings which have been proven to yield better outcomes. Future years' evaluations should focus on the match between risks and needs and youths' stays in various security level placements to determine the extent to which DYC has incorporated this evidence-based principle into practice.

In order to accomplish the preceding two recommendations some changes to the way youth level data is reported will be required. DYC collects a great deal of assessment, placement and financial data; however, access to this data is somewhat limited. While the reprogramming the data extraction products will undoubtedly require DYC's devotion of considerable resources, this process will yield the ability to more directly understand the effects of various components of the continuum of care program on youth outcomes.

DYC has and continues to implement many innovations that bring them closer to a comprehensive evidence-based juvenile justice model. Components of the model are in various stages of planning and implementation. This FY seems to be a critical time to implement a full scale process evaluation. This evaluation would utilize key informant interviews, staff, youth and family surveys, and a review of change and implementation processes. The goal of such an evaluation would be to determine the level of successful implementation of each component of the model and determine areas where additional resources need to be devoted to increase fidelity.

One of DYC's Key Strategies is to employ quality staff. Similarly, a key component of the successful implementation of an evidence-based model is that a majority of staff members throughout the continuum of care demonstrate knowledge of and adhere to its underlying

principles[16]. It will also be important to assess staff adherence at a variety of levels to more fully understand the degree to which DYC staff members are implementing these principles and philosophies.

[16] Research in Brief: The New Discipline of Implementation. National Institute of Corrections and Justice System Assessment and Training.

Appendix

Colorado Division of Youth Corrections
Assessment Services
Assessment Instruments

I. UNIVERSALLY APPLIED INSTRUMENTS

INSTRUMENT	INTENDED PURPOSE	EMPIRICAL SUPPORT	NORMED JJ POPULATION
Initial Commitment Classification Instrument (ICCI)	Risk Classification; Security Level Designation	Yes	Yes
Colorado Juvenile Risk Assessment (CJRA)	Identification of risk and protective factors linked with probability for re-offense; Identification of criminogenic needs used for case management and service delivery decisions	Yes	Yes
Substance Use Survey (SUS)	Substance use screening to determine need for additional, in-depth substance use assessment	Yes	Yes
Adolescent Self Assessment Profile (ASAP-II)	Substance use assessment to determine extent of drug and alcohol use and level of prescribed drug and alcohol services	Yes	Yes
Colorado Client Assessment Record (CCAR)	Assessment of current mental health condition and status; Assists with identification of treatment needs	Yes	No
Jesness Inventory-Revised	Comprehensive measure of personality and psychopathology	Yes	Yes
Neuropsychological Screening Questionnaire	Rule out the occurrence of brain injury specifically pertaining to traumatic brain injury, substance-induced brain injury, brain injury resulting from pre-natal alcohol and/or drug exposure, fetal alcohol syndrome, and other notable brain impairment unrelated to IQ; Results determine comprehensive neuropsychological evaluation need	No	No
Woodcock Psycho-Educational Battery III Tests of Achievement	Achievement testing in reading, mathematics, written language, science, social studies, and humanities	Yes	No
Career Scope	Interest and aptitude assessment for ages 16 years and older	Yes	No

II. DISCRETIONARY PSYCHOLOGICAL INSTRUMENTS

INSTRUMENT	INTENDED PURPOSE	EMPIRICAL SUPPORT	NORMED JJ POPULATION
Beck Depression Inventory (BDI-II)	Brief criteria-referenced assessment for measuring the severity of depression.	Yes	No
Revised Children's Manifest Anxiety Scale (RCMAS)	Brief self-report inventory measuring the level and nature of anxiety symptomatology.	Yes	No
Trauma Symptom Checklist for Children (TSCC)	Objective tool that measures the severity of trauma related symptoms in children and adolescents.	Yes	No
Cognistat	Neurobehavioral cognitive status exam used for neuropsychological screening.	Yes	No
Rorschach Inkblot Test	Projective test that measures personality structure and dynamics, as well as psychopathology.	Yes	No
Hare Psychopathy Checklist	Assessment of psychopathic (antisocial) personality disorders in corrections and forensic populations.	Yes	Yes (adult population)
Thematic Apperception Test (TAT)	Projective test that measures an individual's perception of interpersonal relationships.	Yes	No
Eating Disorder Inventory –3 (EDI-3)	Self-report tool that measures symptomatology associated with eating disorders	Yes	No
Conner's Rating Scales Revised (CRS-R)	Objective test that measures severity of Attention-Deficit/Hyperactivity symptomatology	Yes	No

INSTRUMENT	INTENDED PURPOSE	EMPIRICAL SUPPORT	NORMED JJ POPULATION
Short Category Test	Neuropsychological test that measures problem solving skills and ability to learn new information	Yes	No
Brief Symptom Inventory (BSI)	Brief measure of psychological symptoms	Yes	No
Millon Adolescent Clinical Inventory (MACI)	Objective adolescent inventory that assesses personality disorders and clinical syndromes.	Yes	No
Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)	Objective test that measures adolescent psychopathology.	Yes	No
Minnesota Multiphasic Personality Inventory 2 (MMPI-A 2)	Objective test that measures adult psychopathology.	Yes	No
Millon Clinical Multiaxial Inventory-III (MCMI-III)	Objective adult inventory that assesses personality disorders and clinical syndromes	Yes	No
Reynolds Adolescent Depression Scale-2 (RADS-2)	Brief screening measure of depression in adolescents.	Yes	No
Suicidal Ideation Questionnaire (SIQ)	Screening for suicidal ideation and intent in adolescents	Yes	No
Wechsler Intelligence Scale for Children (WISC-IV)	Cognitive test that assesses children and adolescents overall cognitive ability and level of intelligence	Yes	No
Wechsler Adult Intelligence Scale (WAIS-IV)	Cognitive test that assesses adults overall cognitive ability and level of intelligence.	Yes	No

III. DISCRETIONARY PSYCHOLOGICAL INSTRUMENTS

INSTRUMENT	INTENDED PURPOSE	EMPIRICAL SUPPORT	NORMED JJ POPULATION
Beck Depression Inventory (BDI-II)	Brief criteria-referenced assessment for measuring the severity of depression.	Yes	No
Revised Children's Manifest Anxiety Scale (RCMAS)	Brief self-report inventory measuring the level and nature of anxiety symptomatology.	Yes	No
Trauma Symptom Checklist for Children (TSCC)	Objective tool that measures the severity of trauma related symptoms in children and adolescents.	Yes	No
Cognistat	Neurobehavioral cognitive status exam used for neuropsychological screening.	Yes	No
Rorschach Inkblot Test	Projective test that measures personality structure and dynamics, as well as psychopathology.	Yes	No
Hare Psychopathy Checklist	Assessment of psychopathic (antisocial) personality disorders in corrections and forensic populations.	Yes	Yes (adult population)
Thematic Apperception Test (TAT)	Projective test that measures an individual's perception of interpersonal relationships.	Yes	No
Eating Disorder Inventory –3 (EDI-3)	Self-report tool that measures symptomatology associated with eating disorders	Yes	No
Conner's Rating Scales Revised (CRS-R)	Objective test that measures severity of Attention-Deficit/Hyperactivity symptomatology	Yes	No
Short Category Test	Neuropsychological test that measures problem solving skills and ability to learn new information	Yes	No
Brief Symptom Inventory (BSI)	Brief measure of psychological symptoms	Yes	No

IV. OTHER DISCRETIONARY INSTRUMENTS

INSTRUMENT	INTENDED PURPOSE	EMPIRICAL SUPPORT	NORMED JJ POPULATION
Practical Adolescent Dual-Diagnosis Interview (PADDI)	Drug and alcohol and mental health assessment to determine convergence of drug and alcohol use with mental health functioning; Supplemental to the ASAP	Yes	No
Woodcock-Johnson Psycho-Educational Battery of Cognitive Tests	Assessment and identification of cognitive functioning	Yes	No
J-SOAP	Sex offense specific risk evaluation; Provides considerations for typological classification	Yes	Yes
ERASOR	Sex offense specific risk evaluation; Provides considerations for typological classification	Yes	Yes
Affinity	Sex offense specific risk evaluation; Provides considerations for typological classification	Yes	Yes
Abel Assessment of Sexual Interests (AASI)	Sexual interest inventory	Yes	No