Evaluation of the Continuum of Care Program

Annual Report: Fiscal Year 2011 – 2012

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

CCAR	Colorado Client Assessment Record
CofC	Continuum of Care
DCP	Discrete Case Plan
DYC	Division of Youth Corrections
FY	Fiscal Year
MDT	Multi-Disciplinary Team
TRAILS	Automated data system used by DYC

Executive Summary

This report is in response to the request for information submitted to the Governor by the Colorado Joint Budget Committee on April 25, 2012. This report specifically addresses Item 3; Department of Human Service, The Division of Youth Corrections, actual use of budgetary flexibility. Item 3 reads as follows:

The Division is requested to provide a report to the Joint Budget Committee by November 1 of each year concerning its proposed and actual use of budgetary flexibility. The report should specify funds that have been or are anticipated to be transferred and how the changes will affect services, including the numbers and types of institutional and community placements anticipated to be used for youth in commitment and detention placements.

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 fourth 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 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 six 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 Arrangements, 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 58.2% in FY 2011 – 12, 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 70.5% in FY 2011 – 12. When youth

requiring intervention are included, 88.0% of newly committed youth in FY 2011 – 12 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 2011 – 12 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 youth newly discharged from parole who had three valid CJRA assessments aligning with intake, parole board referral, and parole discharge 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 Arrangements, Attitudes and Behaviors, Aggression and Skills.
    - From intake to parole, youth risk factors decreased in seven areas: School, Current Relationships, Family Living Arrangements, 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 anticipated 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 alone 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 2011 – 12.

- The percentage of the budget spent on treatment declined 12% from FY 2008 – 09 to FY 2009 – 10. This drop coincided 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 report adds another cohort of youth to the five years of data presented last year. Again, it appears that youth entering the commitment system have intense and complex needs. In fact, more than 90% of newly committed youth required substance abuse and/or mental health treatment, with over 50% of newly committed youth in FY 2011 – 12 requiring treatment for both.

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:

- 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 communication strategies, specifically the use of Motivational Interviewing.
- Assess the implementation of the Multi-Disciplinary Team approach to creating Discrete Case Plans for all youth in terms of both practice and philosophical shifts.
- Enhance assessment at later time points in the commitment episode, including at the time of parole and discharge so that change can be demonstrated.

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.

While DYC is no longer required to provide an update to the legislature on the Continuum of Care initiative, it is agreed that a limited status report is beneficial for both DYC and the legislature. Previously, DYC was required to report on the impact of budgetary flexibility, including three components: (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 fourth year in a row, DYC was unable to take advantage of this budgetary flexibility opportunity. During FY 2011 – 12, there were (1) no funds shifted from Contract Placements to Parole Program Services. Consequently, there were (2) no services purchased with flex funding and (3) no youth impacted by budgetary flexibility in FY 2011 – 12. 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.

CRIMINOGENIC RISK

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

- An examination of the youth served by the Continuum of Care during FY 2011 – 12 and critical changes in the Continuum of Care youth since FY 2006 – 07, and
- 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.

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[2]. 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 are 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[3].

It is clear from the literature that in addition to anti-social and criminal behavior as well as 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 5.1 percent in FY 2011 - 12. During the same time period, the percent of youth with co-occurring substance abuse and mental health treatment needs increased

[2] 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.

[3] 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 51.3%. In addition to those with co-occurring needs, an additional 43.5% 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 over 50% of newly committed youth in FY 2011 – 12 requiring treatment for both.***

Historical Change in the Severity and Complexity of Youth Needs

A useful method for determining whether the severity and complexity of youth needs has changed over time is to examine the needs of cohorts at the time of entry into the Continuum of Care across successive fiscal years. 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 2011 – 12[4]. 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 six year time span.***

CRIMINOGENIC RISK

Delinquency is defined by both negative and positive behavioral influences. The influences most strongly linked to delinquency are categorized into risk and protective factors.

*"**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."*

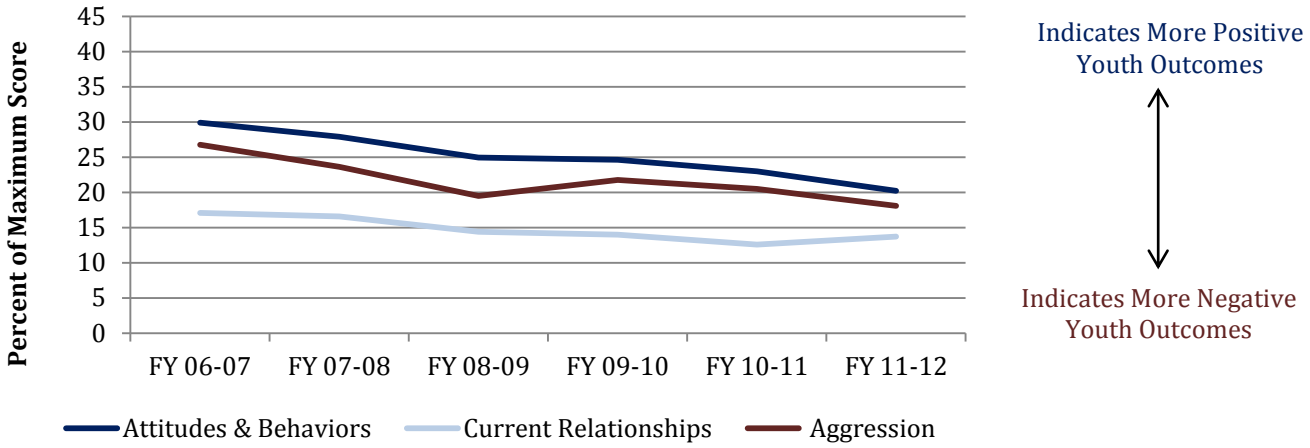
-Jessor, Turbin, and Costa, 1998[5]

[4] Across the six years included in the analyses, a total of 122 youth were committed during more than one FY. Consequently these youth are included in multiple cohorts.

[5] 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

Figures 1 displays 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 1. Mean Initial CJRA Protective Scores across Cohorts

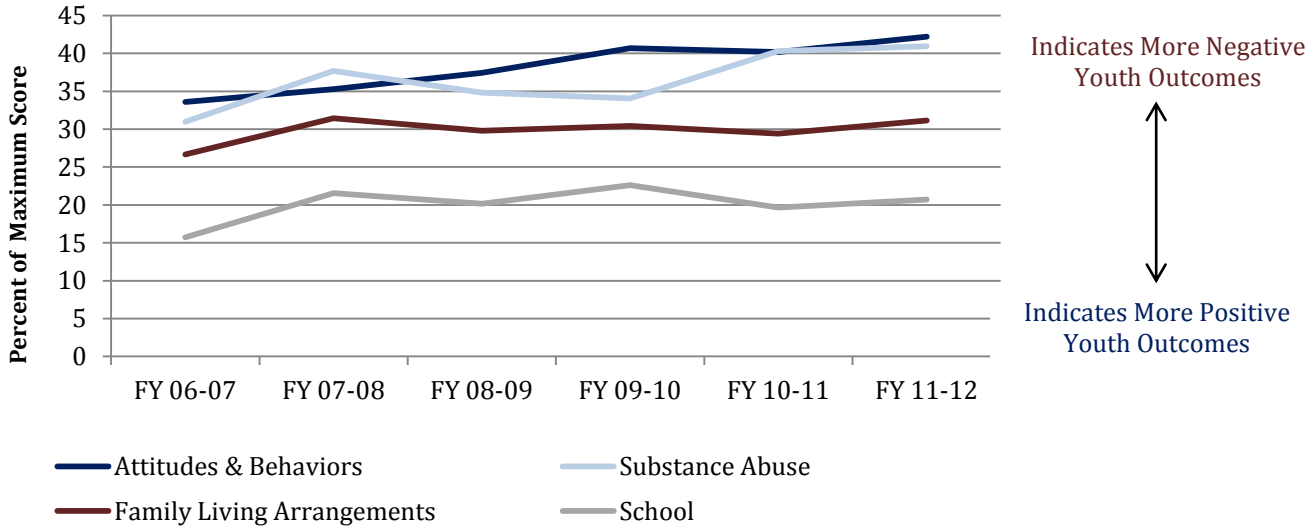


Across successive cohorts, there was a gradual decline in three protective factors: Attitudes & Behaviors, Current Relationships, and Aggression. Protective factors, when present, reduce the likelihood of reoffending. Consequently, a decline in protective factors indicates that on average, successive cohorts possessed fewer self, family, and peer factors that would reduce the likelihood of reoffending. Scores for Attitudes & Behaviors, Current Relationships and Aggression declined 9.7%, 3.4 %, and 8.7% respectively since FY 2006 – 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 Arrangements, and School (see Figure 2 which also displays CJRA scores as a percentage of total possible score). 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 six cohorts examined. The largest observed change in risk was for the

substance abuse domain which increased 10.0% between FY 2006 – 07 and FY 2011 – 12. Overall, risk and protective factors show a concerning trend of a youth population with increasing criminogenic treatment needs.

Figure 2. Mean Initial CJRA Risk Scores across Cohorts



NEED FOR PROFESSIONAL MENTAL HEALTH INTERVENTION

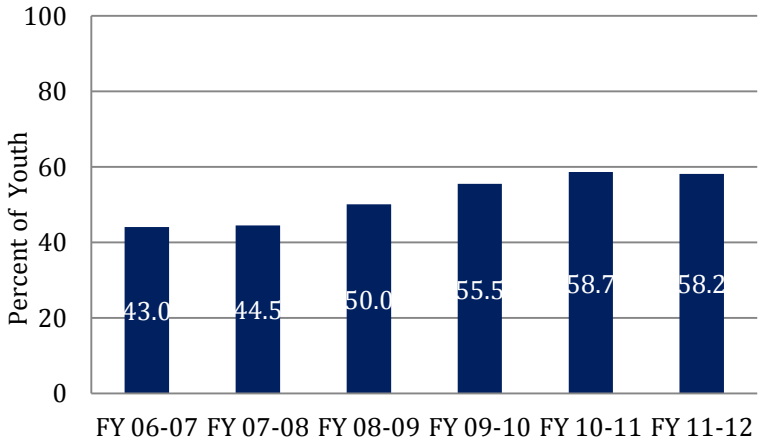
Initial mental health assessment data were also examined across successive cohorts. Mental health assessment data were available from two assessment tools: the CJRA and the CCAR. The CCAR data was included to depict mental health symptoms in this report for the following reasons: 1) the CJRA current 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[6]. 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

[6] 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.

scores of 5 or higher indicate "*Symptoms are present which require formal, professional mental health intervention.*"

Figure 3 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 six successive cohorts between FY 2006 – 07 and FY 2011 – 12.

Figure 3. Percent of Youth in Need of Mental Health Intervention across Six Cohorts

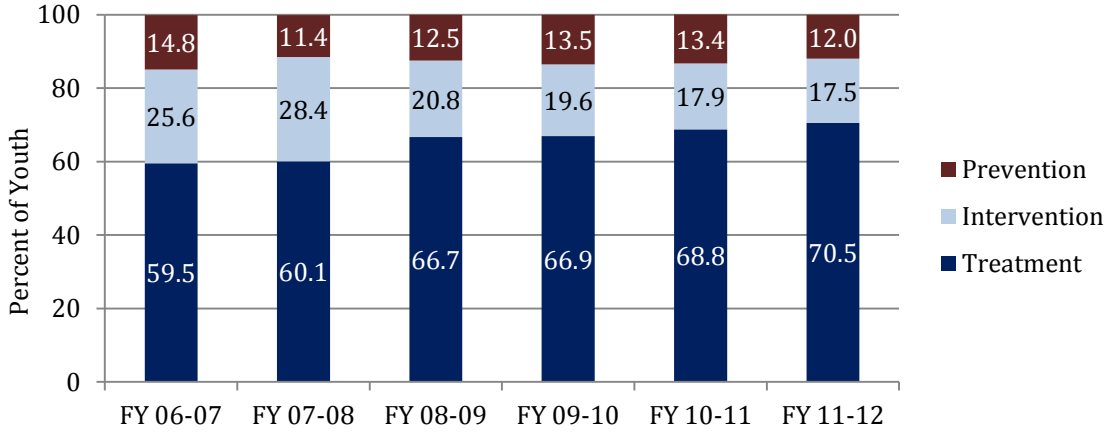


This figure also depicts the startling statistic that for the past four fiscal years, at least *half* of the newly committed population had mental health needs that required professional intervention. It is important to note that while the mental health needs exhibited by the youth may not directly affect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

NEED FOR SUBSTANCE ABUSE TREATMENT

While mental health needs are significant, treatment needs are even higher for substance abuse. Figure 4 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 six years, the majority of newly committed youth required treatment services for substance abuse. During FY 2011 – 12, 70.5% of newly committed youth had Treatment level needs, which is an 11% decrease from FY 2006 -07. 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 4. Percent of Youth in Need of Substance Abuse Treatment by Cohort

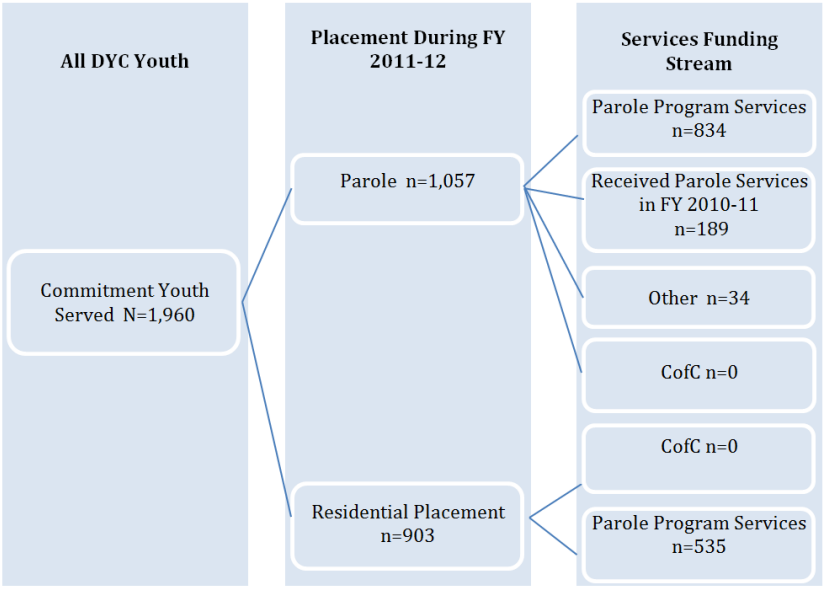


Continuum of Care Youth Served during FY 2011– 12

During FY 2011 – 12, DYC served 1,960 unique youth in commitment (see Figure 5). More than half of these youth (n=1,057) spent some portion of the fiscal year on parole. The remaining 903 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 78.9% (n = 834) received transition and parole services paid for by the parole programs services line item in the budget. Of the 223 youth on parole who did not receive services in this fiscal year, 189 received services during the prior FY. The remaining 34 youth, like all committed

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

Figure 5. Funding for Parole and Transition Services during FY 2011 – 12



In addition to youth on parole, more than half (n = 535) 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; or could also include treatment services designed to follow the youth into, or better prepare the youth for the community.

YOUTH DEMOGRAPHICS

The following two figures (6 and 7) depict the demographic distributions of the entire commitment population as well as youth newly committed this year. Tables 1 and 2 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 6. Ethnicity of Committed Youth

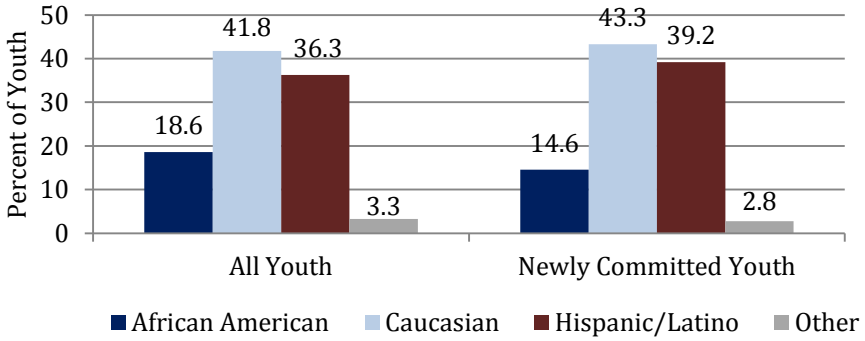


Figure 7. Gender of Committed Youth

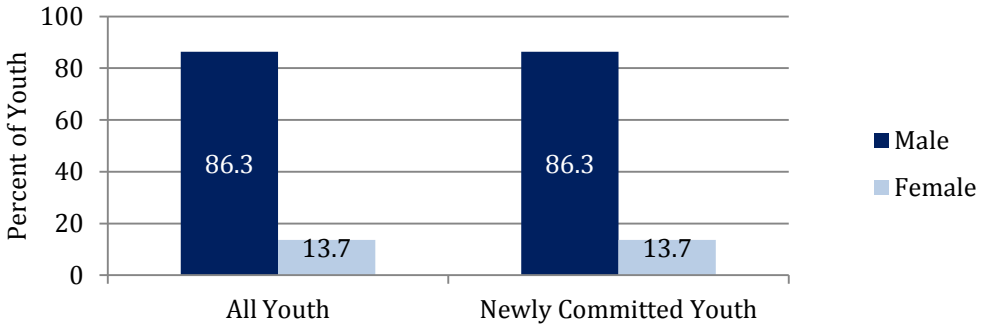


Table 1. Original Commitment and Offense Types

Variable	All Youth	Newly Committed Youth
	n = 1,960	n = 533
Original Commitment Type	**Percent**	**Percent**
Non-Mandatory	68.5	66.6
Mandatory	19.7	19.7
Repeat	8.5	11.3
Violent	0.9	0.4
Aggravated	2.2	1.9
Missing	0.2	0.2
Original Commitment Charge	**Percent**	**Percent**
Felony	59.7	57.6
Misdemeanor	33.6	34.3
Petty	0.2	0.0
Missing	6.5	8.1

*For the 17 youth with two commitments, the most recent commitment record was utilized for computations.

Table 2. Mean Age at Commitment

	All Youth	Newly Committed Youth
	n = 1,960	n = 533
Age at Commitment	**16.7**	**16.8**

EFFECTS OF TREATMENT ON YOUTH DISCHARGED IN FY 2011 – 12

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 2011 – 12 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 domains were calculated between the CJRA conducted at initial assessment and those done at parole and discharge using raw domain scores. *Increase*s 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 just prior to 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 placement 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 8 depicts the gains in protective factors.

Figure 8. Improvement in Mean CJRA Dynamic Protective Factors from Intake to Parole and from Intake to Discharge

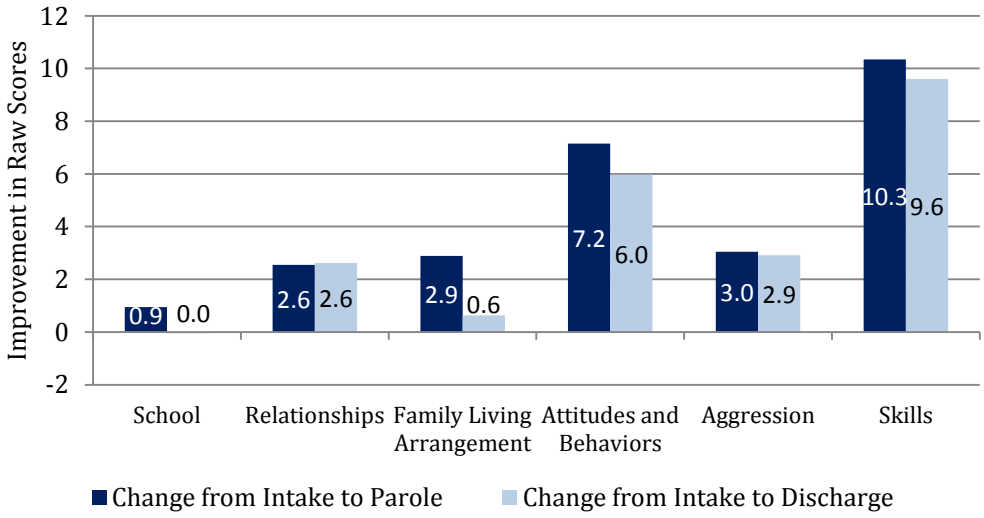
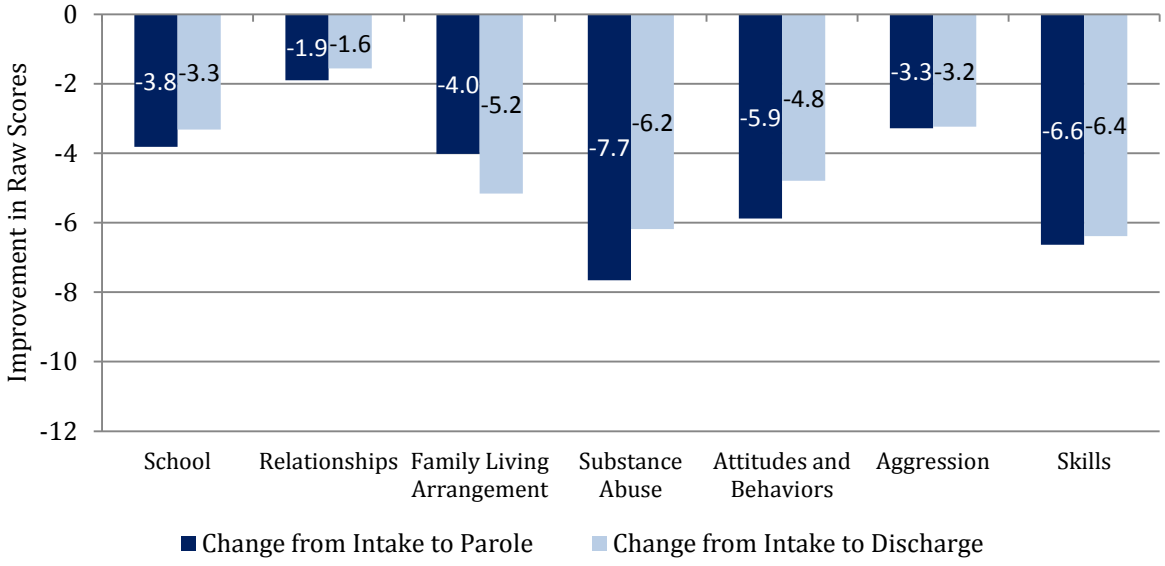


Figure 9 depicts the reduction of risk that occurred as youth progressed through the Continuum of Care. The bars are oriented in a downward direction, illustrating the decrease in risk factors.

Figure 9. 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[7] 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[8])***. 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 youth to become responsible, productive citizens of Colorado.

The FY 2011 – 12 report utilizes categories of services, supervision, support and treatment, that DYC has historically utilized. Throughout FY 2011 – 12, DYC evaluated all services provided to youth as well as categories of services to determine whether a better system of categorization can be used. Starting in FY 2012 – 13, new categories will be utilized. Below is the description of the historic categories that will be utilized for the final time in this report.

Supervision is designed to temporarily constrain/monitor youth behavior. Residential placement is the most extreme form of 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. In the community, supervision might consist of tracking and day reporting with a parole officer, electronic monitoring, and substance use testing as needed.

[7] 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.

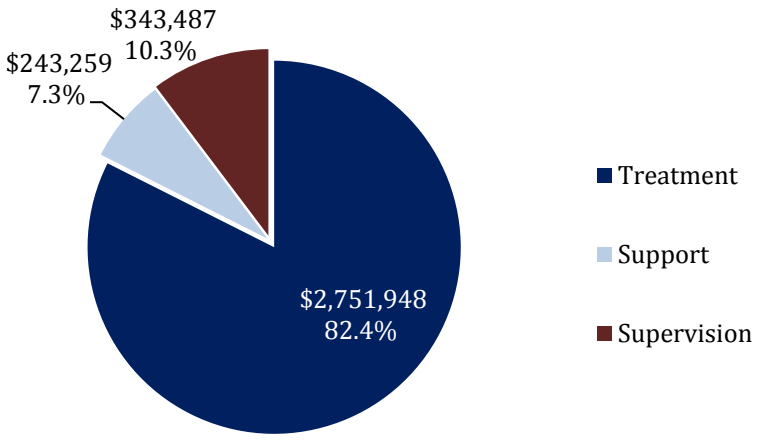
[8] Drake, E. (2007). Evidence-based juvenile offender programs: Program description, quality assurance, and cost. Washington Institute for Public Policy. Document No. 07-06-1201 Accessed at www.wsipp.wa.gov, September15, 2011

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.

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 2011 – 12 (see Figure 10). Supervision occupies the second greatest proportion of spending followed by support.

Figure 10. Expenditures by General Category Direct Service Dollars

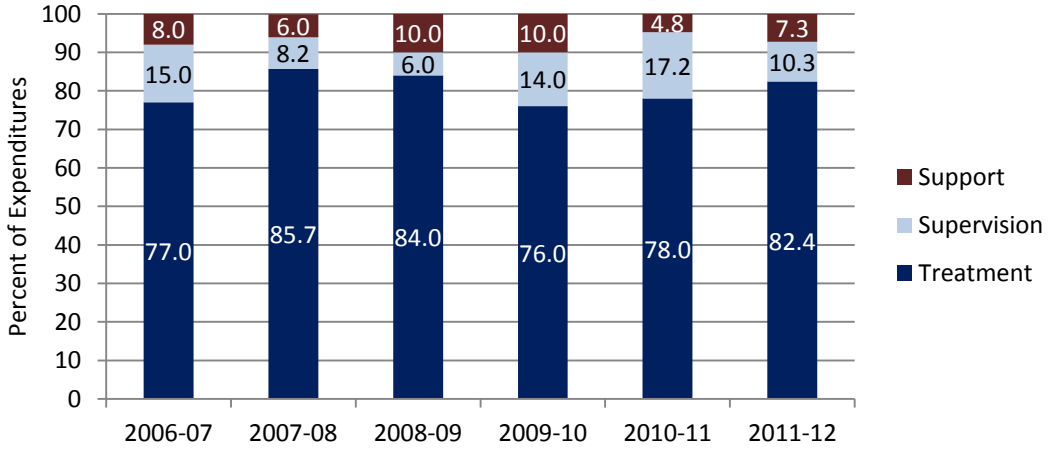


For the past six years, treatment spending has encompassed the greatest proportion of the budget. The relative percentage spent on treatment has, however, changed fairly substantially. ***The percentage of the budget spent on treatment declined 12% from FY***

2008 – 09 to FY 2009 – 10. This drop coincided 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. During FY 2011 – 12, DYC attempted to adjust spending to ensure treatment services were prioritized to the greatest extent possible resulting in a rise in the *percent* of dollars spent on treatment even while the *absolute amount* of treatment spending declined by over one million dollars.

Figure 11 depicts the percent of direct service dollars spent on support, supervision and treatment over the past six fiscal years. Substantial fluctuations can be seen in the percent of dollars spend on supervision and treatment. 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 11. Expenditures by Category over the Past Six Years

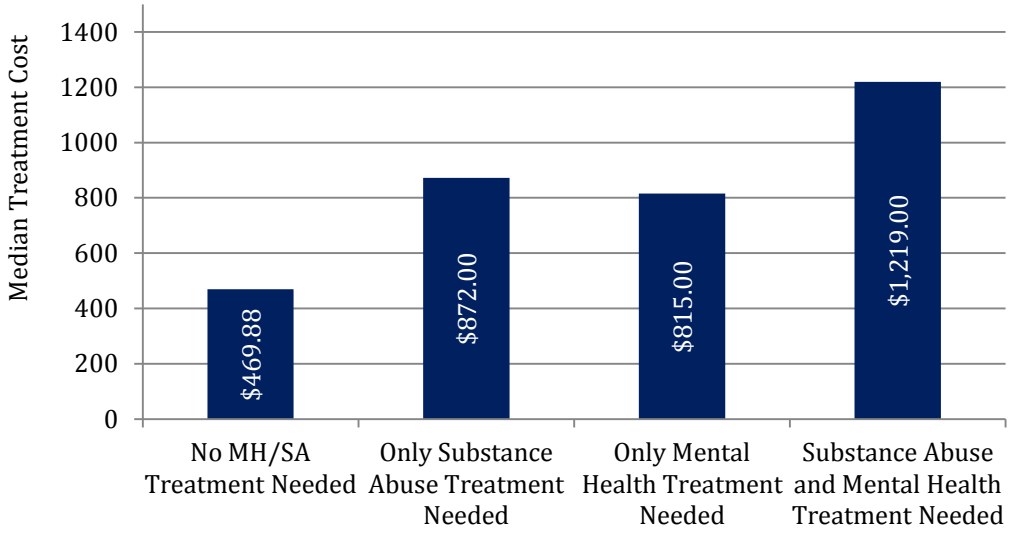


Even given these tough economic circumstances, DYC has implemented policies to match treatment to the needs of the youth. As described above, DYC has an extensive assessment protocol for all youth that leads to treatment decisions. One indicator of high youth treatment need is Overall Symptom Severity on the CCAR. An elevated domain score (five

and higher) indicates the need for professional mental health intervention. DYC also assesses youth for their substance abuse treatment needs, rating each youth as needing treatment, intervention, or prevention services. One would expect that treatment expenditures would be higher for youth with mental health treatment needs and substance abuse treatment needs than for those youth without mental health or substance abuse treatment needs.

Figure 12 compares the median treatment dollars spent during FY 2011 – 12 on youth with mental health and/or substance abuse treatment needs versus those who have neither of those treatment needs. The spending on those with mental health and substance abuse treatment needs greatly surpassed the spending on those with neither treatment needs indicating that DYC personnel recognized the need for additional treatment and were able to obtain it for these youth.

Figure 12. Median Parole/Transition Treatment Dollars Spent by Mental Health and Substance Abuse Treatment Needs



Summary & Recommendations

This report adds another cohort of youth to the five years of data presented last year. Again, it appears that youth entering the commitment system have intense and complex needs. In fact, more than 90% of newly committed youth required substance abuse and/or mental health treatment, with over 50% of newly committed youth in FY 2011 – 12 requiring treatment for both. Criminogenic protective factors continue to decline while risk factors increase for each subsequent cohort of youth.

DYC has made a concerted effort to prioritize parole and transition services spending on treatment and support. During FY 2011 – 12, the proportion of the overall budget spent on these two categories increased over the previous fiscal year. Furthermore, it appears that spending was targeted to those youth with the greatest needs. Spending on youth with either substance abuse or mental health needs was far greater than those without but substantially less than those youth with co-occurring substance abuse and mental health needs.

RECOMMENDATIONS

While describing the youth population served in the continuum of care is an important component, evaluating the practices of serving these youth will lead to a more complete understanding of the program. DYC has recently implemented a number of best practices for communicating with youth, determining their treatment needs, and helping to access needed services. These practices are at different levels of integration in the DYC system so it will be important to assess not only the implementation process but also the fidelity of adherence.

For example, Motivational Interviewing (MI) is a communication approach which promotes mutual respect between youth and staff and encourages youth-driven behavior change. Nearly all DYC staff have been trained in this method of communication. To be used effectively staff must understand the basic principles and apply them consistently in all

communication with youth. To evaluate the integration of MI in the DYC system it will be necessary to assess staff knowledge of the practice as well as their likelihood to utilize it when working with youth. The literature suggests that full integration of this type of communication may lead to better youth outcomes especially related to attitudes and behaviors. It would be impossible, however, to attribute the improvements seen in youths' CJRA scores to this practice without first evaluating its incorporation in the system.

Another evidence based practice implemented by DYC is the utilization of Multi-Disciplinary Teams (MDT) to create Discrete Case Plans (DCP) for youth treatment and placement decisions. MDTs represent not only a shift in practice but also a philosophical change. To assess the effects of MDTs, it will first be necessary to determine the extent to which those involved in the process (assessment staff, client managers, service providers, the youth and their families) adhere to the MDT model. It will be necessary to collect data from all MDT stakeholders in order to get a comprehensive picture of its application within the continuum of care.

One final recommendation would be to increase the level of assessment at both the time of parole and at discharge from DYC. Currently, the CJRA is the only assessment routinely administered at these time points. While this instrument provides a picture of the youths' likelihood to recidivate it does not give an indication as to whether other risk factors have been addressed while the youth was in residential commitment. Evaluation of educational, psychosocial, substance use, and mental health status could prove quite valuable at these later time points.