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JDTC GUIDELINES EVALUATION

JDTC Evaluation Brief:
Baseline and Service Data from Ten Sites Using Needs Based Assignment

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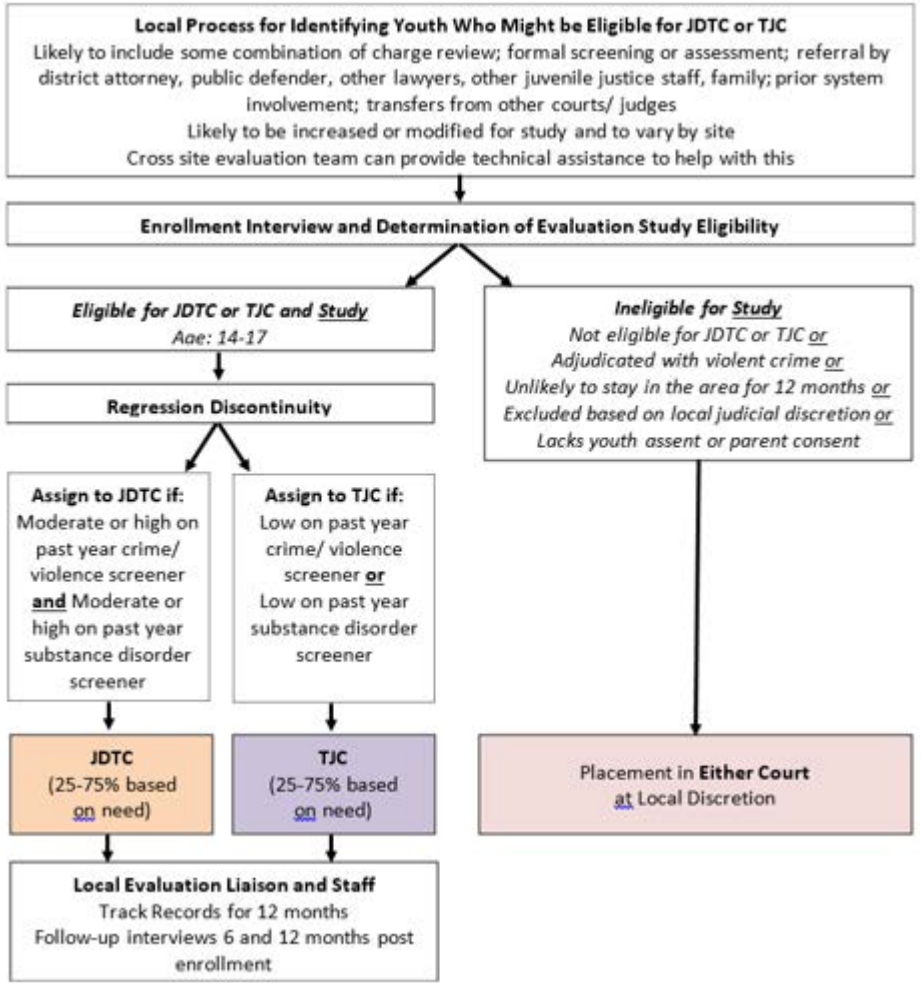
Background. Early juvenile drug treatment courts (JDTC) followed a format similar to adult drug courts, however, this format did not address the unique needs of juveniles. In 2003, the 16 Strategies were developed to address these unique needs by a consensus panel of practitioners and researchers. Research with courts following the 16 Strategies failed to provide convincing evidence that this "model" was associated with significant reductions in recidivism or drug use. In 2016, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) released a new set of research-based and practice-informed guidelines, developed through a process of translation of extant research about JDTCs and related interventions into comprehensive, reasonable, actionable, understandable, and measurable guidelines.[1] To better understand the utility of these new guidelines, OJJDP provided funding for the JDTC Guidelines Cross-Site Evaluation. This study compares youth outcomes from 10 JDTCs with 10 Traditional Juvenile Courts (TJC) in the same jurisdictions. Two sites used a randomized controlled trial, and eight sites followed needs-based assignment using a regression discontinuity design based on a standardized screener when placing youth into a court (Figure 1)[2]. The court assignment process begins with the youth being determined as likely to be eligible for JDTC and TJC based on charges, records, or other local process. For JDTC eligibility, the youth must be between 14 and 17 years of age, and not adjudicated with a violent offense. For study eligibility, the youth had to be in the community for 12 months and consent/assent obtained from the youth and parent/guardian. Youth were assigned to JDTC if they scored moderate to high on both the substance use and crime/violence domain. Youth were assigned to TJC if they scored in the low range on either domain. Youth data were captured at baseline and at 6- and 12-month follow-ups using the study-specific version of the GAIN Quick.[3] The youths' official records were abstracted for recidivism, biological testing, treatment and substance use information. The degree to which the JDTC evidence-based guidelines were implemented at each site was assessed via an



[1] Office of Juvenile Justice and Delinquency Prevention (OJJDP). (2016). *Juvenile Drug Treatment Court Guidelines.* Washington, DC: Author. Retrieved from https://www.ojjdp.gov/juvenile-drug-treatment-court-guidelines.html.

[2] Dennis, M., Estrada, B., Baumer, P., Smith, C., Miles, C., Belenko, S., ... & Carey, S. (2019). Juvenile Drug Treatment Court (JDTC) Guidelines Cross-Site Evaluation Plan. United States Department of Justice, National Criminal Justice Reference Service. https://www.ncjrs.gov/pdffiles1/ojjdp/grants/252719.pdf

[3] Dennis, M. L., & Davis, J. P. (2021). Screening for more with less: Validation of the Global Appraisal of Individual Needs Quick v3 (GAIN-Q3) screeners. Journal of Substance Abuse Treatment, 126, 108414.

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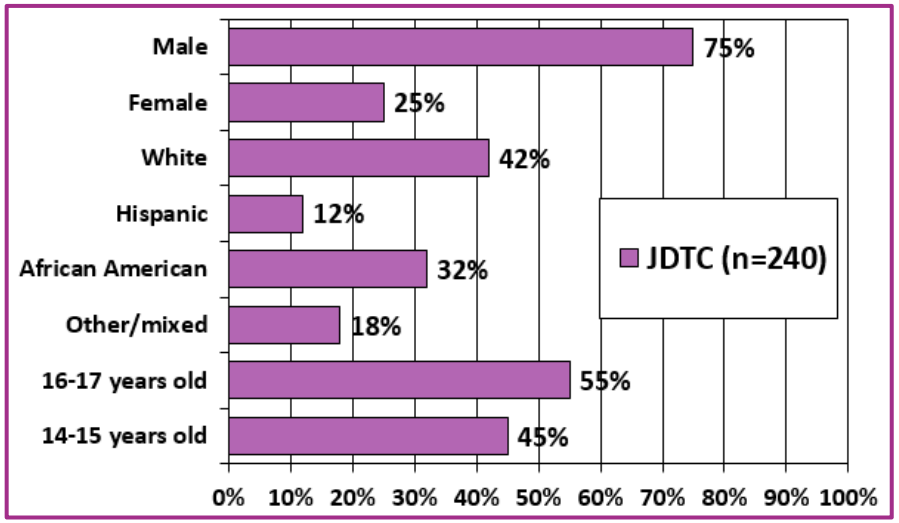
in-depth court self-assessment collected at baseline, again 2 years later and via structured site visits conducted once during implementation. This brief describes the baseline (intake) data from the 8 sites using needs-based assignment. This data can assist the juvenile justice field in the understanding of the characteristics of youth entering the juvenile justice system, the extent to which the use of standardized screening helps identify youth in need, and whether JDTCs are successful in referring the youth and succeed in getting youth the services they need.

Figure 2. Demographics at Study Enrollment

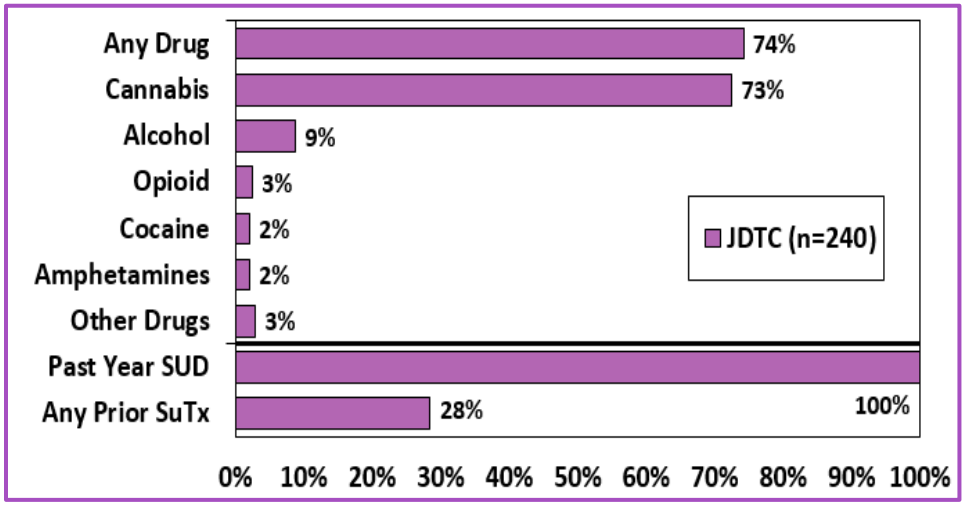


How did Youth Participate in the Study? A total of 415 youth were enrolled into the study between June 2018 and December 2020 in ten sites. They were then screened by the evaluation liaison staff with the GAIN Quick to determine need for drug treatment and risk of recidivism, resulting in 175 youth assigned to TJC and 240 assigned to JDTC. This brief reports on the JDTC group and provides a picture of the youth presenting to the JDTC system.

Who is being served in the JDTC programs? Three-quarters of the JDTC youth enrolled in the study were male, with the plurality self-identifying as White (42%), followed by African American (32%), Hispanic (12%) and 18% who identified as some other race/ethnicity or mixed. All youth were between the ages 14-17, with 55% being 16-17 years old (Figure 2).

To what extent does standardized screening help identify youth in need and target JDTC services to those most in need? Following JDTC guideline 2.3, youth were screened using the validated Youth Survey tool to facilitate referral to substance use disorder treatment. As shown towards the bottom of Figure 3, 100% of the youth in the JDTC program met the criteria for a Substance Use Disorder and 28% had one or more prior episodes of substance use treatment. The youth also disclosed the number of days they used various substances over the past 90 days, with weekly use calculated as 13 or more days of use during that timeframe. Cannabis use was by far the most frequently reported, with almost three-quarters of JDTC youth using it weekly. Nine percent of the youth used alcohol weekly, 4% used stimulants (including cocaine) weekly, and 3% used opioids (including heroin) or other drugs weekly (Figure 3).

Figure 3. Weekly Substance Use at Study Enrollment



Additionally, Figure 4 displays the percent of youth in JDTC who were in the moderate to high severity range on 7 domains: substance use (5 items), internalizing and externalizing mental disorders (5 and 6 items each), crime and violence (5 items), school problems (4 items), lifetime victimization (4 items) and wellbeing (6 items). Not surprisingly, as most of the youth were assigned to JDTC based on need, 100% reported moderate to high severity

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Figure 4. Youth Needs at Intake

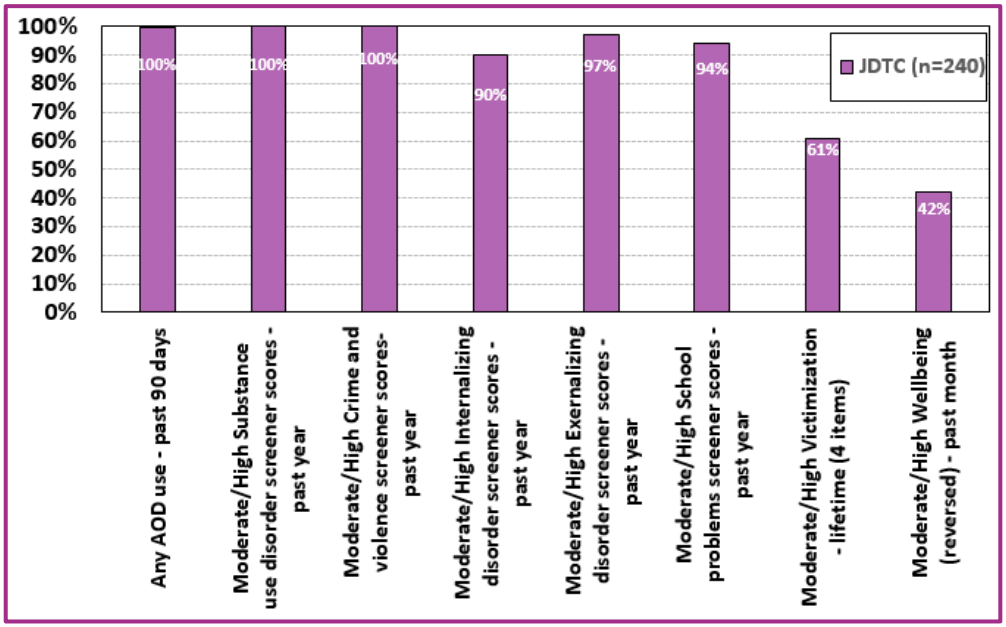
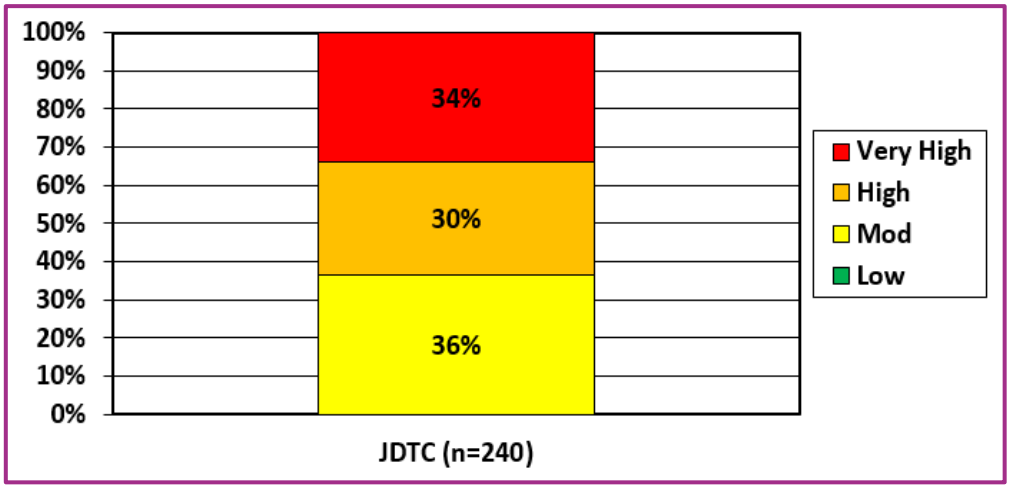


Figure 5. Youth Risk of Recidivism at Study Enrollment



substance use disorder problems (which equates to a likely substance use disorder diagnosis) and crime and violence problems. Almost all youth scored in the moderate to high range in internalizing/externalizing disorders and school problems (90%, 97%, and 94% respectively). Almost two-thirds (61%) of youth reported moderate to high severity of lifetime victimization problems, and 42% reported moderate to high severity of problems in general wellbeing.

Finally, Figure 5 shows the percent of youth at each level of recidivism risk which predicts the likelihood of recidivism in the next 12 months[1]. The risk measure was based a combination of the substance disorder screener and the crime/violence screener administered at baseline. Each screener was scored and problems classified as Low, Moderate, or High. The resulting nine combinations of the severity of substance use and crime and violence (from Low-Low to High-High) were further classified into four levels of recidivism risk (Low, Moderate, High, and Very High) with higher levels of risk indicating higher prediction of recidivism 12 months after baseline. Approximately one third of the youth were classified as moderate, high and very high risk for recidivism. By definition, youth with "low" risk of recidivism were excluded from needs-based assignment to JDTC. Together, these data show that using a standardized screener can successfully target youth in most need of services

What services did youth receive? According to the JDTC Guidelines, ongoing monitoring and case management should be utilized to ensure youth receive the services they need to improve behavioral health outcomes (5.4). Figure 6 compares records data results for the service cascade from the initial assessment of need through referral to substance use treatment initiation, engagement (participating 30 or more days and 2 or more sessions after intake), and continuing care (session in 91-180 days) for both JDTC and TJC. Relative to the youth assigned to TJC, those assigned by the screener to JDTC were significantly (p<.05) and clinically (odds ratio [OR]>1.2) more likely to meet the criteria for need from screener, urine, staff, family, or other referral (45% vs 100%, OR=121.0); be referred by court staff to substance use treatment (27% vs. 74%, OR=7.7); initiate substance use treatment (71% vs. 22%, OR=8.7); stay engaged in treatment for at least 4 weeks (14% vs. 46%, OR=5.2); and still

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be receiving continuing care after 90 days (6% vs. 18% OR=.34). Additionally, in comparison to previous reports from juvenile community supervision agencies in 33 counties, the JDTC retention rates of just those youth who initiated treatment were better in both engagement (16% vs 65%, OR=9.7) and continuing care (9% vs 25%, OR=3.4).[4]

What types of treatment did youth receive? Placement into a continuum of care and evidence-based substance use disorder treatment is another key recommendation from the guidelines (6.1 & 6.2), and eighty percent of the JDTC youth received outpatient treatment, followed by intensive outpatient (15%) and other placements (1%; Figure 7). In addition, 74% of the JDTC youth were placed into one or more evidence-based types of treatment (e.g., Motivation Enhancement Therapy/Cognitive Behavior Therapy, Seeking Safety, Seven Challenges, Functional Family Therapy, Adolescent Community Re-enforcement Approach, other Cognitive Behavior Therapy, Multi-Systemic Therapy), with the remainder getting locally developed treatment approaches.

Implications for juvenile justice. Based on baseline and records data, the 8 JDTC programs were successful in assessing youth's JDTC eligibility and making needs-based assignment to JDTC using a 10-item screening tool to assess need for substance use disorder treatment and risk of recidivism. Figure 6 validates the screening process successfully targeted the youth who would benefit most from substance use treatment (e.g., those with likely substance use disorder and high likelihood of treatment initiation and retention). While some of the TJC youth were referred to treatment, fewer initiated or stayed in treatment in comparison to those assigned to JDTC. Figure 7 also demonstrates that the JDTC programs were placing youth along a continuum of care and prioritizing evidence-based outpatient services found to be most effective in the prior meta analyses[5] and that are recommended in the guidelines.

Figure 6. Substance Use Treatment (SU Tx) Service Cascade

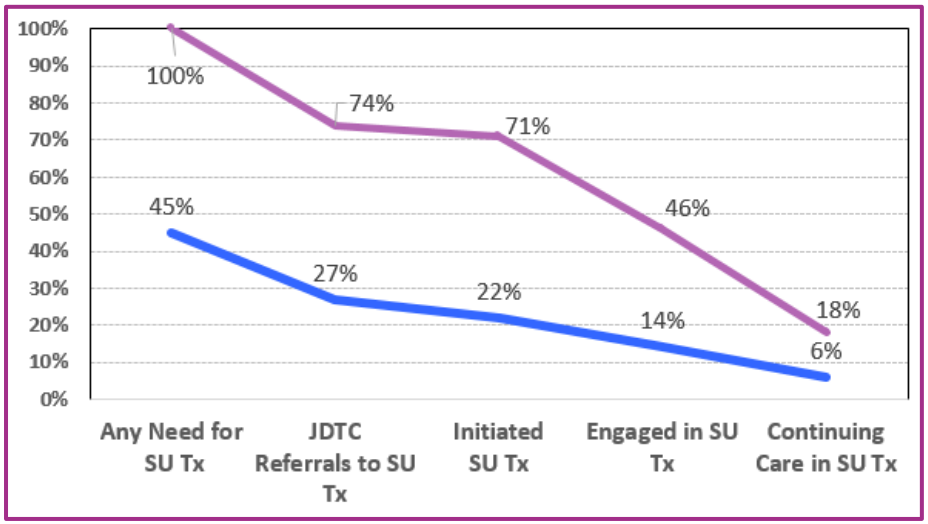
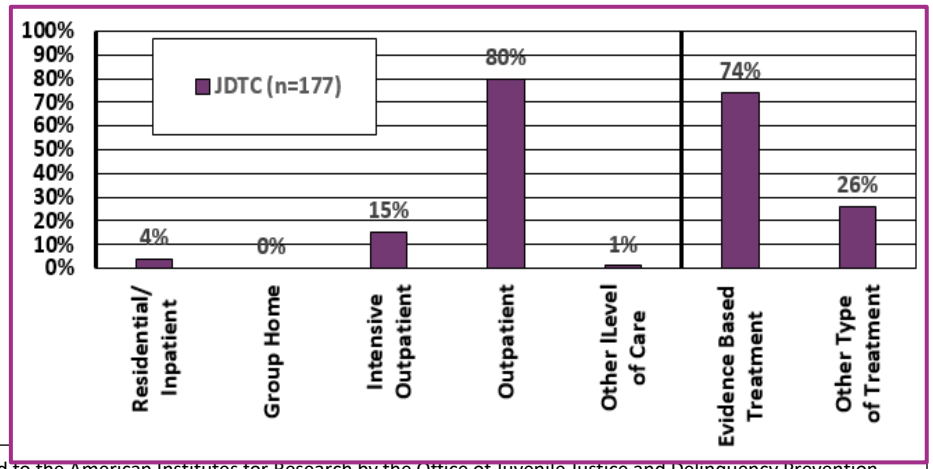


Figure 7. Level of Care and Treatment Modalities



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[5] Tanner-Smith, E. E., Lipsey, M. W., & Wilson, D. B. (2016). Juvenile drug court effects on recidivism and drug use: a systematic review and meta-analysis. *Journal of Experimental Criminology, 12*(4), 477-513.