Chemical Dependency Disposition Alternative

Report to the Washington State Legislature January 2000

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EXECUTIVE SUMMARY

The Chemical Dependency Disposition Alternative (CDDA) codified in RCW 13.40.165, became effective July 1, 1998. This disposition alternative provides local juvenile courts with a sentencing option for chemically dependent youth, allowing judges to order youth into treatment instead of confinement. RCW 70.96A.520 requires that:

> *"The department shall prioritize expenditures for treatment provided under RCW 13.40.165. The department shall provide funds for inpatient and outpatient treatment providers that are the most successful, using the standards developed by the University of Washington under section 27, chapter 338, Laws of 1997." In addition, " the department shall, not later than January 1 of each year, provide a report to the Governor and the Legislature on the success rates of programs funded under this section."*

To comply with this legislation, process and outcome evaluations have been designed to support the annual reports to the Governor and Legislature. This report describes the implementation of CDDA legislation, status of the outcome evaluation to date, data from the assessments to determine CDDA eligibility, and results from a process evaluation regarding implementation of CDDA.

Currently, 32 of 33 juvenile courts have implemented CDDA programs. A total of 369 youth have been placed in CDDA. Twenty-one have successfully completed 12 months of intensive treatment and supervision, 68 have been discharged, and 280 are still active in the treatment and supervision continuum

The CDDA outcome evaluation will compare recidivism, substance abuse, family functioning, school performance, and other measures of success between CDDA sanctioned and non-CDDA sanctioned youth. Outcomes will be compared at 3, 6, 12, and 18 months from the date CDDA eligibility is determined.

Recruitment for the CDDA outcome evaluation began in January 1999. As of September 1, 1999, a total of 102 youth from 7 counties have been recruited into the outcome evaluation. The majority of participants recruited thus far fall into the non-CDDA comparison group (N = 84); only 18 CDDA youth have been recruited. The small number of CDDA participants (N = 18) currently in the study precludes statistically or clinically meaningful comparisons from being made at this time.

The report to the Governor and Legislature in 2000 will provide information on short-term outcomes (3 and 6 months) and initial information on 12-month outcomes. The final report containing all outcome data will be presented in the December 2003 report to the Governor and Legislature.

Recommendations from the process evaluation regarding the implementation of CDDA include:

- Continue standardization of the CDDA screening procedure using the Washington State Risk Assessment Tool.

- Continue standardization of assessment to determine chemical dependency using the CDDA eligibility assessment tool.

- Expand CDDA eligibility to include youth with a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) substance abuse diagnosis.

- Allow greater discretion in determining CDDA eligibility of B+ offenses under RCW 13.40.165, especially for Violation of the Uniform Controlled Substance Act (VUCSA) sales or delivery charges, or cases where substance use was a contributing factor.

- Provide probation officers and prosecutors information from research studies demonstrating that all chemically dependent juveniles can benefit from treatment, regardless of their motivation and/or past treatment failures.

- Encourage dedicated CDDA probation officers and treatment staff to work together throughout the 12 months of CDDA supervision to promote use of the most effective treatment and sanctions.

- Encourage counties to utilize detention-based and intensive outpatient programs for locally sanctioned youth awaiting inpatient treatment.

- Provide increased incentives for locally sanctioned juveniles' participation in CDDA.

- Work with local juvenile courts, JRA, and the Division of Alcohol and Substance Abuse to meet the increasing need for inpatient treatment of locally sanctioned CDDA youth.

Chemical Dependency Disposition Alternative
2000 Report to the Legislature

I. Introduction

Chapter 338, Laws of 1997, created the Chemical Dependency Disposition Alternative (CDDA) and was effective July 1, 1998. The CDDA legislation was codified in RCW 13.40.165. This disposition alternative provides local juvenile courts with a sentencing option for chemically dependent youth, allowing judges to order youth into treatment instead of confinement. The Department of Social and Health Services' Juvenile Rehabilitation Administration (JRA), in collaboration with the department's Division of Alcohol and Substance Abuse (DASA), was given the responsibility of designing and implementing the program.

This legislation also required the University of Washington (UW) to develop standards for measuring the treatment effectiveness of CDDA. These standards were developed by the Alcohol and Drug Abuse Institute (ADAI) of the UW and presented in the 1997 report entitled "Effectiveness Standards for the Treatment of Chemical Dependency in Juvenile Offenders: A Review of The Literature" submitted to the Legislature January 1, 1998. These effectiveness standards will be used to determine the efficacy of the CDDA program on an annual basis as required by RCW 70.96A.520.

CDDA represents a collaboration of JRA, local juvenile courts, DASA's interests in using community-based programs as an alternative to detention, as well as the Legislature's interest in providing sentencing alternatives for chemically dependent juveniles. CDDA also represents a union of juvenile court-administered services and county-coordinated drug and alcohol treatment systems. CDDA provides local communities with an incentive to implement interventions for juvenile offenders that research demonstrates to be effective in reducing substance use among chemically dependent youth. In providing chemically dependent juvenile offenders with effective treatments, substance use should decrease, as should involvement in criminal behaviors. CDDA should not only reduce the state's costs of incarceration for juveniles, but provide a cost-effective means of improving the overall functioning of a juvenile while keeping him or her within the local community.

This report describes the implementation, to date, of the CDDA legislation statewide, as well as the outcome and process evaluation for CDDA. Descriptions of each county's CDDA program and unique features of these programs are provided in Appendix A.

II. Implementation of CDDA to Date

Although CDDA became available to all juveniles committing crimes after July 1, 1998, processing requirements of local juvenile courts delayed juveniles from entering CDDA until as late as November 1998.

To be eligible to be placed on the CDDA program, a youth must:

- be between 13 to 17 years of age,
- not have current A- or B+ charges,

- be chemically dependent, and
- not pose a threat to community safety.

Currently, 32 of the 33 juvenile courts have developed CDDA programs. The remaining juvenile court will implement a CDDA program beginning January 1, 2000. Of the 32 counties with active CDDA programs, 8 have plans in place to access Title 19 matching funds to increase fiscal resources for CDDA.

Since July 1, 1998, juvenile courts have placed a total 369 juveniles in CDDA. Sixty of these youth are committable," meaning they were eligible for 15-36 weeks of commitment to JRA. The remaining 280 are "locally sanctioned" youth eligible for 0-30 days in detention and up to 12 months of community supervision. To date, 21 juveniles have successfully completed 12 months of intensive treatment and supervision, 68 have been discharged, and 280 are still active in the treatment and supervision continuum. Reasons for discharging a youth from CDDA included commission of a new offense, failure to comply with program requirements (i.e., reporting to probation officer, treatment attendance), and termination of probation.

III. CDDA Evaluation

A. Evaluation Overview

Legislation associated with CDDA requires that:

> *"…the department shall prioritize expenditures for treatment provided under RCW 13.40.165. The department shall provide funds for inpatient and outpatient treatment providers that are the most successful, using the standards developed by the University of Washington under section 27, chapter 338, Laws of 1997. The department may consider variations between the nature of the programs provided and clients served, but must provide funds first for those that demonstrate the greatest success in treatment within categories of treatment and the nature of persons receiving treatment."*

The ability of the outcome evaluation to document statistically that one provider is more effective than another is severely limited for several reasons. There are four CDDA treatment modalities, each with numerous providers: (1) detention-based outpatient; (2) inpatient; (3) intensive outpatient; and (4) standard outpatient. The number of juveniles treated by each provider will, therefore, be relatively small. There is also wide variation in services being provided in each treatment modality (e.g., one inpatient program provides family education, another provides family meetings, another family therapy). These factors make it impossible to make statistically meaningful comparisons of individual provider outcomes. The outcome evaluation will be able to describe the aggregate outcomes of juveniles treated across the various providers and indicate which configuration of services is related to the most positive outcomes for locally sanctioned and committable juveniles based on measurement of the effectiveness standards.

To best use resources, the outcome evaluation is being conducted in eight counties. Counties

were chosen based on their size, how inclusive the county's CDDA model was of the elements of effective treatment included in the "1997 Effectiveness Standards" report, and by geographic location. The eight counties where the research will be conducted are:

Benton/Franklin	Kitsap	Spokane
Clark	Pierce	Yakima
King	Snohomish	

It is estimated, based on the number of juveniles placed in CDDA and recruited into the outcome evaluation last year in these eight counties, that the outcome evaluation will consist of 130 juveniles on CDDA and 130 juveniles who are eligible for CDDA, but do not participate in CDDA. If counties recruit greater numbers of youth than currently anticipated, up to a limit of 200 CDDA participants and 200 non-CDDA youth will be included in the study. JRA and UW are actively working with the eight counties to increase recruitment for the outcome evaluation.

In the CDDA outcome evaluation, assessments of substance use, criminal activity, and functioning in several important areas (e.g., family, social, and school) of juveniles in CDDA will be compared to those of juveniles who are eligible for CDDA, but do not participate in CDDA. These comparisons will be made at several time points: at baseline, which is the date the Adolescent Drug Abuse Diagnoses (ADAD) and Kiddie-Schedule for Affective Disorders and Schizophrenia (K-SADS) substance abuse module is administered, and again at 3, 6, 12, and 18 months from the date of the ADAD/K-SADS administration.

It should be noted that the youth in the comparison group may also receive substance abuse treatment, but not 12 months of CDDA-sanctioned treatment services. Therefore, the comparison group is not a "no treatment" group. Youth from the CDDA and comparison groups will all be followed for the entire 18-month study period, without regard to treatment status.

The effectiveness standards that will be used to measure outcomes of the two groups are:

- reduced criminal recidivism as defined, under a legislative directive, by the Washington State Institute for Public Policy as:
  - reduced criminal convictions and/or terms of community supervision
  - increases in completion of any restitution to victims ordered by the court

- reduced substance use as evidenced by:
  - reduction in the total number of days of substance use
  - the number of substances an individual currently uses
  - the proportion of positive urinalyses
  - re-admissions to a chemical dependency treatment program (detox, inpatient, or outpatient)
  - number of emergency room visits or inpatient medical hospitalizations

- improved school performance as evidenced by:
  - an improvement in grades
  - a decrease in truancy or dropout and/or number of school disciplinary actions

- improved family functioning as evidenced by:
  - fewer conflicts with family members
  - decreased runaway episodes

- improved social functioning as evidenced by:
  - less time spent with substance-using and/or delinquent peers
  - increased friendships with non-substance using peers

- improved psychological functioning as evidenced by:
  - fewer days of self-reported mood disorders
  - fewer admissions for psychiatric treatment, either inpatient or outpatient

These standards will be evaluated, in part, through repeated administrations (3, 6, 12 and 18 months) of the ADAD/K-SADS, and review of treatment and probation records at each follow-up point. Data regarding substance use and criminal activity will be corroborated at each follow-up by criminal histories, and, whenever possible, by urine drug screens taken by the probation department and/or outpatient substance abuse treatment agencies. Convictions (rather than arrests) will be used as a measure of criminal recidivism in the evaluation of the CDDA programs, as arrest data is difficult and costly to reliably obtain.

The outcome evaluation will also include a cost-benefit analysis conducted by the Washington State Institute for Public Policy. This analysis will provide information on fiscal savings on the costs associated with supervision, re-conviction, and detention of juveniles placed on CDDA treatment.

Initial data regarding short-term outcomes (3 and 6 months) will be available in the year 2001 report to the Legislature. The final report containing all outcome data will be presented in the January 2003 report to the Legislature. A timeline for the outcome evaluation is provided in Appendix B.

In addition to the CDDA outcome evaluation, all ADAD/K-SADS administered throughout the state to determine CDDA eligibility are being assembled in a database at the UW until July 1, 2000. This database contains profiles of all youth with a suspected substance use problem who may have been eligible for CDDA. It is anticipated that information on approximately 1,500 youth will be available in this database.

B. Current Status of CDDA Outcome Evaluation

Recruitment for the CDDA outcome evaluation began in January 1999, and will be completed by September 2000. As of September 1, 1999, a total of 102 youth from seven counties have been recruited into the outcome evaluation. The major difficulty in recruiting study participants is meeting the requirement that an advocate be involved in recruitment when parents are not available, which is most often the case. The State Institutional Review Board (IRB) requires that only an attorney, public defender, prosecutor, guardian ad litem, or chaplain affiliated with the juvenile court may act as youth advocates in the recruitment process. Establishing a workable procedure involving such advocates, who usually have limited time available, has proven to be more complex than

initially anticipated. JRA and UW are working to assist the eight counties in developing viable recruiting procedures with appropriate advocates.

The majority of participants recruited thus far for the outcome evaluation (N = 102) fall into the non-CDDA comparison group (N = 84); only 18 CDDA youth have been recruited. As of October 1, 1999, 59 participants were due for 6-month follow-up interviews. Follow-up interviews have been completed on 53 of those 59 participants (90 percent). Twelve-month interviews begin in mid-October 1999, and 18-month follow-up interviews will begin in April 2000. All interviews will be completed by January 2002.

The small number of CDDA participants (N = 18) currently in the study precludes statistically or clinically meaningful comparisons from being made at this time. Data is available on 834 youth who have been evaluated for the CDDA program from 20 counties. This report presents information on that group of youth.

IV. CDDA Eligibility Assessment Data

A. Information on all Youth Assessed for CDDA

The average youth assessed for the CDDA program was male (75.5 percent), 16 years old, had completed and passed the 8th grade, and for the last year lived with his mother. The ethnic breakdown of the sample is 63.3 percent Caucasian, 11.8 percent Hispanic, 10.1 percent African American, 7.9 percent Native American, and 1.8 percent Asian/Pacific Islander.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) is the official criteria used in the United States to diagnose mental disease, including substance use disorders. Two levels of impairment are assessed by the DSM-IV. "Chemical dependence," the more severe, is characterized by repeated use, despite significant substance-related problems, that typically leads to tolerance, withdrawal, and compulsive drug-taking. "Substance abuse" is characterized by repeated use leading to negative consequences, but does not include symptoms of tolerance, withdrawal or compulsive use. A diagnosis of substance abuse is far more likely in individuals who have recently begun taking the substance. Some individuals, however, have substance-related problems over long periods of time without ever developing substance dependence.

Of the youth whose information was sent to the UW, 74.1 percent (N = 618) received a DSM-IV diagnosis of chemical dependence, 10.3 percent (N = 86) were diagnosed as substance abusers, and 15.6 percent (N = 113) received no formal DSM-IV substance use diagnosis classifying them as substance misusers. As shown in Table 1, the percentage of youth with substance dependence, abuse, and no DSM-IV diagnosis varied across counties.

Table 1				
DSM-IV Substance Use Diagnoses for Youth Evaluated for CDDA				
	Number of	**% Chemically**	**% Substance**	**% No DSM-IV**
County	**Evaluations**	**Dependent**	**Abuse**	**Diagnosis**
Benton Franklin	19	63.2	31.6	5.3
Chelan	2	100	0	0
Clark	20	100	0	0
Columbia	6	66.7	16.7	16.7
Cowlitz	20	75	21.4	10
Douglas	1	0	100	0
King	60	75	13.3	11.7
Kitsap	56	80.4	8.9	10.7
Kittitas	5	60	20	20
Lincoln	2	50	50	0
Okanogan	21	52.4	9.5	38.1
Pierce	86	61.6	7.1	32.1
San Juan	1	100	0	0
Skagit	5	80	20	0
Snohomish	200	60	10.5	29.5
Spokane	159	89.9	8.2	1.9
Thurston	9	88.9	0	11.1
Walla Walla	4	100	0	0
Whitman	1	100	0	0
Yakima	157	80.3	11.5	8.3
Totals	834	74.1%	10.3%	15.6%

Based on the information obtained from the ADAD/K-SADS interview and the ASAM criteria, a specific treatment modality was recommended for each juvenile. The American Society of Addiction Medicine (ASAM) criteria are detailed criteria used to determine the most appropriate level of care along a four-level continuum: (1) outpatient treatment; (2) intensive outpatient/partial hospitalization; (3) medically monitored intensive inpatient and; (4) medically managed intensive inpatient treatment. The ASAM criteria assist evaluators in determining the need for specific intensity of treatment based on the need for detoxification, treatment resistance, co-existing disorders and relapse potential, as well as safety issues.

A treatment recommendation was supplied for 790 juveniles. Table 2 presents the percent of youth recommended for each treatment modality based on their substance use diagnosis. Chemically dependent youth received the majority of recommendations for inpatient, intensive outpatient, and detention-based treatments. Not surprisingly, a recommendation for no treatment was given primarily to youth without a DSM-IV substance use disorder diagnoses.

Table 2
Treatment Recommendations Based on DSM-IV Substance Use Diagnoses

DSM-IV Diagnosis	Inpatient	Intensive Outpatient	Detention-Based Outpatient	Standard Outpatient	No Treatment
Chemically Dependent (N=578)	52.4%	36.5%	4.8%	4.2%	2.1%
Substance Abuse (N=83)	7.2%	42.2%	0.0%	21.7%	28.9%
No DSM-IV Diagnosis (N=129)	3.9%	11.6%	2.3%	15.5%	66.7%

B. Comparisons of CDDA and Non-CDDA Youth

Of the 834 youth evaluated for CDDA, 177 (29.1 percent) were placed on CDDA. RCW 13.40.165 states a youth must be chemically dependent to be eligible for CDDA. Of the 177 youth placed on CDDA, 84.7 percent (N = 149) were diagnosed as chemically dependent, while 8.0 percent (N = 14) were diagnosed as substance abusers, and 7.4 percent (N = 13) received no DSM-IV substance use disorder diagnosis. Explanations of why some non-chemically dependent youth entered CDDA are discussed in the Process Evaluation Section under Step C (page 15).

Treatment recommendations were available for 160 of the 177 CDDA youth. The majority of treatment recommendations were for inpatient, 55.6 percent (N = 89), or intensive outpatient treatment, 30.6 percent (N = 49). Detention-based treatment was recommended for 8.8 percent (N = 14) and standard outpatient treatment for 5.0 percent (N = 8).

There were no significant differences in the proportion of Caucasian, African Americans, Native Americans, or Hispanics in the CDDA and non-CDDA groups. Analyses, however, revealed that significantly fewer eligible females than males entered CDDA. Further analyses indicated that females in CDDA (N = 31) had significantly ($p>0.01$) more psychological, social, alcohol and drug problems than females not in CDDA (N = 168). However, the medical, school, and family problems measured by the ADAD/K-SADS of CDDA and non-CDDA females were not significantly different.

Table 3 presents a comparison of CDDA and non-CDDA youth on several variables. No significant differences were found between CDDA and non-CDDA youth with respect to medical, school, social, psychological, family, or general background variables.

Table 3 Comparison of CDDA and Non-CDDA Youth			
	In CDDA (N = 177)	Not In CDDA (N = 657)	t- or X^2 Value
Age	15.7	15.5	1.70
Ethnicity			9.31
% African American	32.8	67.2	
% Caucausian	28.8	71.2	
% Hispanic	34.2	65.8	
% Native American	30.8	69.2	
% Female	17.5	25.7	11.23*
% Ever Homeless	23.7	19.4	1.62
# of Times Hospitalized	0.81	1.1	0.78
Days of Medical Problems in Previous Month	2.7	2.6	0.05
Highest Grade Passed	8.6	8.6	0.18
% Currently in School	63	61	3.30
Days Truant in Previous Month	27	27.6	0.23
# Days Worked in Last Month	4.6	6.6	1.71
Dollars Earned Previous Month	104.06	112.81	0.30
% Previous Inpatient Mental Health Treatment	11.3	11.4	1.50
			* p < 0.01

Several significant differences between CDDA and non-CDDA youth were found in their involvement with illegal activities. As shown in Table 4, significantly more CDDA youth reported illegal income during the previous year. Moreover, significantly ($p<.05$) more CDDA than non-CDDA youth reported having made over $1,000 illegally in the previous year (26.6 percent vs. 19.7 percent respectively). CDDA youth also reported significantly fewer probation violations compared to non-CDDA youth.

With respect to substance use, Table 5 shows CDDA youth reported using significantly more drugs than non-CDDA youth during the previous six months and had used crack cocaine for a longer period than non-CDDA youth. No significant differences in the age at first use, or duration of use of any other substances were revealed between groups. A significantly greater proportion

Table 4
Comparison of Criminal Behavior for CDDA and Non-CDDA Youth

Variable	In CDDA (N=177)	Not In CDDA (N=657)	t- or X2 Value
# of Lifetime Arrests	7.7	7.5	0.14
Days of Illegal Activity in Previous Month	11.3	11.1	0.09
# of Offenses Committed in Previous 3 Months	17.5	18.5	0.26
% Reporting Illegal Income Last Year	58.8	42.6	15.90*
# Times Picked up by Police	9.2	8.3	1.02
# Time Violated Probation	8.8	12.6	1.89

*p<0.01

With respect to substance use, Table 5 shows CDDA youth reported using significantly more drugs than non-CDDA youth during the previous six months and had used crack cocaine for a longer period than non-CDDA youth. No significant differences in the age at first use, or duration of use of any other substances were revealed between groups. A significantly greater proportion of CDDA than non-CDDA youth ($p<0.05$) reported spending "a lot" of time with drug-using peers (42.5 percent vs. 34.7 percent respectively). There were no significant differences between CDDA and non-CDDA youth in the percentage of reported alcohol or drug problems of immediate family members.

Table 5
Comparison of Substance Use in CDDA and Non-CDDA Youth

Variable	In CDDA (N=177)	Not In CDDA (N=657)	t- or X2 Value
Age Alcohol First Used	12.2	12.3	0.57
Age Any Drug First Used	11.2	11.2	0.87
Age Tobacco First Used	9.7	9.5	0.35
# of Drugs Used in Previous Six Months	2.8	2.2	3.88*
# of Drugs Used in Previous Month	2.1	1.8	2.93**
Months of Regular Alcohol Use	26.8	23.8	1.54
Months of Regular Marijuana Use	30.8	29.0	0.97
Months of Regular Amphetamine Use	5.3	3.6	1.79
Months of Regular Cocaine Use	4.2	2.6	1.74
Months of Regular Crack Use	2.6	0.7	2.70**
Months of Regular Hallucinogen Use	4.2	2.8	1.67
Months of Regular Tobacco Use	29.0	30.0	0.55
# Previous Inpatient Substance Use Treatments	0.6	1.3	1.69

In summary, youth admitted into CDDA reported no more severe medical, school, social, family, or psychological problems than youth not placed in CDDA. CDDA youth did report significantly more use of drugs, were more likely to be chemically dependent, and appeared to have used most drugs for a longer period of time than non-CDDA youth. However, only the duration of crack use was significantly greater for CDDA than non-CDDA youth. CDDA youth reported more involvement with illegal activity than non-CDDA youth, but fewer formal violations of probation, perhaps making them less of a risk for a disposition alternative.

V. Process Evaluation

In addition to determining whether CDDA is more effective than standard probation services and which substance abuse treatment modalities are most successful, there is substantial interest in what processes and decisions are involved in moving a juvenile through each of the steps (A-E) outlined in Figure 1.

To obtain this qualitative information, individuals involved with CDDA were interviewed in 14 counties:

Benton/Franklin	King	Skamania
Clark	Kitsap	Snohomish
Clallam	Klickitat	Spokane
Cowlitz	Okanogan	Yakima
Grant	Pierce	

These counties were chosen based on geographical location, size, and stage of CDDA implementation.

In each county, individuals representing the following positions were interviewed: Juvenile County Court Administrator, County Alcohol and Drug Coordinator, CDDA Project Coordinator, assessors for CDDA, public defenders, prosecutors, other attorneys, and juvenile court judges. Additionally, the chair of the Washington Association of Juvenile Court Administrators and the chair of the Washington Association of County Alcohol and Drug Coordinators were interviewed, along with several inpatient and outpatient treatment providers for CDDA. Interviews were conducted via phone between September 1 and October 22, 1999.

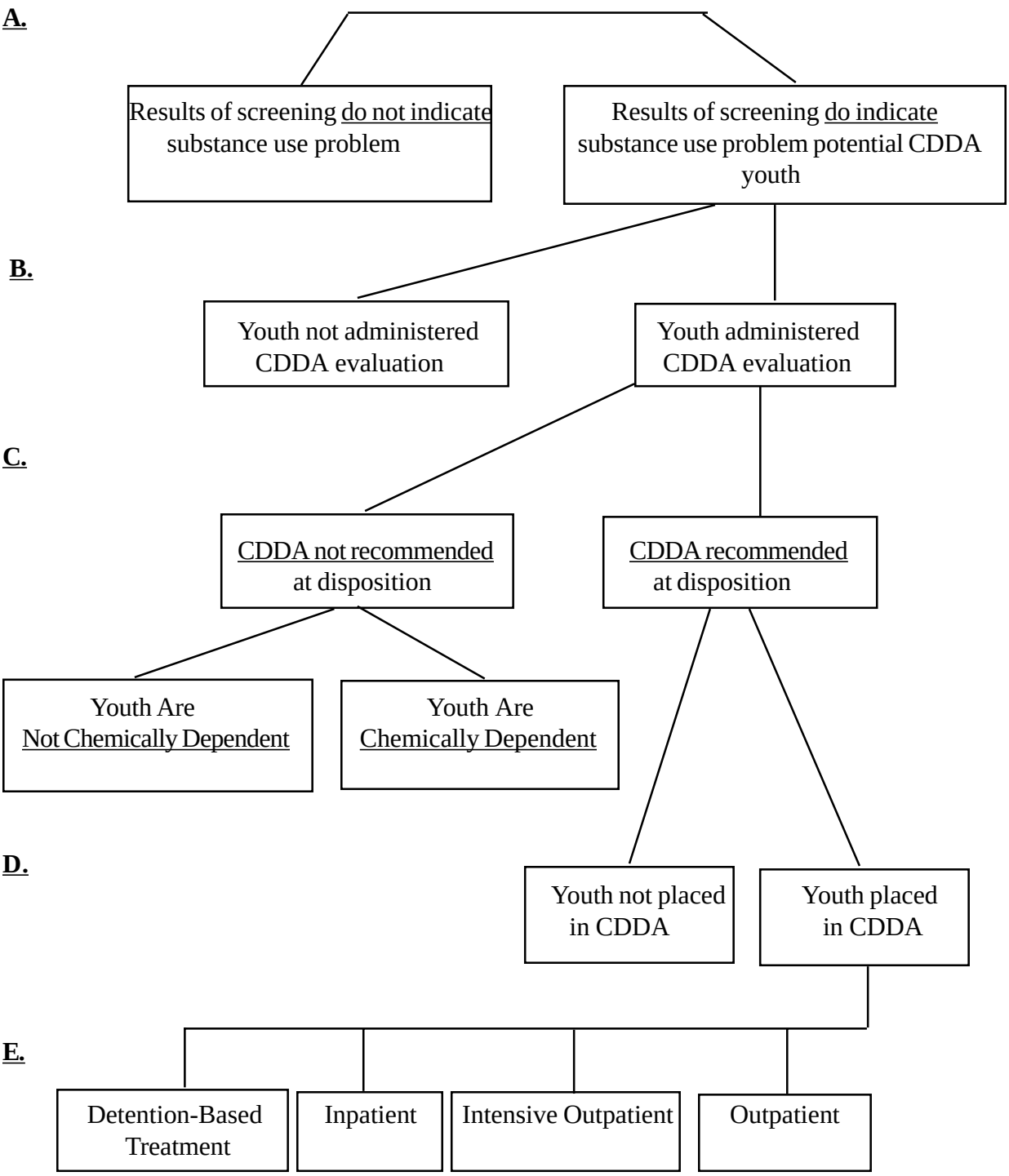
Three counties were still in the process of implementing their CDDA models. Interviewees in those counties felt they did not have enough information to comment on all questions. Prosecutors, attorneys, and judges felt they did not have knowledge of screening and assessment procedures for CDDA and did not comment on questions related to those processes. Below is a list of questions asked, and a summary of responses to those questions, as well as suggestions regarding each step. A list of all questions asked is provided in Appendix C.

Step A. ***"How are juveniles screened for substance abuse problems in your county? Is the Drug and Alcohol section of the Washington State Risk Assessment Tool (WSRAT) used? If not, why not?"***

Of the 11 counties with active CDDA programs, 9 use the WSRAT as a screening tool. Youth whose alcohol or drug use is judged to cause impairment in functioning on the WSRAT are referred for a full CDDA evaluation. Two counties prefer to administer the WSRAT later in the judicial process and continue to screen youth for substance use problems with a variety of formal and informal means. In these counties, youth who had not previously been evaluated for CDDA, but were found to have a possible substance use problem on the later administration of the WSRAT, are then referred for a CDDA evaluation.

Figure 1

Recommended Juvenile Court Procedures for CDDA



Although the majority of counties used the WSRAT as a screen to identify potentially eligible CDDA youth, this is not the only means by which a youth can be referred for a CDDA evaluation. Intake and probation officers make CDDA referrals based on knowledge of a juvenile's past and/or current behavior. Attorneys, public defenders, and even judges request CDDA evaluations for youth. In addition, youth themselves and family members request evaluations for CDDA.

Suggestions:

- Encourage counties to use the substance use sections of the WSRAT as an initial screening device for CDDA.
- Continue referring juveniles for CDDA evaluations based on relevant information obtained subsequent to the initial WSRAT screen (e.g., positive drug screen, attorney requests).

Step B. ***"Are all youth with a positive indicator for substance use problems being assessed with the ADAD/K-SADS? If not, why not?"***

Not all youth with positive indicators for substance abuse are assessed with the ADAD/K-SADS. Youth whose current charge is an A- or B+ offense are not assessed since they are not eligible for CDDA per RCW 13.40.165. Several legal personnel feel more discretion should be allowed in determining eligibility with respect to B+ offenses. Interviewees reported many youth charged with B+ offenses could benefit from substance abuse treatment and would be appropriate candidates for CDDA. Youth without a history of violence who were involved in a serious assault while under the influence of drugs or alcohol are viewed by interviewees as appropriate candidates for CDDA. Several interviewees also reported CDDA treatment may be appropriate for a youth who deals drugs as a means of supporting his/her own habit. Treating drug dealing youth could reduce availability of drugs to others since the treated youth would no longer need to sell drugs to support his own use. Interviewees advocated for increased judicial discretion for B+ charges based on individual case circumstances.

All other legally eligible youth screening positive for substance use problems are assessed with the ADAD/K-SADS. There is substantially less confusion than last year regarding the timing of the CDDA assessment. In order to expedite a youth's entry to treatment, several counties have chosen to administer the ADAD/K-SADS prior to entry of a plea. A cooperative agreement between prosecutors and public defenders that information obtained on the ADAD/K-SADS not be used against the youth was reached in some of these counties. Prosecutors in these counties feel that reducing the time taken to get a youth into treatment is beneficial to all parties. In other counties without cooperative agreements between prosecutors and public defenders, public defenders recommend that juveniles not answer questions about recent illegal activity or any other behavior which could be used against them by prosecutors.

In general, it takes approximately a week from the time a youth is screened to complete the ADAD/K-SADS assessment. A summary report to the probation officer and/or judge is available between 24 hours to 2 weeks in the 14 counties. The total time from screening until submission of the final report is approximately two to three weeks in the surveyed counties.

Several counties have begun using the ADAD/K-SADS as their general intake assessment for juvenile offenders, and some use it as the assessment instrument to determine eligibility for juvenile drug court.

Suggestion:

Allow greater discretion in determining CDDA eligibility of B+ offenses under RCW 13.40, especially for Violations of the Uniform Controlled Substance Act (VUCSA) sales or delivery charges, or cases where substance use was a contributing factor.

Step C. ***"Are all juveniles who are assessed with the ADAD/K-SADS recommended for CDDA? If not, why not?"***

Not all juveniles who are assessed with the ADAD/K-SADS are recommended for CDDA. A primary reason for not recommending a youth for CDDA is that the youth is not found to be chemically dependent on the ADAD/K-SADS assessment. Typically, youth found to be substance abusers or substance misusers are not recommended for CDDA. It must be noted, however, that some youth found to be substance abusers (8.0 percent, N = 14) or misusers (7.4 percent, N = 13) on the ADAD/ K-SADS have entered CDDA. It appears that in some cases assessors are making diagnoses of chemical dependence based on criteria other than those of the Diagnostic and Statistical Manual of Mental Disorders-IV (as assessed by the ADAD/K-SADS). It is also possible that involved personnel concluded that although the youth did not receive a chemical dependency diagnosis, their behavior and substance use justified a recommendation for CDDA.

Requiring a youth to have a serious substance use problem (dependence) in order to enter CDDA is not viewed as the most effective use of resources. The majority of interviewees feel CDDA would be more effective in reducing substance use and illegal behavior if youth who were substance abusers were also eligible for CDDA. Generally, personnel involved with CDDA feel that providing substance abuse treatment to youth with less severe problems, but ones which still justify treatment, could prevent future development of more serious involvement with drugs and illegal behavior.

In the majority of counties, input from several individuals including public defenders/attorneys, prosecutors, probation officers, family members and the youth is necessary prior to arriving at a final disposition recommendation. Any of these parties can object to the youth being recommended for CDDA. Reasons probation officers object to CDDA include the youth posing a potential safety risk to the community, the youth's desire for treatment is seen as a means only to avoid institutionalization, and numerous past substance abuse treatment failures. A few probation officers stated that they would not recommend CDDA for youth requiring inpatient treatment since the process of obtaining inpatient treatment takes too long. Some of these probation officers admitted that their belief is based on past experience and they had not recently attempted to obtain in-patient treatment through CDDA.

Prosecutors objected to CDDA for some of the same reasons. Additionally, some prosecutors feel CDDA does not provide enough monitoring or appropriate sanctions for locally sanctioned youth who violate program requirements.

For committable youth, CDDA was seldom objected to by an attorney or public defender. Public defenders and attorneys primarily object to CDDA for locally sanctioned youth because they feel CDDA requirements are too intensive. An intensive 12-month program results in increased opportunity for youth to fail the terms of treatment and/or supervision and is not viewed as being in the youth's best interests. Despite the fact that the majority of youth in CDDA are locally sanctioned, legal personnel feel there is little incentive for locally sanctioned youth to enter CDDA. For locally sanctioned youth, public defenders/attorneys frequently recommended a deferred sentence instead of CDDA. Deferred sentence programs are viewed by legal personnel as providing greater incentives for youth to successfully complete the program (e.g., retain license, erasure of charge) and are typically shorter in duration than CDDA.

Few committable youth or their families object to CDDA. Several locally sanctioned youth and/or

their families, however, do object to CDDA for the same reasons given by attorneys, and also because of financial concerns (e.g., juvenile worked and helped support family), and/or because CDDA inpatient treatment requires geographical separation of the juvenile from the family.

Suggestions:

- Require that CDDA assessors make substance use diagnoses based only on the DSM-IV criteria as measured by the ADAD/K-SADS.
- Expand CDDA eligibility to include youth with a DSM-IV substance abuse diagnosis.
- Educate probation officers and prosecutors about the intent and the legal sanctions associated with CDDA.
- Provide probation officers and prosecutors information from research studies demonstrating that all chemically dependent juveniles can benefit from treatment, regardless of their motivation and/or past treatment failures.
- Provide increased incentives for locally sanctioned juveniles' participation in CDDA.

Step D. ***"Are all juveniles recommended for CDDA placed on CDDA at disposition? If not, why not?"***

This step principally involves the judge's decision to concur with a recommendation for CDDA. Essentially judges object to CDDA only if they feel that the youth poses a safety risk to the community. Once the decision is reached to recommend CDDA at disposition, the majority of youth are placed on CDDA. In one county, the family is required to be involved in all phases of CDDA treatment and family therapy. If the family is unwilling to comply with these requirements, the judge will not place the youth in CDDA.

Several judges would like more judicial discretion in determining CDDA eligibility. Current discretion exists mainly with the public defenders and prosecutors. For example, public defenders and prosecutors can plea bargain reduction of an initial B+ charge so a youth is eligible for CDDA. If a youth comes before the judge with a B+ charge, the judge has no ability to reduce the charge making the youth eligible for CDDA even if this alternative is appropriate.

Suggestion:

Revise RCW13.40.165 to allow for greater legal discretion around CDDA eligibility of B+ offenses.

Step E. ***"Do all the juveniles who are placed in CDDA enter the recommended treatment program? If not, why not?"***

Most juveniles placed on CDDA enter the recommended treatment program. Typically, inpatient beds are quickly and easily available for committable youth. For locally sanctioned youth, however, waiting periods of up to three months are encountered. In this situation, several counties place youth in intensive outpatient or detention-based programs (if available in their county) until an inpatient bed is available. This strategy appears to work well, and in a few cases, youth no longer required inpatient treatment when the bed became available.

Although CDDA was developed primarily for committable youth, currently the majority of CDDA

youth are locally sanctioned. Counties have utilized CDDA to provide substance abuse treatment for numerous youth who previously went untreated due to lack of fiscal resources. Many of these youth require inpatient treatment, but even under CDDA, fiscal resources are limited for their inpatient treatment. CDDA can not reduce the time it takes to obtain inpatient treatment for locally sanctioned youth. Extensive delays in obtaining appropriate treatment are viewed as counterproductive to recovery. Moreover, staff and youth involved in obtaining inpatient treatment often become frustrated and give up (e.g., youth fails CDDA and returns to drug use; staff no longer makes CDDA referrals of youth requiring inpatient treatment). The current demand for inpatient treatment for publicly funded, indigent, low-income youth in Washington State appears to exceed the available number of inpatient beds. CDDA referrals for inpatient treatment are increasing the demand for the already limited number of inpatient beds.

Suggestions:

- Work with DASA to meet the increasing need for inpatient beds for locally sanctioned CDDA youth.
- Work with local juvenile courts, JRA, and DASA to meet the increasing need for inpatient treatment of locally sanctioned CDDA youth.
- Encourage counties to use detention-based and intensive outpatient programs for locally sanctioned youth awaiting inpatient treatment.

Step F. ***"Do all juveniles who enter CDDA treatment complete the initial phase of treatment?"***

No, not all juveniles have completed the initial phases of CDDA supervision and treatment. There are many reasons why youth fail to complete the initial phase of CDDA. Juveniles who leave treatment prematurely without permission and repeatedly fail to attend scheduled treatment and/or probation meetings are revoked from CDDA. CDDA is also revoked if a youth is involved in on-going substance use and/or illegal activity. Treatment and probation staff generally increase the intensity of supervision and treatment when presented with evidence a youth is still involved with substance use and illegal activity (e.g., positive urine drug screen, arrest) in an attempt to reduce negative behaviors rather than immediately revoking CDDA. If such behaviors persist, however, CDDA is revoked.

Suggestion:

Encourage specialized CDDA probation officers and treatment staff to work together throughout the 12-months of CDDA supervision to promote use of the most effective treatment and sanctions.

Step G. ***"Do all juveniles who complete the initial phases of CDDA treatment complete the 12 months of treatment and supervision?"***

CDDA is a 12-month program. The first youth entered the program in November 1998; however, the majority of youth did not enter CDDA until 1999. There have been 21 youth who have successfully completed the program. Seventy-five percent (280) of the total youth placed on CDDA are still active in the program.

The reasons for failing are essentially the same reported for Step F. Additionally, some locally sanctioned youth feel that CDDA program requirements are too intensive and opt to have CDDA revoked, in

favor of serving a short period of time in detention, and then going on standard probation. For locally sanctioned youth, the incentives for completing 12 months of CDDA are not as compelling as the incentives for committable youth.

Suggestion:

- The suggestion for Step F also applies here.

A. Additional Comments:

Personnel in surveyed counties expressed few concerns regarding CDDA treatment of committable youth. For committable youth, CDDA is working much as planned, although fewer committable youth have entered CDDA than originally anticipated. Somewhat unexpectedly, the majority of youth entering CDDA throughout the state are currently locally sanctioned. The use of CDDA for locally sanctioned youth provides evidence of the need for substance abuse treatment services for youth involved in the juvenile justice system. Despite the use of CDDA for locally sanctioned youth, several concerns regarding CDDA for locally sanctioned youth were voiced.

As alluded to previously, counties are concerned about the incentives for locally sanctioned youth to enter and successfully complete CDDA. Many interviewees want the ability to blend the services associated with CDDA and that of existing programs. Juvenile drug court is viewed as a particularly appropriate program to blend with CDDA. Although currently there are only three functional juvenile drug courts in Washington, many more are in the planning stages. Like CDDA, drug court is a 12-month supervision program that incorporates substance abuse treatment. Unlike CDDA, drug court does not require a youth be chemically dependent to participate and provides locally sanctioned youth the strong incentives of retaining one's drivers license and dismissal of the current charge if the program is successfully completed.

Another difference between CDDA and drug court is that drug court requires weekly meetings in front of the judge to discuss treatment progress. County personnel, especially public defenders/attorneys, judges, and prosecutors, feel these weekly meetings with the judge are extremely beneficial to youth and encourage progress towards treatment goals. The vast majority of interviewees stated that CDDA could benefit from increased supervision and contact with the judge, as required in drug court. Blending drug court and CDDA would enable counties to treat more youth and provide locally sanctioned youth increased incentives for program completion.

Several additional concerns were voiced, most of which were also expressed during last year's interviews. Counties continue to want greater flexibility regarding the allocation of CDDA funds. Counties feel it is reasonable to require targets regarding the number of juveniles to be assessed and treated under CDDA, but they should have the flexibility to decide how funds can best be used to meet those targets. For example, some counties use Title 19 matching funds to supplement CDDA funds for treatment, but do not have adequate funds for transportation of juveniles and families, family therapy, needed administrative and probation support, or mental health evaluations. In addition, the billing for CDDA when using blended funds (e.g., Title 19) is still found to be complicated and confusing.

Counties continued to generally view CDDA positively. CDDA has increased cooperation, communication, and understanding between local juvenile courts and county alcohol and drug service

systems. CDDA is seen as a mechanism that affords counties the ability to provide substance abuse treatment to an increased number of youth in need. Without CDDA, many youth would be unable to access substance abuse treatment. Without appropriate treatment, the likelihood that a youth will develop more severe substance use and/or legal problems in the future is believed to be greatly increased.

CDDA Treatment Model

Prescreen
Washington State Risk Assessment Tool
Or SASSI/PESQ

Substance Abuse Indicated by Screen

CDDA Assessment
ADAD/K-SADS

Youth is Chemically Dependent and Court-Ordered to CDDA
All youth receive 12 months of supervision and enter one of the following models of treatment.

Detention-Based Treatment	**Inpatient Treatment**	**Intensive Outpatient Treatment**	**Outpatient Treatment or Individual Outreach**
30 Day	**30-90 Days**	**90 Days**	**9-12 Months**
* A minimum of 72 hours of direct treatment services within the 30 days. * Group, relapse, individual, and family therapy. Clinical consultation for mental health issues.	* Level I and Level II facilities. A minimum of 20 hours counseling per week. * Group, individual, and family therapy. * Urinalysis Testing *Level II is available for youth with additional issues, such as mental illness. Facilities are locked or staff secure.	* 9 hours of group, and individual therapy per week. * Urinalysis testing * Family Therapy * Case Management	* 1-3 hours of group and/or individual therapy per week. * Urinalysis testing * Family Therapy * Case Management
Intensive Outpatient 90 Days Outpatient 8 Months	Intensive Outpatient 90 Days Outpatient 7.5 Months	Outpatient 9 Months	

Current Treatment Models by County

All treatment programs include a combination of increased supervision by juvenile courts, a case manager, a family services component, and a combination of the treatment modalities listed below.

Detention-Based Treatment:	Clallam, Clark, Columbia/Walla Walla, Kitsap, Kittitas (tied to Yakima), Okanogan, Pierce, Thurston, and Yakima
Inpatient Treatment:	Adams, Asotin/Garfield, Benton/Franklin, Chelan, Clallam, Clark, Cowlitz, Douglas, Ferry/Stevens/Pend Oreille, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Lincoln, Mason, Okanogan, Pierce, Pacific/Wahkiakum, San Juan, Skagit, Snohomish, Spokane, Thurston, Whatcom, Whitman, and Yakima
Intensive Outpatient Treatment:	Adams, Asotin/Garfield, Benton/Franklin, Chelan, Clallam, Columbia/Walla Walla, Cowlitz, Douglas, Ferry/Stevens/ Pend Oreille, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Okanogan, Pacific/Wahkiakum, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, Whitman, and Yakima.
Community-Based Outpatient Treatment:	Benton/Franklin, Clallam, Clark, Ferry/ Stevens/Pend Oreille, Island, Lincoln, Snohomish, Pierce, and Yakima

Description of Requirements for CDDA Treatment Modalities

Inpatient Treatment

- Level I and Level II provide a minimum of 20 hours of counseling services per week in accordance with WAC 440-22-410.
- Services shall include individual, group, and family services.
- Level II treatment is available for youth with issues in addition to chemical dependency such as mental health issues. The facilities contracted for CDDA are locked or staff secure.

Detention-Based Outpatient Treatment

- A minimum of 72 hours of direct treatment services within the 30 days.
- Treatment components would include: chemical dependency group counseling, education, family counseling and/or family issues group counseling, relapse prevention planning and counseling, individual counseling, case management, and continuing care planning.
- Clinical consultation to address mental health and other clinical complications.

Intensive Outpatient Treatment

- A minimum of 3 hours of group counseling a week.
- 1 hour of individual counseling a week.
- 1 hour of case management advocacy a week.
- Weekly urinalysis.
- Family services (family therapy and or parent training).

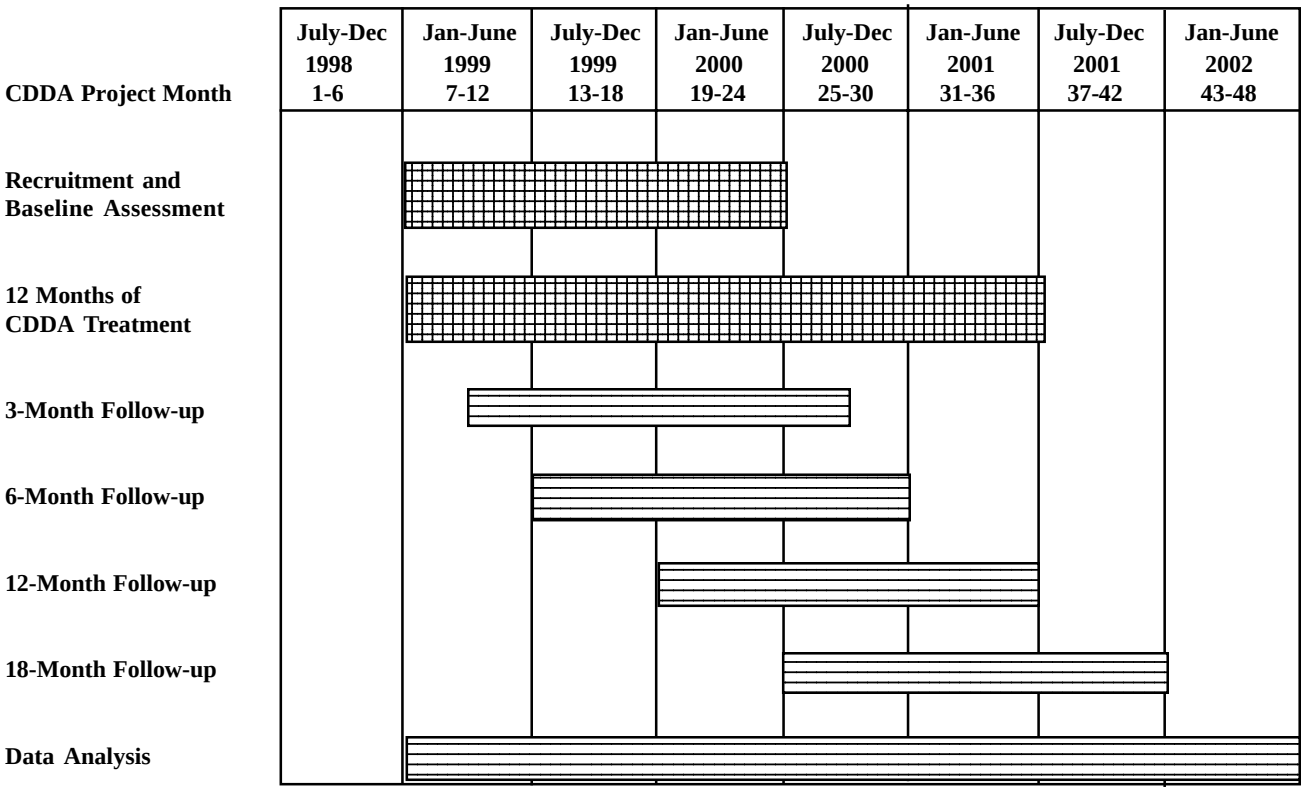
Outpatient Treatment

- 1 hour of support group a week.
- 1 hour of individual counseling a week.
- Family services (Family Therapy and/or Parent Training/Support).
- 1 hour of case management advocacy/week.
- Urinalysis (weekly).

Individualized Outreach

- 1-2 hour of individual counseling a week.
- Family services (Family Therapy and/or Parent Training/Support).
- 1 hour of case management advocacy/week.
- Urinalysis (weekly).

TIMELINE FOR CDDA EVALUATION



Process Evaluation Questions

1. **What is your county's current CDDA model?**

2. **What is your treatment model (e.g. family therapy, cognitive, mixture)?**

3. **What do you see as particular strengths/weaknesses of your model?**

4. **What is the current status of CDDA in your county (active, planned etc.)?**

5. **What is/what will be your role in CDDA program?**

6. ***If <u>not</u> implemented* ---- Why? (e.g. barriers, contractual issues, attitudes, court issues)**
   Is there an anticipated start date?
   What processes/systems have worked well to date?
   General strengths/weaknesses of CDDA?

7. ***If implemented* ---- When did CDDA formally start in your county?**
   What processes/systems have worked well?
   What processes/systems have not worked well?
   General strengths/weaknesses of CDDA?

8. **What changes, if any, would you like to see in CDDA?**

9. **What aspects of CDDA, if any, would you like to stay the same?**

10. **How are juveniles screened for substance abuse problems in your county; is the Drug and Alcohol section of the Washington State Risk Assessment Tool (WSRAT) used? If not, why not?**

11. **Are all youth with a positive indicator for substance use problems being assessed with the ADAD/K-SADS? If not, why not?**

12. **What is the timeframe from screening to assessment?**

13. **Are all juveniles who are assessed with the ADAD/K-SADS recommended for CDDA? If not, why not?**

14. **Are all juveniles recommended for CDDA placed on CDDA at disposition? If not, why not?**

15. **Do all the juveniles who are placed in CDDA enter the recommended treatment program? If not, why not?**

16. **Do all juveniles who enter CDDA treatment complete the initial phase of treatment?**

17. **Do all juveniles who complete the initial phase of CDDA complete the full 12 months? If not, why not?**

18. **How many youth in your county have successfully completed CDDA?**

19. **What are the main reasons that youth do not complete CDDA?**

20. **Who does the case management for CDDA in your county?**

21. **Is that person responsible for the whole 12 months of CDDA?**

22. ***For court personnel* ---- Do you have any concerns/issues regarding CDDA treatment?**

23. ***For treatment personnel* ---- Do you have any concerns/issues with the legal process involved in CDDA?**

24. **Do you see any benefit in placing drug court sanctioned youth into your CDDA program? Explain.**

25. **Other Issues:**

    * **Funding**
    * **Screening**
    * **Assessment**
    * **Mental health issues**
    * **Gender**
    * **Culture/language**
    * **Court/treatment referral process, judge's decision**
    * **Communication between agencies and/or individuals**
    * **Case management issues**
    * **Reporting/tracking issues -- paperwork**
    * **Committable vs. locally sanction youth**
    * **Any other issues related to CDDA I've missed that you'd like to address/discuss?**