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## FINAL REPORT OF THE CROSS-SITE EVALUATION OF THE JUVENILE DRUG TREATMENT COURT (JDTC) GUIDELINES: EXECUTIVE SUMMARY

**Context.** Meta-analysis of 41 experimental or quasi-experimental evaluations comparing Juvenile Drug Treatment Courts (JDTC) and Traditional Juvenile Courts (TJC) showed both approaches exhibited similar effects on recidivism, but with JDTC costing more. However, there were large variations in results, with 9 studies where JDTC did significantly better, 3 where JDTC did worse, and 29 where JDTC and TJC outcomes were similar. In light of this wide variation in JDTC impacts, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) funded an initiative to better understand this evidence, develop new JDTC guidelines, and evaluate them in a field trial. This is the executive summary of the evaluation's final report.

**JDTC Guidelines.** The 2016 JDTC Guidelines include 31 evidence-based guideline statements organized into 7 objectives: 1) Focus the JDTC philosophy and practice on effectively addressing substance use and criminogenic needs to decrease future offending and substance use and increase positive outcomes; 2) Ensure equitable treatment for all youth by adhering to eligibility criteria and conducting an initial screening; 3) Provide a JDTC process that engages the full JDTC team and follows procedures fairly; 4) Conduct comprehensive needs assessments that inform individualized case management; 5) Implement contingency management, case management, and community supervision strategies effectively; 6) Refer participants to evidence-based substance use treatment, to other services, and for prosocial connections; and 7) Monitor and track program data with an emphasis on ensuring equitable outcomes for all youth. The Guidelines also include summaries of the supporting research and considerations for implementation for each guideline statement.

**Evaluation Design.** The goals of the evaluation were to: a) Determine the extent to which it is feasible to implement the 2016 JDTC Guidelines and illustrate the kinds of adaptation courts make to use them; b) Compare youth outcomes in JDTCs relative to TJC; c) Identify evidence for the relative importance of the different Guidelines; and d) Recommend changes to the Guidelines based on a-c. The evaluation was conducted across 10 counties with a JDTC and TJC. In 2 sites, youth who were eligible for JDTC **and** TJC were randomly assigned (RA) to JDTC vs. TJC to rigorously test the direct effect of JDTC's impact relative to TJC. In 8 sites, youth who were eligible for JDTC **or** TJC were assigned to the most appropriate court using a needs-based assignment rule (a method called regression discontinuity) to test the Guidelines' recommendation to focus JDTC on youth with moderate to high risk of recidivism and mild to severe SUD. Court self-assessments and site visits were used to assess guideline compliance, change, and logic models. Youth records and youth surveys were administered at baseline, and 6 and 12 months after enrollment to evaluate differences in recidivism (new arrests); b) substance use; c) mental health symptoms and d) other outcomes (e.g., well-being, family functioning, peer risk and support, involvement in prosocial structured activities, academic performance). All data were gathered the same way across both types of assignment mechanism and court.

**Court Self-Assessments of JDTC Guideline Achievement.** **At baseline** there was substantial overlap between JDTC and TJC in their alignment with the JDTC Guidelines. This was likely due to shared staff, resources, environment, and the similarities between JDTC Guidelines and general juvenile justice reform over the past decade. **At follow-up** JDTC alignment improved to between 71% to 90% (with half the JDTC achieving 88% or more). This was largely due to training and technical assistance provided to the JDTC as the TJC did not change as much.

**Variation in JDTC Guideline Achievement.** The notable areas where JDTC alignment was higher initially and more so at follow up included using a) incentives to motivate behavior change and favor incentives over sanctions; b) screening, assessment, and urine testing; c) processes or policies to ensure equity of access to services; and d) adoption of new practices during the course of the study. There was considerable variation in how JDTC implemented the guidelines (discussed at length in site visit and logic model findings), particularly in the areas of family engagement and screening/assessment. The challenge for all JDTC (and TJC) was that none of the sites/courts met the goals of having brief detention stays (generally 2 days or less) or using detention only when the youth is a danger to themselves or others or may abscond.

**Impact of JDTC vs. TJC on Youth.** Youth assignment to JDTC (vs. TJC) was associated with a) increased retention in the substance use treatment cascade, b) reduced cannabis, alcohol, and other drug use; c) reduced rearrest, and d) some improvement in mental health treatment/symptoms. The effect on recidivism was primarily driven by the effect of JDTC

on youth with **high** need for substance use treatment and **high** risk of recidivism. The latter was a more restricted subset than recommended in original guidelines.

**Variation in Effects by Site.** The size of the JDTC vs. TJC effects varied by site. The TJC in one site did better than JDTC. It is notable that this was the site with the smallest difference in Guideline implementation between JDTC and TJC. This finding provided further evidence of the value of the Guidelines in promoting effective program practices.

**Efficient Evaluation of Need and Risk.** A 10-item youth screener from the Global Appraisal of Individual Needs (GAIN) was used in this evaluation to triage low, moderate, and high need for substance use treatment *and* risk of recidivism. The findings of this simple tool were overridden by local courts/staff in less than 5% of the cases. The measure of need accurately predicted retention along a juvenile justice to substance use treatment services cascade (i.e., need, referral, initiation, engagement, continuity of care). This result validated that the tool predicts which youth are likely to show up to, be admitted to, and stay in treatment. Combining need and risk was a very reliable predictor of rearrest in the next 6 to 12 months. It was then used as a control to show that the effects of JDTC (vs TJC) on recidivism were being driven by the subset of youth with high need and high risk.

**Correlates of Original Placement Rule.** Referring youth with **moderate/high** need and risk to JDTC also resulted in that group of youth having higher rates (than youth in TJC) of co-occurring problems (mental health, trauma, victimization) and family environmental risk. Further restricting the target population to only those with **high** need and risk would have led to even higher rates – particularly for trauma and victimization.

**Recommendations for Guidelines.** It was recommended that the JDTC Guidelines, and related training and technical assistance: a) use evidence-based screening on need/risk to assist with placement; b) focus on those with high need/risk; c) measure/monitor youth movement along the behavioral health services cascade to track general performance and to catch health disparity / operational issues to ensure youth who need services receive them; d) to improve communication and the quality of data sharing between juvenile justice and behavioral health agencies; e) add more information to improve the use of urine testing (particularly for cannabis) and minimize use of detention through implementation of alternative approaches to behavior change; f) collaborate across sites to create a common data set as most courts have small numbers of youth; and g) clarify several terms/practices with which some JDTC struggled (e.g., screening vs. assessment, case management). The evaluation report was one of several sources used to revise the guidelines and training and technical assistance protocols.

**Strengths and Limitations.** The evaluation had several strengths including building on recent summaries of evidence, collaboration across multiple sites and stakeholders, mixed methods, standardized measures, larger sample sizes, and higher follow-up rates than most earlier studies. However, it is also important to acknowledge several limitations. The preliminary design assumptions that each site could recruit and assign 150 youth to each of two courts within 2 years proved unrealistic for individual sites. Similarly, the assumption that the TJC was using discrete staff/resources and not using many of the same strategies recommended in the guidelines was incorrect to varying degrees in all sites. Variation in how JDTC implemented the guidelines and the training/technical assistance their received also presented challenges for the evaluation that might have been better addressed by a more long-term commitment to common data and workforce development with monitoring over time as used in much of health care. Complicating matters further, the 2020 COVID pandemic hit during the middle of the study, causing changes in many procedures, lower case flow, and lower follow-up survey completion rates. Technically there were also issues with the non-normal distribution of several outcomes, and violations of the assumption of the needs-based assignment model that JDTC would only produce a shift in the regression line. In practice, JDTC changed both the regression line and the slope. While this result limited the number of sites/youth and power of many analyses, the multiple sources of data still provide a consistent emerging picture.

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