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Juvenile Drug Treatment Court Guidelines

OJJDP Office of Juvenile Justice and Delinquency Prevention
Working for Youth Justice and Safety

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Foreword

Juvenile drug treatment courts are designed for youth with substance use disorders who come into contact with the juvenile justice system. These courts offer an important way to respond to the needs of substance using youth and treat their complex disorders, which require specialized interventions. Overall, studies about the effectiveness of juvenile drug treatment courts have been inconclusive. Until now, these courts have had no research-based guidelines to follow. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) initiated the Juvenile Drug Treatment Court Guidelines project to fill that need.

The United States faces a serious substance use problem among youth. When OJJDP first began this initiative in 2014, an estimated 1.3 million adolescents (1 of every 20 youth) ages 12 to 17 had a substance use disorder.[1] Substance use disorders during adolescence can have particularly damaging and lifelong consequences. Early drug use may alter brain maturation, contribute to lasting cognitive impairment of certain functions, and significantly increase short- and long-term susceptibility for developing a substance use disorder.

Substance use disorders are prevalent among youth involved in the juvenile justice system. Adolescents with substance use disorders frequently have mental health disorders, traumatic histories, and other risk factors that present unique challenges for the courts.

OJJDP has partnered with a research team, experts in the field, and other federal agencies to develop guidelines based on research and evidence that support judges and professional court staff, young people with substance use disorders, and their families. The research team conducted a systematic review of literature from the juvenile justice, child welfare, public health, and education research fields to inform their work. We recognize that it is important to further assess gaps in knowledge and examine whether the guidelines change practice and improve outcomes for youth. Together, we will continue to evaluate, refine, and update the guidelines as additional research becomes available.

We hope these guidelines will help juvenile drug treatment court staff improve the lives of the youth they serve. We hope they help keep youth out of further contact with the juvenile justice system and help them increase their sense of belonging and self-worth, improve their mental and physical health, thrive at home, and succeed in school and work.

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[1] Hedden, S.L., Kennet, J., Lipari, R., Medley, G., Tice, P., Copello, E.A.P., and Kroutil, L.A. 2015. *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. HHS Publication No. SMA 15-4927, NSDUH Series H-50. Retrieved from www.samhsa.gov/data.

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Introduction

A juvenile drug treatment court (JDTC) is a specially designed court docket for youth with substance use disorders at medium to high risk for reoffending. It is intended to provide youth with specialized treatment and services. JDTCs were modeled after adult drug treatment courts, which have been shown to be effective for reducing recidivism and subsequent drug use in adults. Evidence about the effectiveness of courts using a JDTC-type model is inconclusive due, in part, to weak study designs, inconsistency in the populations studied, and uncertainty about the extent to which evidence-based treatment was available.

Despite the rich body of practice guidance that was developed to support the implementation of *Juvenile Drug Courts: Strategies in Practice* (Bureau of Justice Assistance, 2003), no comprehensive set of research-based guidelines existed to inform the structure and work of the JDTCs. In response to that need, the following guidelines provide guidance based on high-quality syntheses of research on and applicable to JDTCs.

The Research-Based Approach to the Juvenile Drug Treatment Court Guidelines

In 2014, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) identified a need to create research-informed guidelines for juvenile drug treatment courts that would build off of previous work and promote effective practice and high-quality service delivery for youth with substance use disorders. In October 2014, OJJDP awarded a cooperative agreement to the American Institutes for Research (AIR) for this project. AIR is partnering with the Court Centered Change Network, George Mason University, Vanderbilt University, and WestEd to develop the research base for these guidelines.

The project team established a systematic, transparent, evidence-based protocol to translate the extant research about juvenile drug courts and related interventions into comprehensive, reasonable, actionable, understandable, and measurable guidelines.

Following this protocol, the authors systematically reviewed thousands of articles from the juvenile justice, child welfare, public health, and education research literature to locate high-quality and rigorous studies on juvenile drug treatment court programs and other interventions for adolescents at risk of justice involvement.

OJJDP and AIR engaged with federal staff, researchers, judges, practitioners, families, and youth to inform the development of both the protocol and the guidelines.

The complete protocol, including the research syntheses and list of project partners, is available at www.ojjdp.gov/JDTC/protocol.pdf.

The Research About Juvenile Drug Treatment Courts

The goal of the Initiative to Develop Juvenile Drug Treatment Court Guidelines is to synthesize all of the evidence from juvenile drug treatment courts (JDTCs) to determine the implementation components associated with the best outcomes and to supplement this understanding with research from related fields and interventions serving the same target population. To understand specific outcomes from JDTC programs, the research team identified 46 randomized and well-controlled quasi-experimental evaluation studies that reported on the effects of JDTCs compared to traditional juvenile court processing and used research synthesis techniques to examine implementation characteristics and outcomes related to recidivism (for delinquent offenses and drug offenses) and drug use outcomes across these studies. The results indicated that, overall, JDTCs were no more or less effective than traditional juvenile court processing for reducing recidivism or drug use. However, the quality of the evidence from these studies was seen as a limitation in drawing firm conclusions on the effectiveness of JDTCs, a finding consistent with previous research on JDTCs and seen in the supplemental study that looked at interventions from related youth-serving fields.

Despite the need to improve the quality and rigor of JDTC and other adolescent treatment studies, the authors identified common implementation themes associated with more positive JDTC outcomes. Many of these themes align with previous research reported in the drug treatment and juvenile justice literature and are consistent with research on effective adolescent interventions from the fields of child welfare, public health, and education. A panel of experts with experience in JDTC settings and individuals working in and with JDTCs across the country who participated in a series of public webinar listening sessions approved these implementation themes. After refining the research themes with feedback through these critical stakeholders, the authors developed the following research-based and practice-informed guidelines. The full report is available at www.ojjdp.gov/Juvenile-Drug-Treatment-Court-Guidelines.html.

Conceptual Framework of the Guideline Statements

The Juvenile Drug Court and Juvenile Drug Treatment Court Models

About half of the youth in the juvenile justice system have problems related to alcohol or drugs (Cooper, 2001; Teplin et al., 2002), and juvenile justice systems have become the leading source of referral for adolescents entering treatment for substance use problems (Ives et al., 2010). Beginning in the early 1990s, one approach to address the problem of justice-involved youth with substance use disorders was to adapt adult drug court models for youth by emphasizing family-based and developmentally appropriate services for adolescents (Belenko, 2001; Dennis, Baumer, and Stevens, 2016; Rossman et al., 2004). The latter model is important because adolescents with substance use disorders differ from their adult counterparts in several ways, such as being in earlier stages of cognitive and physical development (e.g., concrete versus abstract reasoning, expansion of pain and pleasure centers in the brain prior to the maturation of the reasoning centers, and smaller body size leading to lower tolerance) that make them more susceptible to peer influences, victimization, and the adverse effects of substance use. These differences potentially limit the effectiveness of adult models when applied to youth (National Institute on Drug Abuse, 2014; Tapert et al., 2004; Winters, 1999).

The first decade of juvenile drug court (JDC) implementation saw increasing recognition of the need to (1) provide additional staff training (many staff were unfamiliar with adolescent development or its implications); (2) involve families and schools; (3) provide greater protections to youth; (4) work with community partners to address youth's multiple co-occurring needs; and (5) reduce health disparities in problem identification, service delivery, and outcomes. These lessons were translated into the document *Juvenile Drug Courts: Strategies in Practice* (Bureau of Justice Assistance, 2003). The 16 strategies in *Juvenile Drug Courts* were developed by expert consensus to serve as a framework for planning, implementing, and operating a juvenile drug court. In 2010, van Wormer conducted a survey of 115 JDC staff and found that, although nearly three-quarters of those staff agreed or strongly agreed with the 16 strategies, many of them reported having little access to training or other resources. More than one-quarter of those surveyed indicated they wanted more help so they could better understand the treatment process, better understand the assessment process, be more gender and culturally responsive, and successfully engage family members.

Adolescents with substance use disorders pose a major challenge for the juvenile justice system. Adult drug courts have been shown to effectively address substance use disorders in adults who offend, but the differences between adults and youth necessitate adaptations to make the drug court model suitable for use in juvenile courts. Evaluations of JDCs have yielded mixed results to date, with much of the evidence pointing to the conclusion that juvenile drug courts do not achieve better outcomes than traditional juvenile courts serving youth with substance use disorders. Yet, two evaluations with randomization and high methodological rigor demonstrated that providing evidence-based treatment made the JDC more

effective than a drug court with treatments that are not evidence based (Henggeler et al., 2006; Dakof et al., 2015). In addition, the largest quasi-experiment to date demonstrated that evidence-based treatment with a drug court does as well as or better than evidence-based treatment alone in a matched cohort of justice-involved youth (Ives et al., 2010).

Because treatment is a key element in an effective approach to juvenile court participants with substance use disorders, the guidelines presented here are intended for juvenile drug *treatment* courts. A central goal of this initiative to establish guidelines is to translate the best evidence into a series of research-informed guidelines to further improve practice. In the context of JDTCs, there are overarching considerations for a juvenile justice system where contact with youth is rare, fair, and effective. It is also important to consider the developmental perspective in juvenile justice and family engagement in the JDTC process.

The Developmental Perspective in Juvenile Justice

Over the past decade, the juvenile justice system has seen significant and effective reform, most of which is based on applying an adolescent development lens to all programs, services, practices, and policies. The U.S. Supreme Court and its recent decisions[2] show that science and research are influencing practice changes within juvenile court systems. Juvenile crime continues to remain low (after a peak in the mid-1990s) and courts continue to focus on "right-sizing" the system once again.

There are seven hallmarks to the developmental perspective in juvenile justice (National Research Council, 2014), and the JDTC guidelines are consistent with those hallmarks. For example, it is important that JDTCs serve only those youth who meet the eligibility criteria—whenever appropriate, youth should be diverted from the juvenile court process altogether. The JDTC's response should be individualized for each participant, based on assessment from validated risk and needs instruments. JDTC participants should be detained only when it is absolutely necessary for public safety reasons, and this has implications for the use of detention as a sanction. Juvenile drug treatment courts must pay careful attention to whether their practices result in disparate treatment for any groups of youth, and it is critical that youth perceive JDTCs as being fair. Finally, family engagement needs to be a major priority for the courts.

JDTC teams are encouraged to develop expertise on the developmental perspective (National Research Council, 2013) and to consider whether current policies and practices are in fact creating future barriers to success for youth, simply because the program participants are being punished for normal adolescent behaviors.

Family Engagement

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) conducted a series of family listening sessions that explored, in part, the challenges and potential solutions to family engagement issues (Office of Juvenile Justice and Delinquency Prevention, 2013). Participants in the listening sessions emphasized that parents and guardians often feel they are seen as "bad parents" and are therefore not included in the decisionmaking process; they perceive their input is not valued. Parents and guardians also expressed that the courts need to understand that financial, time, and transportation pressures can make it difficult for parents to be involved. Working parents might find it difficult to attend court hearings during the workday, and those who do not live close to the JDTC might not be able to attend all sessions.

[2] See *Roper* v. *Simmons,* 542 U.S. 551 (2005) regarding the juvenile death penalty and *Graham* v. *Florida,* 560 U.S. 48 (2010) regarding life without parole for juveniles.

JDTCs should operate in such a way that parents and guardians are engaged as valued partners in all aspects of the process. Because youth are still developing the cognitive, social, and emotional skills that shape their decisionmaking and behavior, it is critical for JDTCs to recognize that the community, peers, and family significantly affect adolescent development. The research that informs the development of the guidelines shows that the family can play a critical collaborative role with the JDTC if effectively engaged, yet can be a barrier to successful program completion when this does not happen. The guidelines reflect a vision that effective JDTCs will recognize and build on families' strengths, values, and diversity, and will honor and support families before, during, and after their children participate in the JDTC.

Objectives and Guideline Statements

According to the research, juvenile drug treatment courts should follow these guidelines, which are organized within key objectives. Additional information regarding the research supporting these statements and considerations for implementation and practice is provided in the Objectives, Guideline Statements, and Supporting Information section.

Objective 1. Focus the JDTC philosophy and practice on effectively addressing substance use and criminogenic needs to decrease future offending and substance use and to increase positive outcomes.

Guideline 1.1. The JDTC team should be composed of stakeholders committed to the court's philosophy and practice, and to ongoing program and system improvement. The team should include collaborative relationships with community partners.

Guideline 1.2. The roles for each member of the JDTC team should be clearly articulated.

Guideline 1.3. The team should include participants from local school systems, with the goal of overcoming the educational barriers JDTC participants face.

Guideline 1.4. The JDTC should ensure that all team members have equal access to high-quality regular training and technical assistance to improve staff capacity to operate the JDTC and deliver related programming effectively. Such training and technical assistance should focus on:

- The nature of substance use disorders and the dynamics of recovery.
- Staff skill development and effective case management.
- Screening and assessment for substance use and criminogenic needs, particularly relating to the development of treatment plans.
- Adolescent development and the developmental perspective for juvenile justice programming.
- Cultural competence in working with youth and families.
- Family engagement and working with caregivers through a trauma-informed lens.
- The use of effective contingency management strategies (e.g., incentives and sanctions).
- The purpose of each intervention implemented for JDTC participants, the evidence of its value, and how it aligns with the JDTC's mission.
- The effective use of evidence-based practices (that address co-occurring mental health issues and other co-occurring issues such as family dysfunction) in substance use treatment.

Guideline 1.5. JDTCs should be deliberate about engaging parents or guardians throughout the court process, which includes addressing the specific barriers to their full engagement.

Guideline 1.6. JDTCs should provide court-certified or licensed onsite interpreters for parents or guardians with limited English proficiency and for those with a hearing deficiency. In addition, all documents should be translated into the native language of non-English-speaking youth and parents or guardians.

Objective 2. Ensure equitable treatment for all youth by adhering to eligibility criteria and conducting an initial screening.

Guideline 2.1. Eligibility criteria should include the following:

- Youth with a substance use disorder.
- Youth who are 14 years old or older.
- Youth who have a moderate to high risk of reoffending.

Guideline 2.2. Assess all program participants for the risk of reoffending using a validated instrument.

Guideline 2.3. Screen all program participants for substance use using validated, culturally responsive screening assessments.

Guideline 2.4. Potential program participants who do not have a substance use disorder and are not assessed as moderate to high risk for reoffending should be diverted from the JDTC process.

Guideline 2.5. JDTCs should ensure that eligibility criteria result in equity of access for all genders; racial and ethnic groups; and youth who are lesbian, gay, bisexual, transgender, queer or questioning, intersex, and gender nonconforming (LGBTQI–GNC) and Two-Spirit.[3]

Objective 3. Provide a JDTC process that engages the full team and follows procedures fairly.

Guideline 3.1. JDTCs should work collaboratively with parents and guardians throughout the court process to encourage active participation in (a) regular court hearings, (b) supervision and discipline of their children in the home and community, and (c) treatment programs.

Guideline 3.2. The judge should interact with the participants in a nonjudgmental and procedurally fair manner.

Guideline 3.3. The judge should be consistent when applying program requirements (including incentives and sanctions).

Guideline 3.4. The JDTC team should meet weekly to review progress for participants and consider incentives and sanctions based on reports of each participant's progress across all aspects of the treatment plan.

Objective 4. Conduct comprehensive needs assessments that inform individualized case management.

Guideline 4.1. Needs assessments should include information for each participant on:

- Use of alcohol or other drugs.
- Criminogenic needs.
- Mental health needs.
- History of abuse or other traumatic experiences.
- Well-being needs and strengths.
- Parental drug use, parental mental health needs, and parenting skills.

Guideline 4.2. Case management and treatment plans should be individualized and culturally appropriate, based on an assessment of the youth's and family's needs.

Objective 5. Implement contingency management, case management, and community supervision strategies effectively.

Guideline 5.1. For each participant, the application of incentives should equal or

[3] LGBTQI–GNC is an acronym for a group of lesbian, gay, bisexual, transgender, queer or questioning, intersex, and gender nonconforming individuals. "Two-Spirit" is a term that some Native Americans use to identify LGBTQI and gender variant persons only within their community. Many variations of this acronym may be used depending on context. Individuals may employ any number of terms to describe their sexual orientation and/or gender identity. The terms and letters used to represent those terms in this document are meant neither to be exhaustive nor exclusionary of other terms an individual may use to describe their sexual orientation and/or gender identity.

exceed the sanctions that the JDTC applies. Incentives should be favored over sanctions.

Guideline 5.2. Participants should feel that the assignment of incentives and sanctions is fair:

- Application should be consistent; i.e., participants receive similar incentives and sanctions as others who are in the court for the same reasons.
- Without violating the principle of consistency described above, it is also valuable to individualize incentives and sanctions.

Guideline 5.3. Financial fees and detention should be considered only after other graduated sanctions have been attempted. Detention should be used as a sanction infrequently and only for short periods of time when the youth is a danger to himself/herself or the community, or may abscond.

Guideline 5.4. Ongoing monitoring and case management of youth participants should focus less on the detection of violations of program requirements than on addressing their needs in a holistic manner, including a strong focus on behavioral health treatment and family intervention.

Guideline 5.5. A participant's failure to appear for a drug test and otherwise tampering with drug test results should be addressed with immediate, graduated sanctions.

Guideline 5.6. The JDTC team should be prepared to respond to any return to substance use in ways that consider the youth's risk, needs, and responsivity.

Objective 6. Refer participants to evidence-based substance use treatment, to other services, and for prosocial connections.

Guideline 6.1. The JDTC should have access to and use a continuum of evidence-based substance use treatment resources—from in-patient residential treatment to outpatient services.

Guideline 6.2. Providers should administer treatment modalities that have been shown to improve outcomes for youth with substance use issues. These modalities include, but are not limited to, the following:

- Assertive continuing care. Programs that provide integrated and coordinated case management services for youth after they are discharged from outpatient or inpatient treatment, including home visits, client advocacy for support services, and integrated social support services.
- Behavioral therapy. Programs based on operant behavioral principles that use incentives (e.g., gift certificates) to reward abstinence and/or compliance with treatment.
- Cognitive behavioral therapy. Programs based on theories of classical conditioning that focus on teaching adolescents coping skills, problem-solving skills, and cognitive restructuring techniques for dealing with stimuli that trigger substance use or cravings.
- Family therapy. Programs based on ecological approaches that actively involve family members in treatment and address issues of family functioning, parenting skills, and family communication skills.
- Motivational enhancement therapy. Programs that use supportive and nonconfrontational therapeutic techniques to encourage motivation to change based on clients' readiness to change and self-efficacy for behavior change.
- Motivational enhancement therapy/ cognitive behavioral therapy. Programs that use a combination of motivational enhancement and cognitive behavioral therapy techniques.
- Multiservice packages. Programs that combine two or more of these approaches. These programs use a combination of behavioral therapy, cognitive behavioral therapy, family therapy, motivational

enhancement therapy, pharmacotherapies, and/or group and mixed counseling in a comprehensive package.

Guideline 6.3. Service providers should deliver intervention programs with fidelity to the programmatic models.

Guideline 6.4. The JDTC should have access to and make appropriate use of evidence-based treatment services that address the risks and needs identified as priorities in the youth's case plan, including factors such as trauma, mental health, quality of family life, educational challenges, and criminal thinking.

Guideline 6.5. Participants should be encouraged to practice and should receive help in practicing prosocial skills in domains such as work, education, relationships, community, health, and creative activities.

Objective 7. Monitor and track program completion and termination.

Guideline 7.1. Court and treatment practices should facilitate equivalent outcomes (e.g., retention, duration of involvement, treatment progress, positive court outcomes) for all program participants, regardless of gender, race, ethnicity, or sexual orientation.

Guideline 7.2. A youth should be terminated from the program only after the JDTC team has carefully deliberated and only as a last resort after full implementation of the JDTC's protocol on behavioral contingencies.

Guideline 7.3. Each JDTC should routinely collect the following detailed data:

- Family-related factors, such as family cohesion, home functioning, and communication.
- General recidivism during the program and after completion, drug use during the program, and use of alcohol or other drugs after the program ends.
- Program completion and termination, educational enrollment, and sustained employment.
- Involvement in prosocial activities and youth-peer associations.

Objectives, Guideline Statements, and Supporting Information

This section presents the JDTC objectives and guideline statements with accompanying research evidence and practice considerations. The research evidence and practice considerations sections provide summaries of the research that underlies each guideline statement and offer relevant implications for practice and implementation.

Objective 1. Focus the JDTC Philosophy and Practice on Effectively Addressing Substance Use and Criminogenic Needs To Decrease Future Offending and Substance Use and To Increase Positive Outcomes

Guideline 1.1. The JDTC team should be composed of stakeholders committed to the court's philosophy and practice, and to ongoing program and system improvement. The team should include collaborative relationships with community partners.

Research evidence and practice considerations. Organizations that serve youth across several systems that identify common goals, agree to share resources, and coordinate effectively through a strong stakeholder team experience greater success with their interventions (Belenko et al., 2009; Campie and Sokolsky, 2016; Carpenter et al., 2013; Green et al., 2009). JDTCs are, by design, problem-solving agencies. Within this framework, various stakeholders collaborate to find innovative and effective strategies to address problems pertaining to specific JDTC cases (Bureau of Justice Assistance, 2002).

The Bureau of Justice Assistance's Models of Effective Court-Based Service Delivery for Children and Their Families project identified nine components that are important for building a comprehensive approach to service coordination. First, the role of the court in coordinating services should be clearly spelled out in the JDTC policy manual. Second, the judge's role in leading the coordination of services is a critical component of a comprehensive approach. Third, a steering (or policy) committee can provide a forum to discuss issues pertaining to the coordination of services. Fourth, case-level service coordinators are needed. Fifth, a central resource should be established to compile and provide current information about available services in each jurisdiction. Sixth, the court should monitor service agencies' compliance with court referrals. Seventh, routine data collection should allow for self-assessment of the service coordination activities. Eighth, creative approaches should be used to provide services. Finally, it is important to provide cross-training so court staff (including the judge) and service providers can understand the context in which each person operates.

JDTCs can use existing high-quality training programs such as the Multi-System Collaboration Training and Technical Assistance Program. Training programs developed for JDTCs may also be found at the Juvenile Drug Court Information Center and OJJDP's National Training and Technical Assistance Center.

Guideline 1.2. The roles for each member of the JDTC team should be clearly articulated.

Research evidence and practice considerations. Clarity of team member roles is an important aspect of collaboration. This includes how each role fits into the team dynamic (Wilson, Olaghere, and Kimbrell, 2016). Defined roles allow JDTCs to communicate and share information, which enhances effectiveness (Dickerson, Collins-Camargo, and Martin-Galijatovic, 2011; Shaffer and Latessa, 2002). Although team members share in the goal of providing services to youth, individual partners may interpret a youth's action in different ways. This can lead to a lapse in or duplication of services, overall confusion, and even different institutional outcomes for youth (Dickerson, Collins-Camargo, and Martin-Galijatovic, 2011; Paik, 2009). Thus, it is important for the JDTC team to find ways to work together collaboratively.

The role for each team member should be in writing and signed by the team member to ensure clarity about areas of responsibility (Gatowski et al., 2016). A recent National Council of Juvenile and Family Court Judges publication describes the core responsibilities for each JDTC team member (Thomas, 2016):

- The judge serves as the JDTC chairperson and has ultimate accountability and oversight for the team members, imposing conditions of probation, making decisions about admissions, approving case plans, imposing incentives and sanctions, and setting criteria for graduation from the program. The judge also presides over court hearings.
- The JDTC coordinator is the primary point of contact between the judge and the rest of the team. The coordinator manages and oversees all of the team's activities, coordinates court hearings, establishes and maintains community partnerships, and ensures compliance with all reporting requirements and performance management.
- The clinical treatment supervisor (or clinical treatment liaison) provides the substance use treatment perspective for the team, ensures that screening and assessments for all participants are effectively implemented, monitors treatment plans and their fit with criminogenic risk and needs assessments, and identifies and documents the continuum of treatment services to ensure that participants receive the treatment they need.
- The juvenile probation officer (and/or a juvenile probation supervisor) supervises and monitors JDTC participants outside of the court setting, develops and monitors compliance with case plans, administers drug tests, and follows up with participants to ensure they participate in treatment programming, attend school, and have access to recovery support.
- The JDTC treatment provider is responsible for all related treatment services, including culturally responsive drug and alcohol treatment, mental health treatment, drug screening, and clinical monitoring; delivers treatment programming with fidelity to evidence-based practice models; and provides regular treatment progress reports for each participant to the team.
- The state's attorney (or prosecutor) represents the state, helps identify eligible JDTC participants, and participates in court hearings.
- The public defender represents the expressed interests of and advocates for the youth participants, giving them a voice in court.
- The school representative presents the schools' perspective so the JDTC is aware of concerns and school-based resources that may serve the team, sensitizes the team to the culture and context of the school environment, and participates in planning for aftercare from the perspective of the courts.

- As appropriate, there may also be a cultural liaison on the team. This could include tribal representatives or community cultural leaders.

Gurnell, Holmberg, and Yeres (2014) developed a tool to assist in defining team roles and drafting a team charter. Step 13: Clarify roles and responsibilities of the operations team in *Starting a Juvenile Drug Court: A Planning Guide* walks through the roles of key team members and provides worksheets to assist in effective team decisionmaking, creating ground rules, resolving conflicts, and adding new members.

Guideline 1.3. The team should include participants from local school systems, with the goal of overcoming the educational barriers JDTC participants face.

Research evidence and practice considerations. School is an important protective factor in JDTC success, as poor academic performance is a risk factor linked to recidivism (Sanchez, 2012). Research shows that youth who do not attend school may have higher numbers of delinquency referrals than those who do attend (Rodriguez and Webb, 2004). According to Linden (2008), JDTC programs should explore alternative educational opportunities for youth through outreach in local school systems, with the goal of developing prosocial opportunities for program participants. Teachers and school administrators can be important assets when they support and care for the youth; however, schools can also be barriers if they do not cooperate with and invest in the youth or if they are quick to expel youth (Mericle et al., 2014; Wilson, Olaghere, and Kimbrell, 2016). In addition, there is often a lack of recovery support in schools and afterschool programs. JDTCs should be aware of the risk associated with adolescent substance use disorder and that youth will return to the same environments they lived in before they were part of the JDTC. Where available, recovery high schools provide safe learning environments within larger schools to provide peer support in small groups. These programs are effective in supporting recovery and enhancing academic performance (Moberg and Finch, 2007).

There is much to be gained if the JDTC is successful at working together with the schools where JDTC participants are enrolled (Holmberg, 2013). In theory, both the schools and the JDTC have the same ultimate goal for the young people they serve: that they become productively engaged adult citizens in the local community. A more proximate goal, though, is that the youth are likely to do better in school both academically and behaviorally, which will be more likely if they do not use substances and if they work on their recovery. In addition, if the youth are successfully engaged in school, they are likely to do better in the JDTC program and stay out of trouble.

Ideally, a representative from the local schools will be an active participant on the JDTC team. In larger urban areas, the particular school that the representative is from will likely serve only a minority of the youth in the JDTC at any one time, which means that it will be important to find creative ways for JDTCs and schools to work together. In many jurisdictions, the partnership with the school may be the hardest to solidify of all the JDTC's community partnerships. Although it is important for the participants to be actively involved in their schools, the youth in the JDTC represent a very small portion of all students at any given school. In addition, JDTC participants tend to be students who exhibit problem behaviors in school.

Holmberg (2013) offers strategies for building successful partnerships with schools. JDTCs should make educational goals a priority for each youth, which may include tracking individual progress on school attendance, keeping up with homework assignments, staying out of trouble in school, and

maintaining academic performance. JDTCs could also offer flexible strategies for communicating with school personnel on a regular basis rather than requiring school representatives to meet with the JDTC team in person. A number of JDTCs hold some hearings and meetings at the school; families may find that it is easier to participate at the school than at the courthouse. In addition, parents or guardians should be trained to advocate on behalf of their children's educational rights. Finally, it is important to explore a full range of educational options to find the best fit for each participant because all youth may not necessarily thrive in public secondary schools.

For more information and ideas on how to collaborate, see *Engaging Schools in the Juvenile Drug Court: Promising Strategies from the Field* and Step 15: Lay the groundwork for collaboration with schools in *Starting a Juvenile Drug Court: A Planning Guide*.

Guideline 1.4. The JDTC should ensure that all team members have equal access to high-quality regular training and technical assistance to improve staff capacity to operate the JDTC and deliver related programming effectively. Such training and technical assistance should focus on:

- The nature of substance use disorders and the dynamics of recovery.
- Staff skill development and effective case management.
- Screening and assessment for substance use and criminogenic needs, particularly relating to the development of treatment plans.
- Adolescent development and the developmental perspective for juvenile justice programming.
- Cultural competence in working with youth and families.
- Family engagement and working with caregivers through a trauma-informed lens.
- The use of effective contingency management strategies (e.g., incentives and sanctions).
- The purpose of each intervention implemented for JDTC participants, the evidence of its value, and how it aligns with the JDTC's mission.
- The effective use of evidence-based practices (that address co-occurring mental health issues and other co-occurring issues such as family dysfunction) in substance use treatment.

Research evidence and practice considerations. When adopting an intervention, staff at all levels should be trained to understand the program's purpose, what the research says about its likely impact, and how it aligns with the agency's mission (Campie and Sokolsky, 2016). In the context of JDTCs, this would apply to the court and each collaborating agency. In addition, it is beneficial to provide interdisciplinary training for all JDTC partners on the program's philosophy, policies, and procedures. This helps partners understand different components of the justice system, treatment providers, and community support/resources for the program goals, as well as how each agency or organization achieves its goals through collaboration (Choo et al., 2016). Regular training helps staff develop skills and manage cases effectively, which can also keep the program focused on its mission and minimize staff turnover (Wilson, Olaghere, and Kimbrell, 2016).

The goal of training, which may result from a combination of federal, state, and local opportunities, is to understand the principles of the JDTC model and the importance of team collaboration (van Wormer, 2010). Linden and colleagues (2010) identified the following key elements of a training curriculum for JDTCs: a holistic approach to the multidimensional

problems of youth and families, leadership, and collaboration within the JDTC team; innovative strategies for prosocial development; defining the population (eligibility and exclusion criteria); the role of the schools; adolescent development; mental health, substance use, and co-occurring disorders; engaging families; and evidence-based practices. Dickerson and colleagues (2011) note that to achieve the highest level of collaboration among JDTC court members, it is important to provide cross-training so all members understand and are able to perform each other's roles. For the court and legal team, this cross-training would focus on clinical issues; for the therapeutic team, it would focus on legal issues. Additional topics that should be required of all JDTC stakeholders include implicit bias and cultural competence, family dynamics, and motivational interviewing to facilitate engagement (Gatowski et al., 2016).

Cultural competency training will also help equip the JDTC team to work effectively with youth and families (Beach, Price, and Gary, 2005). Juvenile justice professionals who work with LGBTQI–GNC youth will also benefit from training on concepts such as sexual orientation, gender identity, and gender expressions, as well as Prison Rape Elimination Act standards, rules, and regulations pertaining to this population. Such training will allow those who work in the field to assess any inherent biases and enhance their knowledge of discriminatory practices or policies that can interfere with the administration of fair and beneficial treatment to LGBTQI–GNC youth. Further, this training will stress that all youth deserve to be treated with fairness, dignity, and respect regardless of their gender identity or means of expression. This type of training is also important when dealing with youth and families of color. Finally, Salvatore and colleagues (2011) noted that it is also important to train staff on the developmental perspective in juvenile justice and in evidence-based substance use treatment approaches.

Technical assistance matters as well. In all implementation phases, the availability of high-quality technical assistance can improve staff capacity to deliver the program effectively (Campie and Sokolsky, 2016), and research shows that outcomes improved when staff had access to technical assistance (Mihalic, Fagan, and Argamaso, 2008; Spoth et al., 2011). Organizations that had such access on a regular basis sustained both the quality of implementation and successful results over time (Cox et al., 2012; Hurley et al., 2006; Reyes et al., 2012).

Technical assistance and training resources for Juvenile Drug Treatment Courts include the Center for Court Innovation, the National Council of Juvenile and Family Court Judges, and the National Center for Mental Health and Juvenile Justice.

Guideline 1.5. JDTCs should be deliberate about engaging parents or guardians throughout the court process, which includes addressing the specific barriers to their full engagement.

Research evidence and practice considerations. A lack of family and parental support and involvement creates challenges across the JDTC system (Wilson, Olaghere, and Kimbrell, 2016). Although there is often an initial improvement in the home environment in terms of family support for all youth in the JDTC, the largest and most sustaining improvements are found for those youth who successfully complete the program (Thompson, 2006). Family support seems to prepare youth to do better in the JDTC, which, in turn, appears to result in greater improvement in family support in the home (Thompson, 2006). Yet, in a study by Townsend (2011), JDTC court administrators

stated that a common predictor of program failure was lack of parental support. Judges also noted that when parents or guardians do not support the courts, a greater likelihood exists that their children will not succeed in the JDTC (Townsend, 2011).

It is important for the JDTC to think broadly about who is considered "family" and to defer to the family itself to define who fills that role. Likewise, the court should be flexible in defining family and what family support looks like for each participant. In addition, the court should allow the definition of family and family support to change over time if needed.

It is important for parents (or nonparental legal guardians) to engage in the process. In some cases another family member, a caring adult, a mentor, or a recovery coach may stand in for the parent or guardian (Salvatore et al., 2010). The court might consider designating another responsible adult, even if the legal status of the parent or guardian has not changed. Each JDTC must structure the use of sanctions and incentives so participants are not negatively affected if their family fails to engage or participate in the program, particularly if youth demonstrate a desire to cooperate and improve.

Families should have a primary role in making decisions for their child's care and treatment (Custwoth-Walker, Pullman, and Trupin, 2012). JDTCs should ensure that families receive information (written, audio, and verbal, in their spoken language) that allows them to make informed decisions. Family members should also have the opportunity to obtain answers to questions at any point during the course of the program. Courts must also identify barriers that keep the family from participating, including the timing of hearings, physical settings where meetings and hearings take place, and the family's level of comprehension, and engage the family in resolving these barriers. The JDTC needs to engage families through activities, events, and services to demonstrate that they value the youth and families as partners.

Finally, the JDTC team needs to ensure that at least one family member or other adult will be available to participate in decisionmaking activities for each child.

The Campaign for Youth Justice (2013) published *Family Comes First*, a workbook for juvenile justice agencies seeking to engage meaningfully with families. The workbook describes the following features of a transformed justice system, which offer a framework that can be applied in JDTCs: (1) families will be supported before and after challenges arise; (2) families will have access to peer support from the moment a youth is arrested until he or she leaves the system; (3) families will be involved in decisionmaking processes at the individual, program, and system levels to hold youth accountable and keep the public safe; (4) families will be strengthened through culturally competent treatment options and approaches; and (5) families will know their children are prepared for a successful future. Recommendations from *Family Comes First* include having a designated staff person, who ideally has been involved in the JDTC as either a family member or participant, to lead the family engagement activities and connect with local family support organizations so families receive the support they need.

Resources to help the JDTC engage participants' families include *Family Comes First; Safety, Fairness, Stability: Repositioning Juvenile Justice and Child Welfare to Engage Families and Communities;* and Topic 03: Engaging the Family in *Starting a Juvenile Drug Court: A Planning Guide*.

Guideline 1.6. JDTCs should provide court-certified or licensed onsite interpreters for parents or guardians with limited English proficiency and for those with a hearing

deficiency. In addition, all documents should be translated into the native language of non-English-speaking youth and parents or guardians.

Research evidence and practice considerations. Because clear evidence exists that family support is an important factor in successful graduation, especially among Latino youth (Hiller et al., 2010), it is important to ensure that JDTC programs employ the family's native language (Wilson, Olaghere, and Kimbrell, 2016). Fradella and colleagues (2009) found that the family's level of acculturation, especially language barriers, had a significant impact on JDTC program graduation rates. Using native-language therapists, court interpreters, and social workers and providing necessary documents in the appropriate language can mitigate these concerns (Fradella et al., 2009). Some JDTCs with a large portion of non-English-speaking clients, parents, or guardians provide a court-appointed interpreter or employ bilingual staff (Choo et al., 2016).

Professional court interpreters possess native-level proficiency in both English and another language, including sight translation, consecutive interpreting, and simultaneous interpreting, and have been designated by the court to perform interpretive services (National Center for State Courts, 2016; United States Courts, 2016). Various levels of certification exist for court interpreters; this is necessary because the legal language that needs to be conveyed is often complex (United States Courts, 2016).

Information about the requirements for courtroom interpreters, as well as self-assessment tools and exam resources, can be found at the websites for the National Center for State Courts, National Association of Judiciary Interpreters and Translators, and United States Courts.

Objective 2. Ensure Equitable Treatment for All Youth by Adhering to Eligibility Criteria and Conducting an Initial Screening

Guideline 2.1. Eligibility criteria should include the following:

- Youth with a substance use disorder.
- Youth who are 14 years old or older.
- Youth who have a moderate to high risk of reoffending.

Research evidence and practice considerations. It is important to convince clients that JDTC processes can effectively address their needs and thereby increase the likelihood that they will succeed. Youth who have a substance use disorder have higher rates for successfully completing JDTCs than those who use drugs or alcohol but do not have a substance use disorder (Wilson, Olaghere, and Kimbrell, 2016). Youth who do not meet the criteria of a diagnosis may be less likely to complete the program (Boghosian, 2006). According to the Center for Substance Abuse Treatment (2005), substance use disorders refer to both substance abuse and substance dependence. Guideline 2.3 contains a discussion of approaches to the screening and assessment of substance use disorders.

A recent evaluation of Reclaiming Futures, as integrated with juvenile drug courts, found that participating youth had better outcomes in terms of reduced substance use when strict program eligibility criteria existed and the youth had serious substance use and delinquency problems (University of Arizona, Southwest Institute for Research on Women, 2015). As with all juvenile justice programs, the intensive nature of the JDTC intervention makes it particularly well suited for youth who are assessed as medium (or moderate) to high risk for reoffending.

A large body of meta-analytic results on delinquency programming shows that higher risk youth who are involved in programs

are more likely to experience reductions in recidivism (Howell and Lipsey, 2012; Lowenkamp, Latessa, and Holsinger, 2006). For low-risk youth, juvenile justice interventions may at best have no effect and may even be harmful in that recidivism is enhanced (Lowenkamp and Latessa, 2004). In a meta-analysis of drug treatment programs, the risk principle (i.e., greater reductions in recidivism are found when drug treatment programs target higher risk youth) was supported (Prendergast et al., 2013).

Research from juvenile drug courts has also shown that older youth have higher success rates than younger youth (Wilson, Olaghere, and Kimbrell, 2016). Research suggests that these higher rates may be due to increased motivation and maturity (Eardley et al., 2004; Nestlerode, O'Connell, and Miller, 1999).

Youth who do not meet all of the criteria (e.g., they do not have a substance use disorder, are younger than 14 years old, and are at low risk of reoffending) should be diverted from formal JDTC processing into community-based alternatives. See guideline 2.4.

Youth who exceed these criteria and present with additional common co-occurring characteristics, such as mental health diagnoses and other types of offenses, can still participate in the program according to the stated eligibility policy, which does not exclude the possibility of additional needs. The assessment of additional and co-occurring characteristics is addressed in guideline 2.3.

JDTCs routinely exclude certain types of participants. For example, youth who have committed violent offenses may not be allowed to participate in the JDTC (possibly because of funding requirements),[4] although there is no evidence that these youth are less likely to succeed. Prior delinquent activity may also be a concern for the court. As noted in the *Reclaiming Futures* report, however, participants were more likely to reduce substance use behaviors after treatment if they had more serious histories of substance use and delinquent behaviors (University of Arizona, Southwest Institute for Research on Women, 2015).

What should a JDTC do regarding a youth younger than 14 years old who has a substance use disorder and was assessed as a high risk for reoffending? It is important to determine (on a case-by-case basis) whether the available programming—including the full JDTC program and the substance use treatment program—is suitable for the youth in question, given the youth's cognitive development and dependency on adults. JDTCs that decide to enroll participants younger than 14 years old should be prepared to provide additional support and accommodations, which includes an emphasis on assisting and collaborating with the family as described in guideline 3.1.

For more information, refer to the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment, Clearly Defined Target Population and Eligibility Criteria, and Step 10: Define a target population, and set eligibility criteria in *Starting a Juvenile Drug Court: A Planning Guide*.

Guideline 2.2. Assess all program participants for the risk of reoffending using a validated instrument.

Research evidence and practice considerations. Before providing treatment, the most effective juvenile justice programs use validated risk

[4] U.S. Department of Justice-funded juvenile drug courts are required to target nonviolent youth. The term "violent offender" means a youth who has been convicted of, or adjudicated delinquent for, a felony-level offense that (1) has, as an element, the use, attempted use, or threatened use of physical force against the person or property of another or the possession or use of a firearm or (2) by its nature, involves a substantial risk that physical force against the person or property of another may be used in the course of committing the offense [42 USC 3797u-2(b)].

assessment instruments to assess risk for each participant (Howell and Lipsey, 2012). Risk refers to the likelihood of reoffending. The risk principle encompasses two key strategies for practice (Lowenkamp and Latessa, 2004). First, juvenile justice programming should target youth who are assessed as higher risk for reoffending, and those assessed as low risk should be diverted from the juvenile court process. Second, higher risk youth should receive a higher level of treatment and programming.

A guide for courts to identify, select (or develop), and implement an appropriate risk assessment instrument is based on the work of the National Youth Screening & Assessment Project (Vincent, Guy, and Grisso, 2012). A literature review on risk assessment is also available at www.ojjdp.gov/mpg/litreviews/RiskandNeeds.pdf.

Guideline 2.3. Screen all program participants for substance use using validated, culturally responsive screening assessments.

Research evidence and practice considerations. It is already common practice for JDTCs to use needs assessment tools for substance use and/or mental health to determine potential clients' level of substance use disorder and mental health status as well as their family's level of substance use disorder (Choo et al., 2016). Research shows that the needs assessment process must be done using validated tools, assess a greater array of needs (see guideline 4.2), and inform the development of case management and treatment plans (see guideline 4.3). Also, the JDTC team must perform reassessments on a regular basis.

Evidence-based recommendations for JDTCs include using standardized screening and assessment tools; i.e., the tools should include measures that must be delivered in a specific way every time, are supported by a body of research that demonstrates the tools' reliability and validity, and have been tested for use with the specific population that the JDTC serves (Hills, Shufelt, and Cocozza, 2009). It has been noted that high-quality assessments yield information that can help determine eligibility and suitability for JDTC participation and also for appropriate treatment planning decisions, all of which increases the likelihood that participants will successfully complete the JDTC program (Hills, Shufelt, and Cocozza, 2009).

For example, when the Substance Abuse Subtle Screening Inventory–Adolescent 2 (SASSI–A2) was employed to assess needs related to substance use, the result was better predictions for successfully completing the JDTC (Boghosian, 2006). It is also important to assess co-occurring mental health issues because youth with co-occurring disorders are less likely to successfully complete the program (Manchak et al., 2016). A trained clinician typically conducts the highest quality (i.e., validated and reliable) mental health evaluations, which allows JDTC staff to learn of a youth's mental health issues and increases the likelihood that the youth will succeed in the program (Wilson, Olaghere, and Kimbrell, 2016).

Some examples of standardized screening and assessment instruments commonly used with juvenile justice populations include the GAIN–Short Screener and Diagnostic Interview Schedule for Children–IV. Two instruments that have been validated for screening substance use issues in adolescents are the SASSI–A2 and the CRAFFT screening tool. Additional resources on this guideline include tools and training on Screening and Motivational Interviewing.

Guideline 2.4. Potential program participants who do not have a substance use disorder and are not assessed as moderate to high risk for reoffending should be diverted from the JDTC process.

Research evidence and practice considerations. JDTCs should not engage youth who do not meet the minimum eligibility criteria defined

in guideline 2.1. In fact, such youth who are processed through JDTC programs might actually be harmed. A systematic review of research examining the formal processing of system-involved youth found that formal processing does not reduce subsequent delinquent activity; based on official data, it appears to increase the prevalence, incidence, and severity of these acts (Petrosino, Turpin-Petrosino, and Guckenburg, 2010). An increase in self-reported offending followed processing as well. The association with higher risk peers in juvenile justice programs has also been shown to enhance the antisocial activities of lower risk youth. As Lowenkamp and Latessa (2004) suggest, placing low-risk youth in juvenile justice programs may disrupt the very factors that make them lower risk—their schooling may be interrupted, they may lose a job, and their positive relationships with family and peers may be disrupted.

Formal system processing also showed no effect on subsequent offending compared to diversion programs or even doing nothing at all. Petrosino and colleagues (2010) suggest that, in the absence of any apparent benefit to public safety from formal juvenile justice system processing, a strong cost-benefit argument can be made for greater use of diversion programs, which are likely to cost less. Lipsey and colleagues (2010, p. 23) reached the same conclusion based on a meta-analysis of 548 evaluations of delinquency interventions, noting that "juvenile justice systems will generally get more delinquency reduction benefits from the intervention by focusing their most effective and costly interventions on higher risk juveniles and providing less intensive and costly interventions to the lower risk cases."

It is also important to ensure that only those youth with substance use disorders are enrolled in JDTCs. Through JDTC programs, youth diagnosed with a substance use disorder become aware of both the symptoms and negative consequences of their behavior and are more likely to benefit from the experience (Boghosian, 2006; Wilson, Olaghere, and Kimbrell, 2016). Conversely, youth who do not meet the criteria of a diagnosis may be less likely to complete the program (Boghosian, 2006).

Carney and Myers (2012) conducted a meta-analysis of nine studies that compared substance use and behavioral outcomes for youth participating in early intervention programs with outcomes for youth participating in treatment or care as usual. Early interventions are defined as those employed for youth who use substances but do not have a substance use disorder. The early intervention programs examined were brief in nature and were found to be effective for youth who did not have substance use disorders. In addition, these programs can be operated effectively in community-based settings (often in schools) and cost less.

The most effective early intervention programs use an individual format rather than a group format and generally include motivational interviewing and enhancement strategies. Better outcomes are found for interventions that involve multiple contacts (rather than a single contact) over a brief period of time (Carney and Myers, 2012).

More information on evidence-based brief interventions, including a number of models, can be found at the SAMHSA–HRSA Center for Integrated Health Solutions. A recent SAMHSA Treatment Improvement Protocol also focuses on the translation of research to practice regarding brief interventions.

Guideline 2.5. JDTCs should ensure that eligibility criteria result in equity of access for all genders; racial and ethnic groups; and youth who are lesbian, gay, bisexual, transgender, queer or questioning, intersex, and gender nonconforming (LGBTQI–GNC) and Two-Spirit.

Research evidence and practice considerations. It is important to ensure that youth who are at risk of entering and those who are currently involved in the juvenile justice system receive fair and beneficial treatment. Racial and ethnic disparities, gender-responsive needs, and the disparate experiences of LGBTQI–GNC youth must be considered. Youth of color in the juvenile justice system often have experiences and receive treatment that differ from those of white youth, even when controlling for objective criteria such as current offense and offense history. Various contributing factors can result in disparate treatment.

The Office of Juvenile Justice and Delinquency Prevention (2015) has noted that many girls enter the juvenile justice system due to previous experiences with poverty, violence, trauma, and discrimination (e.g., racial, ethnic, and gender discrimination). It is important to address the needs of girls in a developmentally appropriate way, especially in regard to limiting how far girls are formally processed into the juvenile justice system unless they pose a serious threat to public safety. Instead, gender- and culturally responsive, trauma-informed, and developmentally appropriate approaches should be increased.

Recent developments in LGBTQI–GNC studies suggest that this population experiences unique challenges in the juvenile justice system. Nationally, lesbian, gay, and bisexual youth (11 to 21 years old) represent about 5 to 7 percent of the youth population in the United States; however, they make up as much as 15 percent of youth in the juvenile justice system (Hunt and Moodie-Mills, 2012; Majd, Marksamer, and Reyes, 2009). Like other minority groups that are disproportionately represented, LGBTQI–GNC youth are at a higher risk for many negative outcomes, including homelessness; sexual, physical, and mental abuse; continuous juvenile justice system involvement; bullying; and suicide (Mitchum and Moodie-Mills, 2014; Friedman et al., 2011; Burwick et al., 2014; Irvine, 2010; Ryan et al., 2009). OJJDP recognizes the unique challenges that LGBTQI–GNC youth face in the juvenile justice system and understands that it is important to provide competent trainings, programs, and guidance to help juvenile justice professionals better respond to these young people.

Eligibility criteria and court practices should translate to equal access for all groups of youth, equivalent retention of all groups for the duration of the program, and equal treatment in court and other treatment programs. This is a difficult standard to achieve in practice. A helpful benchmark may be to disaggregate the referral cohort for a particular JDTC by demographic characteristics. Equal treatment may be inferred by finding that the demographic breakdown of the referral cohort is similar to the demographic breakdown of those enrolled in the JDTC, which is, in turn, similar to the demographic breakdown of those who graduate from the JDTC and to the demographic breakdown of those who do not graduate.

Implementation quality may be compromised and participant engagement reduced when programs are not a good fit for the readiness of clients in a cultural, physical, or socioeconomic context (Campie and Sokolsky, 2016). The "contextual fit" of an intervention is a crucial aspect of its success and may explain why evidence-based programs have had limited efficacy when used in environments that are very different from those where the program was originally developed and studied (Hodgdon et al., 2013; Mendenhall, Iachini, and Anderson-Butcher, 2013; Schoenwald, Halliday-Boykins, and Henggeler, 2003). The program's ability to adapt to fit the needs of youth may also affect retention (Fox et al., 2004).

Both male and female youth from minority racial and ethnic backgrounds are underrepresented among graduates of juvenile drug courts (Fradella et al., 2009). Research shows that these youth have lower success rates in JDTC programs than white youth and are significantly more likely to be rearrested and convicted of future felonies following program involvement (Carter and Barker, 2011; Miller, Scocas, and O'Connell, 1998; Wilson, Olaghere, and Kimbrell, 2016). Girls have a higher success rate than boys and are more likely to be rewarded and to graduate (Lucas, 2008; Nestlerode, O'Connell, and Miller, 1999). Overall, 17- to 18-year-old white participants were the most likely to be treated and received the most rewards and least sanctions during treatment, which are the greatest predictors of graduation (Jackson and Kupersmidt, 2005; Lucas, 2008).

Cultural competency includes creating policies and procedures that respect and respond to cultural differences between JDTC team members and the youth they serve (National Council of Juvenile and Family Court Judges, 2016). Because culture shapes how youth respond to a situation, youth-focused cultural competency should be part of initial and recurring training for all JDTC members (Borg et al., 2014). A wide variety of youth-oriented cultural competency training programs is available for JDTCs.

JDTC cultural competency begins with an awareness of the court's culture and continues by understanding and appreciating the culture of the youth and their families (Borg et al., 2014). This can be determined by using one of many readily available self-assessment tools (American Speech-Language-Hearing Association, 2016). Court decisions should never be made solely on the JDTC team's cultural perspective, and the JDTC should implement culturally relevant treatment interventions (American Speech-Language-Hearing Association, 2016; Borg et al., 2014). The JDTC should also track success rates to serve as indicators of equitable access to all youth and their families (Borg et al., 2014; National Council of Juvenile and Family Court Judges, 2016).

Resources on ensuring equal access for all youth include *Becoming a Culturally Competent Court*, *Juvenile Drug Courts: Strategy in Practice*, and Topic 04: Cultural Proficiency in *Starting a Juvenile Drug Court: A Planning Guide*.

Objective 3. Provide a JDTC Process That Engages the Full Team and Follows Procedures Fairly

Guideline 3.1. JDTCs should work collaboratively with parents and guardians throughout the court process to encourage active participation in (a) regular court hearings, (b) supervision and discipline of their children in the home and community, and (c) treatment programs.

Research evidence and practice considerations. One of the most important contributing factors to ensure that youth will comply with program rules and will graduate from the JDTC program is family and parental involvement and support (Salvatore et al., 2010; Wilson, Olaghere, and Kimbrell, 2016). Research indicates that participants in the JDTC program are more likely to succeed if parents and guardians engage with the court, which means that they attend court hearings regularly and participate in the process. A true collaborative relationship between the JDTC team and the family appreciates the important role that parents and guardians will play in managing participants' behavior outside of court. This calls for innovative approaches because practical experience and the research literature contain many descriptions of noncollaborative relationships between the JDTC team and the parents and guardians. Challenges to such relationships include situations in which

parents or guardians disagree with the court about behavioral expectations and appropriate disciplinary responses (Bryan, Hiller, and Leukefeld, 2006; Paik, 2011) or hide bad behavior to avoid paying fees (Paik, 2011).

Family members are critical in building positive relationships that help youth change behavioral patterns and, when the family spends time supporting the youth, it is more likely the youth will successfully complete the program (Becerra and Young, 2011). Usually the youth's mother is the parent who attends the JDTC sessions, and a youth whose family member attends is significantly more compliant with the JDTC rules (Salvatore et al., 2010). Research shows that youth's behavior and demeanor are directly linked to their parents' willingness to participate (Thompson, 2000). Involving parents or guardians in status hearings, perhaps by offering incentives, can facilitate their collaboration in behavioral management because they maintain their parental control (Thompson, 2000; Wilson, Olaghere, and Kimbrell, 2016). Research also shows that family therapy can help fully engage parents and guardians in the JDTC process (Thompson, 2000). Courts can help parents and guardians build skills in effective supervision and discipline, and intensive interventions such as parent training classes may increase the likelihood that these positive parenting practices will continue after the family's involvement with the JDTC (Carey, Waller, and Marchand, 2006; Schaeffer et al., 2010).

Parents and guardians often find that the court process is alienating, for example: (1) scheduling and long waits at court hearings may impose difficulties for the parent or guardian and their employer; (2) parents are expected to hold their children accountable, but often if the parent informs the JDTC that the child has been noncompliant, a sanction will be issued that may result in fines that parents and guardians must pay; (3) the JDTC team may not be culturally competent, and parents and guardians feel they are being judged; and (4) the JDTC is one of several programs the youth and parent or guardian must participate in, which all compete for their time.

Families' distrust and misunderstanding based on their initial contact with the JDTC can undermine efforts to get them involved in the process. Matching new families with the parents of youth who have successfully completed the program can mitigate the problem (Custworth-Walker, Pullman, and Trupin, 2012). One suggestion is to appoint a liaison to help the family navigate the process, understand their rights, and answer questions (Office of Juvenile Justice and Delinquency Prevention, 2013). Parents and guardians often feel they have to make decisions in court for their children without fully understanding the terminology or the potential consequences of those decisions. When judges and staff ask if the family has any questions, parents and guardians sometimes remain silent because they feel the judge will misunderstand them or they do not fully understand the situation and their options. Parents and guardians should receive information in a format that is easily accessible, both verbally and in writing, and that takes language barriers into account (Office of Juvenile Justice and Delinquency Prevention, 2013).

Parents and guardians also desire better home-based support to reinforce treatment plans. They often want to get involved and help their children but feel they do not have the necessary training. If youth learn a technique or process while they are in treatment or in custody, parents or guardians can implement it at home if they are adequately trained and prepared. The JDTC team and providers should offer support, information, and resources to families that are relevant to the youth's needs and that will help the family ensure the youth's success (Office of Juvenile Justice and Delinquency Prevention, 2013).

Resources to assist the JDTC team in engaging parents and guardians throughout the court process include the Family Engagement Worksheet and Family Engagement by the National Council of Juvenile and Family Court Judges.

Guideline 3.2. The judge should interact with the participants in a nonjudgmental and procedurally fair manner.

Research evidence and practice considerations. One of the key elements that separates the JDTC from other courts is the personal relationship the judge builds with the youth, which is built on intense supervision and frequent contact (Gurnell, Holmberg, and Yeres, 2014). Staff and treatment providers should provide frequent progress updates to inform this interaction so that judicial decisions are individually tailored for the youth, are fair, and are presented in a way that is not demoralizing or detrimental to the youth's progress (Gurnell, Holmberg, and Yeres, 2014; Mackin et al., 2010c). That is, the judge must be nonjudgmental—the key element is not to come to a judgment, but to hold the youth accountable through the structure of establishing goals and the effective use of graduated incentives and sanctions (Wilson, Olaghere, and Kimbrell, 2016). Mericle and colleagues (2014) found that JDTC success could be enhanced if the judge provides structure and takes responsibility for participants if this is lacking at home. It is also important for judges to intervene in ways that increase youth's self-esteem (Mericle et al., 2014).

The principles of procedural justice are important here. Fair procedures in decisionmaking will enhance the youth's view of the legitimacy of the court and their compliance with its procedures (Mazerolle et al., 2013). Tyler (2003) lays out the key elements of a procedurally fair process. First, youth and families need to *participate* in the proceedings before the judge reaches a decision. Second, youth and families must perceive that the judge is showing *neutrality* in making a decision. Finally, the judge must show *dignity and respect* for the youth and families throughout the interactions in court (Tyler, 2003).

To learn more, review Step 17: Design incentives and sanctions in *Starting a Juvenile Drug Court: A Planning Guide* and Graduated Sanctions. Resources on using sanctions and incentives to reach a goal include Goal-Oriented Incentives and Sanctions and Goal-Oriented Incentives and Sanctions Tip Sheet.

Guideline 3.3. The judge should be consistent when applying program requirements (including incentives and sanctions).

Research evidence and practice considerations. For each participant, judges must consistently apply behavioral contingencies across the full JDTC program (Wilson, Olaghere, and Kimbrell, 2016). In fact, consistency in the application of incentives and sanctions is one of the key factors enhancing the success of the JDTC intervention (Mericle et al., 2014). This is not to say every youth will receive the same incentives and sanctions. They must be individualized for each youth, but the assigned conditions should be applied consistently so the youth knows what to expect (Townsend, 2011). The individualization of programming coupled with the consistent application of judicial discretion allows for effective therapeutic treatment (Paik, 2011). Finally, the most effective way for the judge to achieve the JDTC goals is to apply the principles of behavior modification through positive reinforcement (Salvatore et al., 2011).

Judges should make the juvenile's immediate and long-term goals a priority and also tailor sanctions and incentives to the participants' goals and needs, while still being procedurally

fair and consistent (Gatowski et al., 2016). The JDTC team should develop an individualized plan for each youth that supports consistent responses, including the judge's application of incentives and sanctions to modify behavior. Just as the youth is responsible for his or her behavior, the JDTC is responsible for how incentives and sanctions are applied (Bureau of Justice Assistance, 2003). Sanctions applied inconsistently can actually reinforce undesirable behavior instead of diminish it (Gurnell, Holmberg, and Yeres, 2014).

Resources on graduated sanctions and alternatives to detention include *Making Sense of Incentives and Sanctions in Working With the Substance-Abusing Youth*, Juvenile Sanctions, Developing a Sanctions System Worksheet, Graduated Sanctions Needs Assessment Worksheet, List of Incentives and Sanctions, Incentives & Sanctions Program Workbook, and Alternatives to Detention.

Guideline 3.4. The JDTC team should meet weekly to review progress for participants and consider incentives and sanctions based on reports of each participant's progress across all aspects of the treatment plan.

Research evidence and practice considerations. The therapeutic orientation of JDTC staff is not limited to connecting youth to drug treatment programs; it also includes the multitude of remedies they use to correct youth behavior (Paik, 2011). These individualized remedies, both sanctions and incentives, are most effective if they are imposed immediately (Linden, 2008). Weekly staff meetings should be used both to evaluate youth's compliance and to give staff a better understanding about how to work with each youth over time (Paik, 2011). The effectiveness of this approach depends on the number and types of cases that JDTC staff have to supervise, so staff caseloads should be considered carefully (Paik, 2011). Regular individualized reassessments, including risk level, can help inform the level of supervision a youth should receive and the development of creative accountability measures (Wilson, Olaghere, and Kimbrell, 2016).

The entire JDTC team should meet regularly in advance of the judicial hearings. The policy manual should describe the purpose and format of the meetings, how often the team will meet, and the decisionmaking process (e.g., consensus is often the chosen process) that the team will use to prepare for the court hearings. As described above, the team members' defined roles will include the specific information each is expected to assemble and present to the rest of the team. This information should present concrete evidence on how each participant is progressing through his or her treatment plan. Presenters may provide this information before the staffing meeting; if not, at the meeting they must share all relevant information, be objective, and interpret it well so other team members can understand it, integrate it with the other data being presented, and place it into the larger context of the youth's overall profile. Consistent with the principles of family engagement, parents and guardians should ideally have the opportunity to provide input or to participate in the process prior to the court hearing—in practice, this is not typically how it happens.

A worksheet on selecting and working with treatment providers can be found in Step 21: Select treatment providers and Step 22: Identify service providers in *Starting a Juvenile Drug Court: A Planning Guide*.

Objective 4. Conduct Comprehensive Needs Assessments That Inform Individualized Case Management

Guideline 4.1. Needs assessments should include information for each participant on:

- Use of alcohol or other drugs.
- Criminogenic needs.
- Mental health needs.
- History of abuse or other traumatic experiences.
- Well-being needs and strengths.
- Parental drug use, parental mental health needs, and parenting skills.

Research evidence and practice considerations. If a youth has a substance use disorder, he or she will often have additional co-occurring mental illnesses, histories of abuse or other traumatic experiences, or other co-occurring disorders. He or she should still be treated by a JDTC. If left untreated, these other disorders and traumatic experiences could lead to future delinquency. Many youth who enter JDTC programs have a history of behavioral health disorders and problems at school. In addition, youth may have complicated family relationships that can include substance use and misuse by parents and other family members (Hills, Shufelt, and Cocozza, 2009). To better understand the various challenges a youth may face when he or she enters a JDTC program, JDTCs should screen and assess youth for a range of risks and needs. These assessments need to be completed by the time the youth first appears in the JDTC (ideally at intake), but could also be completed prior to referral to the JDTC. Trained and certified professionals should complete all assessments.

Reductions in recidivism are greater when programming addresses the criminogenic needs of system-involved youth (Dowden and Andrews, 1999). Those needs include a history of antisocial behavior; an antisocial personality pattern; antisocial cognition; antisocial peers; and needs related to family, school, use of leisure time, and substance use (Prendergast et al., 2013). In addition, when JDTC personnel effectively consider a youth's mental health needs, it can lead to a more nuanced understanding about the youth's overall ability to comply with court rules. Such consideration may lay the foundation for a lower likelihood of failure and thus lead to better outcomes (Paik, 2009; Wilson, Olaghere, and Kimbrell, 2016).

Youth with mental illnesses, histories of physical or sexual abuse or other traumatic experiences, or other co-occurring disorders have significantly lower program success rates; therefore, screening is necessary to identify youth who would be a better fit in another type of diversion program—ideally a mental health court if available (Fradella et al., 2009). Sanchez (2012) found that JDTC programs typically do not address the symptoms of posttraumatic stress disorder (PTSD), which in turn leads to less favorable outcomes. Therefore, it is important to incorporate PTSD assessment and treatment into programming. Further, youth with co-occurring disorders are perceived as higher risk and are often given additional requirements or are monitored more closely, which can lead to higher failure rates due to noncompliance (Manchak et al., 2016).

Research suggests that parental drug use, other mental health needs, and a lack of good parenting skills can all negatively impact youth success; therefore, JDTCs need to incorporate treatment and programming for parents and guardians (Wilson, Olaghere, and Kimbrell, 2016). Consequently, researchers and court staff state that one of a JDTC's goals should be to improve its ability to provide structure and guidance, which is crucial to the youth's success, to strengthen the youth's family (Eardley et al., 2004; Schaeffer et al., 2010). Programs that teach parenting skills are also important because youth often come from dysfunctional families and some parents "stop parenting" once their child enters a JDTC program (Hiller et al.,

2010; Wilson, Olaghere, and Kimbrell, 2016). Because of the evident need and the finding that youth with one parent who used substances were more than three times more likely to test positive for drugs (Saddik Gilmore, Rodriguez, and Webb, 2005), Thompson (2000) suggests using family therapy models that incorporate treatment and programming for parents, as well as sanctions against parents if they are unwilling to participate in their child's treatment.

Use of Alcohol or Other Drugs

As previously discussed, and as research strongly supports, all JDTCs should have a thorough formal screening and assessment process to validate diagnoses of youth's alcohol, drug, or other substance use or dependence. The process should help determine if a youth is eligible for a JDTC program and should also provide a complete picture of a youth's substance use issues. The process should incorporate structured assessment interviews that lend themselves to creating this complete picture (Hills, Shufelt, and Cocozza, 2009).

Many comprehensive substance use needs assessment tools are available (see www. ncbi.nlm.nih.gov/books/NBK64362). Some particular examples include the Comprehensive Adolescent Severity Inventory (CASI) and the Teen Addiction Severity Index (T–ASI). Additional resources on this guideline include tools and training on Assessment.

Mental Health Needs

According to Kinscherff (2012), research shows that 60 to 90 percent of youth who come in contact with the juvenile justice system have at least one diagnosable mental health disorder. It is not surprising, then, that research also shows a high prevalence of co-occurring mental and substance use disorders among youth in JDTC programs (Henggeler et al., 2012). Because mental health disorders can impact JDTC treatment outcomes, it is important that JDTCs properly screen and assess youth for such disorders. Research also shows that when co-occurring mental health disorders are not addressed, youth will be less likely to consistently abstain from using alcohol, drugs, and other substances (Hills, Shufelt, and Cocozza, 2009).

According to the 2002 Consensus Conference on Mental Health Assessments in Juvenile Justice Settings, "a comprehensive mental health assessment must be based on careful review of information from multiple sources and must measure a range of mental health concerns" (Wasserman et al., 2003). Wasserman and colleagues (2003) recommend that mental health assessments include direct observation and interviews with youth, mental status examination, chart reviews, and interviews with parents and other caregivers, along with a family history, when possible.

Some risk or needs assessment instruments also gather basic information about mental health and substance use issues (Judicial Council of California, 2011). Some common instruments that cover a range of domains, as well as mental health issues, include the Comprehensive Adolescent Severity Inventory (CASI) and the Teen Addiction Severity Index (T–ASI). Other examples of mental health needs assessment instruments for youth include MAYSI–2 and the Child and Adolescent Functional Assessment Scale (CAFAS).

History of Physical or Sexual Abuse or Other Trauma

In addition to the prevalence of mental health disorders among youth in JDTC programs, the presence of significant symptoms of PTSD and other trauma-related conditions (Hills, Shufelt,

and Cocozza, 2009) strongly suggests that JDTCs need to screen for and assess the contributions of traumatic childhood and current experiences on the mental health and substance use of each youth (Kinscherff, 2012). According to Kinscherff (2012, p. 17), clinicians working with youth in the juvenile justice system, including JDTCs, should "carefully consider trauma in developmental formulation, differential diagnosis, and functional assessment." Failure to do so, Kinscherff argues, may lead to errors in identifying mental health needs as they relate to trauma exposure and thus jeopardize the proper alignment of treatment with need.

To conduct screening for psychological trauma, the National Child Traumatic Stress Network recommends inquiring about a youth's history of exposure to traumatizing events through a range of tools that vary widely in length and comprehensiveness.

Some examples include the Adverse Childhood Experience Questionnaire, UCLA Child/Adolescent PTSD Reaction Index for DSM–5, and Traumatic Events Screening Inventory for Children and Parent Report Form (Ford, Kerig, and Olafson, 2014).

Parental Drug Use, Mental Health Needs, and Parenting Skills

As these guidelines assert, active participation from parents, family members, and other caregivers in the JDTC process is critical for youth to successfully complete a JDTC program. Active family involvement helps support the youth's treatment; it may also strengthen the family and enhance the ability of parents, family members, and caregivers to provide the support, structure, and guidance a youth needs after they complete the program (Hills, Shufelt, and Cocozza, 2009). However, research shows that the parents and family members of youth in JDTC programs often face their own stresses, trauma, and mental and behavioral health issues, including substance use disorders, which can be a risk factor for these youth (Mericle et al., 2014; Thompson, 2000). With this in mind, for JDTC programs to succeed, they must screen for and address family needs. For example, screening and assessment should examine how parental substance use affects bonds with children and how parental role modeling influences youth behavior, and should also seek to identify more positive coping skills for both youth and parents (Hills, Shufelt, and Cocozza, 2009). This information will further inform a comprehensive treatment program within JDTCs.

Examples of these assessments are listed on the Child Welfare Information Gateway. Other available instruments that cover a range of domains, including parent needs, include the Comprehensive Adolescent Severity Inventory (CASI) and the Teen Addiction Severity Index (T–ASI).

Guideline 4.2. Case management and treatment plans should be individualized and culturally appropriate, based on an assessment of the youth's and family's needs.

Research evidence and practice considerations. For JDTCs, the information gained from a comprehensive assessment can be used to (1) initiate a plan for specific treatment, (2) identify other psychosocial needs, (3) describe the individual's specific strengths, or (4) evaluate the individual's motivation for treatment (Hills, Shufelt, and Cocozza, 2009). It is common practice for JDTCs to consist of multiple treatment components in which the youth's developmental needs determine the components that each youth would participate in (Choo et al., 2016). Treatment plans spell out the intensity of services for each youth.

JDTCs should adopt evidence-based case management that takes into account the

participants' special needs and allows some flexibility in the application of case management practices (Center for Substance Abuse Treatment, 2015). Programs that use a more flexible fidelity framework focused on the delivery of specific treatment elements shown to be effective, rather than a prescriptive sequencing of every program element, may be more effective when trying to engage and retain clients whose circumstances make it difficult to follow a regimented program schedule (Campie and Sokolsky, 2016). Strict adherence to fidelity reduced parent engagement but increased youth's satisfaction with the program. Parents and guardians stated that they expected service providers to treat them more as peers and to accommodate requests for changes because of family needs (Byrnes et al., 2010). Results improved when programs balanced the need for fidelity with the need for flexibility (Dusenbury et al., 2004). Lack of flexibility when implementing interventions may also reduce practitioner confidence and commitment for delivering the program as intended (Goldman, 2009).

The Center for Substance Abuse Treatment (2015) describes comprehensive case management that supports substance use treatment. Evidence-based case management involves (1) providing "a single point of contact for multiple health and social service systems"; (2) advocating for the participant and his or her family; (3) being "flexible, community-based, and client-oriented"; and (4) helping the participant and family manage other related needs (Center for Substance Abuse Treatment, 2015, pp. xiii, 13). The best case management will be provided by professionals who understand (1) the different types and causes of addiction and the various problems associated with substance use disorders; (2) the state of the art of evidence-based "treatment, recovery, relapse prevention, and continuing care" to address substance use disorders and any associated problems (Center for Substance Abuse Treatment, 2015, p. 15); (3) the important role that family, community, and support systems play in treatment and recovery; (4) the different options for engaging insurance and health maintenance providers to cover the cost of treatment and recovery services; and (5) how to integrate individual needs, including culturally relevant needs and those specific to youth with special needs, into treatment and other critical services.

JDTCs should provide evidence-based case management with the framework of a trauma-informed juvenile justice system (Dierkhising, Ko, and Halladay Goldman, 2013). As described above, this includes using evidence-based trauma screening and assessment instruments suitable for these youth. In addition, it is critical to establish collaborative relationships with the family to reduce the potential that involvement in the juvenile justice system will itself be traumatizing. A trauma-informed juvenile justice system also includes efforts to reduce disproportionate minority contact and to respond to any observed disparities in how minority youth are treated. It is important to ensure effective continuity of care across the different systems to meet the multifaceted needs of the participants and their families. Finally, it is critical for the JDTC to provide a process and environment that reduces the likelihood that youth will be retraumatized.

For more information on case management that is designed for youth with substance use disorders, see *Comprehensive Case Management for Substance Abuse Treatment*.

Objective 5. Implement Contingency Management, Case Management, and Community Supervision Strategies Effectively

Guideline 5.1. For each participant, the application of incentives should equal or exceed

the sanctions that the JDTC applies. Incentives should be favored over sanctions.

Research evidence and practice considerations. JDTCs use incentives and sanctions to encourage their clients to comply with program requirements. Incentives are typically applied if clients progress through the program and if their family cooperates with the various program phases. Sanctions are generally administered if a juvenile does not comply with the program (for example, missing scheduled events or therapy), tests positive on a drug test or misses a drug screen, does not attend a court hearing, commits a crime, or fails to follow the provisions of his or her probation or treatment (Choo et al., 2016).

Contingency management strategies are often implemented in less than optimal ways because of challenges in training staff to understand and use these principles. Funding is also a concern, including the ability to fund program elements such as incentives and to hire an adequate number of staff (Wilson, Olaghere, and Kimbrell, 2016). Heck (2007) evaluated one JDTC and noted that training staff on the principles of contingency management and using sanctions and incentives would enhance the program's capacity. Hiller and colleagues (2010) conducted focus groups with teams from the JDTCs and found that, although there are typically only limited incentives, JDTCs would like to expand their number and variety. This is likely to involve dedicated staff who can work to secure incentives that are not currently available, such as passes for movies or bowling (Thompson, 2000). Verbal praise can also be used to augment behavioral management strategies when resources for incentives are constrained. Research suggests that praise can be a powerful behavioral motivator when applied under the proper conditions (Henderlong and Lepper, 2002).

An effective system of incentives and sanctions promotes each youth's ability to take responsibility and be accountable for his or her actions while allowing them to complete the program. Based on key ideas drawn from behavioral research and juvenile drug court practice, JDTCs should implement a system of incentives and sanctions that are immediate, certain, consistent, fair, of appropriate intensity, goal oriented, graduated, individualized, and therapeutically sound (Gurnell, Holmberg, and Yeres, 2014). In addition, a balance is needed between incentives and sanctions in the JDTC. Research shows that there should be four incentives for every sanction (Gendreau, Cullen, and Bonta, 1994). JDTCs should use data to monitor the implementation of incentives and sanctions on an ongoing basis, reviewing their effectiveness (Borg et al., 2014) and ensuring that they maintain an appropriate incentives-to-sanctions ratio. JDTCs that conduct surveys with youth and family after graduation can obtain information on the appropriateness and effectiveness of incentives and sanctions (Borg et al., 2014).

A number of resources provide tools for JDTCs to use in planning for and applying incentives and sanctions. Step 17: Design incentives and sanctions in *Starting a Juvenile Drug Court: A Planning Guide* provides important guidance. *Making Sense of Incentives and Sanctions in Working With the Substance Abusing Offender* also provides useful insights into the vital role that incentives and sanctions play in contingency management with JDTC participants.

Guideline 5.2. Participants should feel that the assignment of incentives and sanctions is fair:

- Application should be consistent; i.e., participants receive similar incentives and sanctions as others who are in the court for the same reasons.
- Without violating the principle of consistency described above, it is also valuable to individualize incentives and sanctions.

Research evidence and practice considerations. To reconcile the two facets of incentives and sanctions described above, the objective is to base them on the participant's competency and individualized treatment protocol. Behavioral contracts allow JDTCs to stay both consistent and individualized because if a youth breaks the contract, he or she cannot say that the response is unfair. When a youth does say that the situation is unfair, they often want to have their viewpoint taken seriously. JDTCs should meet with the youth to create a list of incentives and sanctions and update them every 60 to 90 days (Borg et al., 2014). Also, the way in which JDTCs communicate with youth about the sanction (e.g., confrontational or supportive) determines how it is received (Yeres and Gurnell, 2012). Individualization of incentives and sanctions should be aligned with the youth's proximal (short term, not using drugs this week) and distal (long term, such as obtaining a GED) goals (Borg et al., 2014).

Youth generally perceive that counselors and JDTC staff treat them fairly (Wilson, Olaghere, and Kimbrell, 2016). In a survey of JDTC participants, 72 percent of youth felt the judge treated them fairly. In another survey, 75 percent felt the judge treated them fairly even when applying sanctions (Salvatore et al., 2011). Incentives are important to the success of drug courts, and youth indicate that they appreciate the rewards. Increasing incentives can improve graduation rates (Wilson, Olaghere, and Kimbrell, 2016). In one study, the youth noted that earning rewards was a highlight of the JDTC hearings (Whiteacre, 2007). In another study, the percentage of incentives (relative to sanctions) was a significant predictor of graduation (Konecky, 2010). Wilson and colleagues (2016) also found that it is important to individualize incentives and sanctions, including creative strategies. Linden (2008) argued that when incentives and sanctions are individualized, they can facilitate the kind of "reflected appraisals" that contribute to a true change in identity for the participants.

To learn more, review Step 17: Design incentives and sanctions in *Starting a Juvenile Drug Court: A Planning Guide* and Graduated Sanctions. Resources on using sanctions and incentives to reach a goal include Goal-Oriented Incentives and Sanctions and Goal-Oriented Incentives and Sanctions Tip Sheet.

Guideline 5.3. Financial fees and detention should be considered only after other graduated sanctions have been attempted. Detention should be used as a sanction infrequently and only for short periods of time when the youth is a danger to himself/herself or the community, or may abscond.

Research evidence and practice considerations. Normal adolescent behaviors can often include risk taking, impulsiveness, moodiness, forgetfulness, aggression, and experimentation. Unfortunately, many of these behaviors are punished in the JDTC model (they are considered violations of court order and JDTC program guidelines) and result in eventual stays in detention or in the assignment of fees. Research shows that detention is the most commonly used sanction in some JDTCs (Jackson and Kupersmidt, 2005). JDTCs often report using detention for weekend-only stays as sanctions (Choo et al., 2016).

The research on how detention impacts adolescent development and mental health is quite clear. The use of detention actually increases the likelihood of recidivism and negatively impacts future employment and educational opportunities. Detention and length of detention are also related to JDTC failure (Wilson, Olaghere, and Kimbrell, 2016). The amount of time spent in detention is significantly related to JDTC program graduation rates, program failure, and new delinquency charges (Konecky, 2010). Tranchita (2004) found that a youth placed in detention is almost 7.7 times more likely than a youth who was never in detention to fail to graduate from a JDTC program.

Detention should be used sparingly and only as a last resort. It is the least effective and most expensive way to affect changes in behavior (Borg et al., 2014). Mackin and colleagues (2010a) recommend that courts should assess the use of detention and consider replacing it as much as possible with effective, lower cost sanctions. JDTCs should consider whether the assignment of fees is a valuable strategy. Most commonly, fees are assigned based on the youth's behavior, but the parents pay. Some parents and guardians feel it is not fair to pay fees when youth are noncompliant (Wilson, Olaghere, and Kimbrell, 2016). Perhaps even more of a concern for JDTCs is the finding that if parents or guardians believe they may be assessed fees, some of them will hide noncompliant youth behaviors to avoid payment (Paik, 2011).

Resources on graduated sanctions and alternatives to detention include *Making Sense of Incentives and Sanctions in working with the Substance-Abusing Youth*, Juvenile Sanctions, Developing a Sanctions System Worksheet, Graduated Sanctions Needs Assessment Worksheet, List of Incentives and Sanctions, Incentives & Sanctions Program Workbook, and Alternatives to Detention.

Guideline 5.4. Ongoing monitoring and case management of youth participants should focus less on the detection of violations of program requirements than on addressing their needs in a holistic manner, including a strong focus on behavioral health treatment and family intervention.

Research evidence and practice considerations. Case management both facilitates a youth's participation in and, ideally, successful completion of a JDTC program, ensuring that the youth and family are connected to and can access needed supports and services. It also maintains public safety by monitoring each youth's compliance with the requirements and sanctions that the court or probation impose (Gurnell, Holmberg, and Yeres, 2014). Maintaining a balance between these responsibilities is important for a JDTC program to be effective. Balanced case management "puts a human face on the juvenile drug court" while equally maintaining stewardship over public safety (Gurnell, Holmberg, and Yeres, 2014, p. 149). As such, case management ensures that the JDTC actually works, both for the youth served and his or her community (Gurnell, Holmberg, and Yeres, 2014).

The benefits of intensive monitoring are mixed; although it can create opportunities to better address youth's needs, it can also lead to the detection of more violations of program requirements and the administration of *ad hoc* sanctions, resulting in a negative view of youth and lower graduation rates (Wilson, Olaghere, and Kimbrell, 2016). As Paik (2011) notes, when the court focuses heavily on violations and noncompliance, it develops perceptions about how it will or will not be able to work with each youth, which may serve to limit the application of the contingency management that could change behavior and shape the youth's identity.

The balance of case management and supervision, along with monitoring, should be achieved in the context of addressing the youth's needs holistically. This requires individualizing case management and supervision plans. It also will demand effective engagement of the parents or guardians. This balance will also provide the context in which decisions are made about the length of court supervision, the treatment programs to which participants are referred, the frequency of drug tests, and other services to which the youth are referred.

The decisions and considerations that must be explored are described in further detail in Step 16: Provide for case management and community supervision in *Starting a Juvenile Drug Court: A Planning Guide*.

Guideline 5.5. A participant's failure to appear for a drug test and otherwise tampering with drug test results should be addressed with immediate, graduated sanctions.

Research evidence and practice considerations. Every drug court uses urinalysis for drug testing, and some also conduct oral fluid analysis and use breathalyzers to detect alcohol (Choo et al., 2016). Drug testing should be random, observed, frequent, and sensitive to any potential trauma the youth has experienced (Gatowski et al., 2016). JDTCs should develop a standard for testing but increase the frequency as needed for individual youth (Robinson and Jones, 2000).

Research shows a consensus that testing should occur twice a week initially and then weekly during the JDTC's latter stages (National Association of Drug Court Professionals, 2015; Robinson and Jones, 2000). The court should also use spot testing when staff suspect that the youth might be under the influence of a substance. If JDTCs cannot afford frequent testing, they can use a random testing schedule in which the youth calls in daily to check if they have been selected for testing (Robinson and Jones, 2000). The frequency of testing should be the last supervision level lifted (Marlowe, 2008).

Konecky (2010) found that the percentage of youth who failed to appear for drug testing was significantly and positively associated with an increased likelihood for program failure. Further, youth with higher percentages of missed (and positive) drug tests were more likely to fail to complete the program (Konecky, 2010). Thus, youth's failure to appear for drug testing during the initial phase is a warning sign for youth at high risk of program failure (Konecky, 2010; Wilson, Olaghere, and Kimbrell, 2016).

Immediate, graduated sanctions are called for in the event a youth tampers with drug tests, especially through substitution and adulteration (Gurnell, Holmberg, and Yeres, 2014). Such tampering should be seen as a deliberate act of noncompliance, yet most tampering can be eliminated by employing direct observation for urine and other related collections (Gurnell, Holmberg, and Yeres, 2014).

To learn more about using incentives and sanctions with substance users, review *Making Sense of Incentives and Sanctions in working with the Substance-Abusing Youth* and Step 18: Develop a drug testing protocol in *Starting a Juvenile Drug Court: A Planning Guide*.

Guideline 5.6. The JDTC team should be prepared to respond to any return to substance use in ways that consider the youth's risk, needs, and responsivity.

Research evidence and practice considerations. Many JDTCs employ sanctioning models with a reasonable tolerance for return to use, consistent with what is known about successful recovery. Tolerance for return to use is determined on an individual basis (Gatowski et al., 2016). Reactions to return to use should be based on what is known about each youth's goals and progress. For instance, a positive drug screen may result in a minor sanction within the first 30 days of a participant's enrollment in the JDTC, but a similar occurrence in the final phase of the JDTC process would be met with a more serious sanction (Gurnell, Holmberg, and Yeres, 2014). Research shows that return to use is an expected aspect of recovery for many youth. Yet, Polakowski and colleagues (2008) note that treatment and sanctions are often confused with one another and that more restrictive forms of treatment are assigned in response to violations, rather than being based on an assessment of the youth's treatment needs.

It is important to differentiate between treatment and recovery support, especially for these youth. A key threat to an adolescent's

recovery is unstructured leisure time. If youth do not have a positive peer group, it is unlikely they will stop using substances, even when penalties are enforced. JDTCs should be aware of the risk associated with adolescent substance use disorder and that youth will be returning to the same environments they lived in before they were part of the JDTC. There is a lack of recovery support in schools and afterschool programs, and research shows that more than 75 percent of adolescents who leave treatment and return to their school of origin will return to use within 90 days. Although the JDTC may offer additional support to youth and families, peer support in school and after school is critical. It is unrealistic to expect JDTCs to offer these types of supports unless they can operate in the community context. Courts that establish strong referral sources and community partnerships can create additional safety nets that will benefit both youth and the court.

In a systematic review of the literature on recovery for adolescent substance users, Fisher (2014) states there are two broad categories of recovery programs—formal aftercare services and recovery communities. Two evaluations of formal aftercare services have been published: assertive continuing care (Garner et al., 2007) and active aftercare (Burleson, Kaminer, and Burke, 2012). Both programs were associated with a lower likelihood of return to use.

Recovery communities have also taken two different forms in the research literature—recovery high schools and community-based self-help groups. Recovery high schools provide safe learning environments within larger schools to provide peer support in small groups. These programs support recovery and enhance academic performance (Moberg and Finch, 2007). As Fisher (2014) notes, community-based self-help groups, such as adolescent-specific 12-step programs, have shown promise for positive effects. At a recent session on "Recovery for Youth with Substance Use and Co-occurring Mental Health Disorders in K–12 Educational Settings," which the White House Office of National Drug Control Policy hosted, a youth who was currently enrolled in a recovery high school shared her experience in the program. She mentioned that a counselor was assigned to track her progress and said the recovery program provided "her own space, and a safe environment in which to express her feelings. She learned life lessons about accountability, boundaries, and a healthy lifestyle" (Dickard, Downs, and Cavanaugh, 2011, p. 26).

Training materials to learn more about Alternative Peer Groups are available online. A study that describes Recovery Schools is a resource to understand more about the model as it is implemented in 17 different schools. The unique role of positive peer supports is key to understanding the benefits of the Recovery Schools. More information on this guideline include The Risk-Need-Responsivity Model and *Risk Assessment in Juvenile Justice: A Guidebook for Implementation*.

Objective 6. Refer Participants to Evidence-Based Substance Use Treatment, To Other Services, and for Prosocial Connections

Guideline 6.1. The JDTC should have access to and use a continuum of evidence-based substance use treatment resources—from in-patient residential treatment to outpatient services.

Research evidence and practice considerations. Just as youth in JDTCs present with varied risk factors and needs, so too court programs must plan for and provide access to a broad continuum of treatment options for youth and their families. A full continuum of treatment should include home-based outpatient and intensive outpatient treatment; day treatment; individual, group, and family treatment; inpatient treatment; and residential treatment. The continuum should also include prevention

of return to use and other ongoing care (Gurnell, Holmberg, and Yeres, 2014). Although the focus is on treating substance use and related behaviors, JDTCs must be aware that youth and families will have other needs that often contribute to and are the result of their substance use. Therefore, youth and families should have access to other service providers who can help meet those needs (Gurnell, Holmberg, and Yeres, 2014).

In addition to comprehensive treatment and other options, JDTCs should arrange for adolescent-specific (and family-specific, as applicable) care as part of their continuum. Research shows that using adolescent-specific treatment approaches in particular is directly related to retention and treatment success (Gurnell, Holmberg, and Yeres, 2014). A clearly identified referral process should be in place to provide effective coordination for families from court to community. Because families and youth often find it difficult to access and attend treatment services, they should have the opportunity to participate in discussions about where these services are located in the community.

For a JDTC to be able to refer youth and families to a broad continuum of treatment and related options for services, the court must identify all organizations and agencies it will depend on for such services and involve them in the planning process (Gurnell, Holmberg, and Yeres, 2014). Without this involvement, the court may be limited in its knowledge of and ability to refer youth and families to a range of providers. The availability of high-quality treatment resources that span the full continuum will vary in each jurisdiction. It is important to sustain available treatment resources and find ways to develop viable alternatives where gaps exist. Sustainability is more likely when program sites effectively link their needs to those of the larger resource, funding, and policy context (Campie and Sokolsky, 2016; Rhoades, Bumbarger, and Moore, 2012). For example, JDTCs are encouraged to look for ways to align the needs of local providers with available state funding (Campie and Sokolsky, 2016).

A worksheet on continuum of treatment can be found in Step 21: Select treatment providers in *Starting a Juvenile Drug Court: A Planning Guide*, and more information can be found in Developmentally Appropriate Services for JDTCs.

Guideline 6.2. Providers should administer treatment modalities that have been shown to improve outcomes for youth with substance use issues. These modalities include, but are not limited to, the following:

- Assertive continuing care. Programs that provide integrated and coordinated case management services for youth after they are discharged from outpatient or inpatient treatment, including home visits, client advocacy for support services, and integrated social support services.
- Behavioral therapy. Programs based on operant behavioral principles that use incentives (e.g., gift certificates) to reward abstinence and/or compliance with treatment.
- Cognitive behavioral therapy. Programs based on theories of classical conditioning that focus on teaching adolescents coping skills, problem-solving skills, and cognitive restructuring techniques for dealing with stimuli that trigger substance use or cravings.
- Family therapy. Programs based on ecological approaches that actively involve family members in treatment and address issues of family functioning, parenting skills, and family communication skills.
- Motivational enhancement therapy. Programs that use supportive and nonconfrontational therapeutic techniques to encourage motivation to change based on clients' readiness to change and self-efficacy for behavior change.

- Motivational enhancement therapy/ cognitive behavioral therapy. Programs that use a combination of motivational enhancement and cognitive behavioral therapy techniques.
- Multiservice packages. Programs that combine two or more of these approaches. These programs use a combination of behavioral therapy, cognitive behavioral therapy, family therapy, motivational enhancement therapy, pharmacotherapies, and/or group and mixed counseling in a comprehensive package.

Research evidence and practice considerations. It is critical for JDTCs to identify providers that use evidence-based treatment approaches and models. The treatment modalities discussed previously showed evidence of beneficial effects (relative to practice as usual or no treatment) in at least two independent study samples, after adjusting for methodological differences between studies. The results of a systematic review and meta-analysis show that these types of treatment modalities were associated with significant reductions in substance use among youth and were consistently more effective than more generic types of "practice as usual" or "mixed counseling" programs that do not follow a unified approach or model for providing treatment (Tanner-Smith et al., 2015). These findings have implications for the treatment providers that collaborate with JDTCs to provide substance use treatment services for youth involved in the court.

JDTCs are advised to refer participants to substance treatment programs that feature family therapy, motivational enhancement therapy, or cognitive behavioral therapy. Preferably, these programs should follow standardized treatment manuals or protocols. JDTCs should not refer participants to standard community services, stand-alone self-help treatment, or generic counseling programs that do not incorporate family therapy, motivational enhancement therapy, and/or cognitive behavioral therapy components.

More information can be found in a number of online resources: Comprehensive Treatment Planning, National Registry of Evidence-based Programs and Practices, Cognitive Behavioral Therapy, Family Therapy, and Motivational Enhancement Therapy.

Guideline 6.3. Service providers should deliver intervention programs with fidelity to the programmatic models.

Research evidence and practice considerations. Beginning with the seminal work of Lipsey and Wilson (1998), the call for evidence-based outcomes is not reserved for researchers; it now comes from practitioners and policymakers alike. There are also growing concerns about formal justice processing on young people's well-being and the realization that ineffective programs not only harm youth but may lead to increases in justice expenses as youth with unmet needs transition into adulthood (Petrosino, Turpin-Petrosino, and Guckenburg, 2010). While the desire for effective interventions has grown, the means to implement them effectively have not kept pace, often resulting in failed replications and adaptations when taking a single-site program to scale (Drake, Aos, and Miller, 2009; Oxman et al., 2010). Some of these difficulties stem from the policy objective of quickly disseminating evidence-based programs and practices to encourage their adoption without first ensuring these interventions have adequate supports to be implemented with quality (Campie and Sokolsky, 2016). Once a JDTC identifies the treatment and other service needs of youth and their families and identifies providers using evidence-based treatment and service models, programs must ensure that providers implement those practices with fidelity to the model. To implement evidence-based treatments, agencies and clinicians must be trained in how to administer the intervention and adhere to the treatment manual and must be open to adjustments to practice to maintain fidelity (Kerig, 2013). Courts and providers

should discuss and agree on these expectations to promote successful implementation.

As research indicates time and again, poorly implemented evidence-based practices can produce no better outcomes than locally developed programs that do not have an established evidence base (Lipsey, 1992). Research on the science of implementation and change demonstrates that organizations must be ready to implement interventions; key aspects of readiness include a combination of factors inside the organization and within the context in which it operates (Scaccia et al., 2015). Organizations that are not ready to take on an evidence-based practice typically produce poor results; eventually the intervention is de-adopted and replaced (Fixsen et al., 2005). It is important to consider complexities to implementation. On the one hand, when program sites were able to strictly implement a particular intervention, better long-term outcomes were found among participants as much as 18 months after they left the program (Spoth et al., 2002). Research has also demonstrated that programs with higher levels of implementation quality are associated with better outcomes for the youth served (Steinka-Fry, Wilson, and Tanner-Smith, 2013). When more attention is paid to implementation quality, programs can serve more participants and collect more consistent data on program results (Fagan et al., 2012). Yet, it can be difficult to maintain implementation fidelity when programs use teaching and facilitation styles that respond to a primary desire to engage youth more effectively (Pettigrew et al., 2013).

Resources on program fidelity that JDTC personnel will find helpful include *Improving the Effectiveness of Juvenile Justice Programs*, Evidence-Based Programs for Juvenile Justice Reform in Louisiana, and *Ensuring Fidelity to the Juvenile Drug Courts Strategies in Practice—A Program Component Scale*.

Guideline 6.4. The JDTC should have access to and make appropriate use of evidence-based treatment services that address the risks and needs identified as priorities in the youth's case plan, including factors such as trauma, mental health, quality of family life, educational challenges, and criminal thinking.

Research evidence and practice considerations. Evaluations of JDTCs show that effective courts realize that, in addition to varying degrees of substance use problems, the youth they serve also have varying degrees of other risk factors (Shaffer and Latessa, 2002). Many young people enter JDTC programs with histories of delinquent behavior and some continue to offend while they are in the program and after leaving it (Mackin et al., 2010b; Shaffer and Latessa, 2002; Thompson, 2006; Tranchita, 2004). Many youth have experienced trauma in their family and the community, which may contribute to substance use, delinquency, or both (Sanchez, 2012). Further, many youth face family dysfunction and many JDTCs view parents and other caregivers as risk factors to youth's substance use (Bryan, Hiller, and Leukefeld, 2006; Carey, 2004; Mericle et al., 2014; Shaffer and Latessa, 2002; Thompson, 2000). Thus, it is clear that a "one-size-fits-all" approach in JDTC programs will not provide appropriate treatment and support for all youth (Hiller et al., 2010), nor can JDTCs provide all of the services necessary to meet youth's diverse needs. Evidence strongly supports a greater variety and quantity of services in JDTC programs as well as connections with community providers to deliver those services (Bryan, Hiller, and Leukefeld, 2006; Carey, 2004; Hiller et al., 2010; Mericle et al., 2014; Shaffer and Latessa, 2002). In particular, wide-ranging services and supports are needed to address trauma, mental health, family issues, educational challenges, and criminal thinking (Wilson, Olaghere, and Kimbrell, 2016).

In regard to evidence-based treatment services, regardless of the need they are seeking to address, an important consideration is the definition of "evidence based." Without assurance of the scientific rigor through which this term is claimed for any given treatment or service model, JDTCs should ask providers to clarify exactly what it means. Courts should ask questions to determine the models that are used, evidence showing the models' efficacy (and the populations they are effective with), and whether the providers are implementing the models with fidelity (Gurnell, Holmberg, and Yeres, 2014). These considerations are important so JDTCs can ensure their chosen providers are meeting the youth's and families' wide range of needs.

JDTCs can take a number of steps to identify locally available evidence-based treatment programs appropriate for youth. JDTC team members can be a resource for identifying these programs and determining whether they are a good fit for the JDTC and the youth the court serves. Several online clearinghouses offer overviews of evidence-based treatment programs for youth, including Model Programs Guide, National Registry of Evidence-Based Programs and Practices, and the Juvenile Justice Information Exchange.

Guideline 6.5. Participants should be encouraged to practice and should receive help in practicing prosocial skills in domains such as work, education, relationships, community, health, and creative activities.

Research evidence and practice considerations. A systematic review of positive youth development programs showed that a vast array of approaches contributed to positive youth behavior outcomes and also reduced or prevented youth's involvement in problem behaviors, including substance use and delinquent activities (Catalano et al., 2004). The programs examined addressed the following positive youth development outcomes: competence, self-efficacy, prosocial norms, opportunities for prosocial involvement, recognition for positive behavior, bonding with positive adults, positive identity, self-determination, and resiliency. The programs also addressed the following problem behaviors: school suspension, dropout, use of alcohol and other substances, and delinquency (Catalano et al., 2004). Research on JDTCs revealed that participants need more prosocial activities and opportunities and also expressed that it is a challenge to understand and impact youth's peer associations. JDTCs' ability to affect youth's peer associations appears mixed across courts (Wilson, Olaghere, and Kimbrell, 2016). Mentoring is suggested as a way for youth to practice their prosocial skills while reaping the benefits of having an adult role model (Gatowski et al., 2016).

An approach that uses the concepts of positive youth development to refocus juvenile justice interventions is known as positive youth justice (Butts, Bazemore, and Meroe, 2010). This conforms with the ultimate goal—for youth in the juvenile justice system to become productive adult citizens. To this end, the positive youth justice model has 12 key components that arise from the intersection of 2 essential assets (learning/doing or building competence, and attaching/belonging or positive healthy relationships) with 6 different life domains (work, education, community, relationships, health, and creativity) (Butts, Bazemore, and Meroe, 2010).

For more information on developing prosocial skills and JDTC mentoring, review Step 23: Explore enrichment opportunities in *Starting a Juvenile Drug Court: A Planning Guide* and *Mentoring in Juvenile Treatment Drug Courts*.

Objective 7. Monitor and Track Program Completion and Termination

Guideline 7.1. Court and treatment practices should facilitate equivalent outcomes (e.g., retention, duration of involvement, treatment progress, positive court outcomes) for all program participants, regardless of gender, race, ethnicity, or sexual orientation.

Research evidence and practice considerations. In practice, JDTCs find it difficult to provide age-appropriate, gender-specific, and culturally and linguistically competent services. In addition, research points to disparities in the outcomes associated with JDTCs. White youth were more likely to complete the program and had lower recidivism rates than minority youth. Girls were more likely to complete the program and had lower recidivism rates than boys. Older youth had better outcomes than those who were younger. When youth have co-occurring disorders and histories of abuse or other traumatic experiences, they are less likely to succeed in a JDTC (Wilson, Olaghere, and Kimbrell, 2016). Although there is emerging research on LGBTQI–GNC youth in the juvenile justice system (e.g., Majd, Marksamer, and Reyes, 2009; Irvine, 2010), there is currently a dearth of evidence on outcomes for these youth in JDTCs.

Tanner-Smith, Lipsey, and Wilson (2015) noted that an analysis of reductions in substance use showed no evidence of differences related to gender, race/ethnicity, age, comorbidity, or delinquency level. Polakowski and colleagues (2008) also found that individual characteristics did not predict whether youth would complete or fail to complete the program. This somewhat surprising lack of relationship between participant characteristics and treatment effects may be an encouraging finding. It indicates that treatments are relatively robust in their effects; that is, they produce similar outcomes for adolescents with different demographic characteristics and histories. These conclusions are only speculative, but they do suggest that there are other (nontreatment) aspects of the JDTC experience that contribute to the disparate results with regard to outcomes for participants. It is important to monitor and to work toward equivalent outcomes.

> Resources on facilitating equivalent outcomes for all youth include LGBTQ Youths in the Juvenile Justice System, Topic 04: Cultural Proficiency in *Starting a Juvenile Drug Court: A Planning Guide*, and Comprehensive Treatment Planning.

Guideline 7.2. A youth should be terminated from the program only after the JDTC team has carefully deliberated and only as a last resort after full implementation of the JDTC's protocol on behavioral contingencies.

Research evidence and practice considerations. Key JDTC stakeholders agree that although termination should be a last resort, it is important to have strict guidelines to determine when to terminate a youth from the program. These guidelines should be adhered to faithfully (Gatowski et al., 2016). The challenge with such an approach is that typical adolescent behavior often pushes the limits that the court sets, triggering a decision to terminate a participant who may actually benefit from the program (Steinberg, 2014).

Polakowski and colleagues (2008) found that the strongest predictors for successfully completing or leaving a JDTC were factors related to process, such as the use of incentives and sanctions, the consistency of implementing behavioral contingencies with each participant, and youth's retention in community-based substance treatment programs. Incentives are important to JDTC success, and youth appreciate them. Increasing the application of incentives can improve the rates of successful program completion. Conversely, when sanctions are not applied consistently, the court

might view the participants more negatively and it might lead to higher termination rates (Wilson, Olaghere, and Kimbrell, 2016).

Because consistent evidence exists that successful program completion depends on the court's structure and participants' commitment to the process, JDTCs are encouraged to work with each participant individually to find a structure that maximizes the use of incentives, uses graduated sanctions appropriately and consistently, and supports family engagement in meaningful and empowering ways. Appropriate responses to violations committed early in the process could have a positive impact on participants' progress in the program. Referring youth to evidence-based treatment programs and supporting continued involvement also makes it more likely that youth will complete the program successfully.

More information can be found at Teamwork and Step 16: Provide for case management and community supervision in *Starting a Juvenile Drug Court: A Planning Guide*.

Guideline 7.3. Each JDTC should routinely collect the following detailed data:

- Family-related factors, such as family cohesion, home functioning, and communication.
- General recidivism during the program and after completion, drug use during the program, and use of alcohol or other drugs after the program ends.
- Program completion and termination, educational enrollment, and sustained employment.
- Involvement in prosocial activities and youth-peer associations.

Research evidence and practice considerations. Assessments of the perceptions of drug court staff have found that they often view their court's data collection processes as inadequate and are dissatisfied with the process (Shaffer and Latessa, 2002; Shaffer et al., 2002; Wilson, Olaghere, and Kimbrell, 2016). Researchers recommend that juvenile drug courts develop or improve robust management information systems to systematically collect statistics that provide better evidence of program viability and reliability and help secure future funding (Mhlanga and Allen, 2009; O'Connell, Wright, and Clymer, 2003). Further, more detailed information about changes in youth behavior and program processes is needed (Mhlanga and Allen, 2009; Wilson, Olaghere, and Kimbrell, 2016).

Family cohesion is a strong protective factor for substance use and other problem behaviors (MacMaster, Ellis, and Holmes, 2008). Evidence supports the idea that JDTCs' relative effectiveness and the evidence-based treatments they provide can at least partially be attributed to the programs' capacity to "alter well-established family (e.g., parent supervision) ... risk factors for antisocial behavior in adolescents" (Schaeffer et al., 2010, p. 57). Consequently, research shows that family-related factors, such as family cohesion, home functioning, and communication, improve while a youth is involved with the JDTC (MacMaster, Ellis, and Holmes, 2008; O'Connell, Wright, and Clymer, 2003; Schaeffer et al., 2010; Thompson, 2006; Wilson, Olaghere, and Kimbrell, 2016). Further, researchers recommend that JDTCs include treatment strategies for youth with little family support and/or with family dysfunction and also extend a range of intensive treatment services to the entire family unit (Thompson, 2006).

Similarly, feedback from JDTCs indicates that friendship networks can be risk factors for return to use and/or continued delinquency (Linden, 2008). Further, the effectiveness of JDTCs has been linked to the programs' ability to disrupt youth's associations with deviant peers (Schaeffer et al., 2010). In light of these findings, researchers recommend that courts focus on participants' peer networks

(Linden, 2008; Linden et al., 2010; Mhlanga and Allen, 2009). Courts also noted that JDTC participants should have the opportunity to participate in more prosocial activities (Linden 2008; Linden et al., 2010; Mhlanga and Allen, 2009; Schaeffer et al., 2010). However, courts also noted that it is difficult to understand and affect youth peer associations; the ability of JDTCs to do so varies across courts (Wilson, Olaghere, and Kimbrell, 2016).

Application of data should focus on continuous quality improvement rather than efforts to satisfy compliance (Campie and Sokolsky, 2016). Several studies found that some practices can negatively affect staff and can affect data quality when leaders require data collection only for compliance and surveillance purposes (Aarons and Palinkas, 2007; Booker et al., 2011; Bruns, Suter, and Leverentz-Brady, 2008; Chovil, 2010; Henggeler et al., 2008; Hoffmann et al., 1999). Yet, local JDTCs have varied capacities to collect data for evaluation and monitoring purposes, and most JDTCs lack comprehensive and accessible systems to do so (Choo et al., 2016).

More information on data collection and evaluation can be found in Monitoring and Evaluation, Evaluation in Juvenile Drug Court Webinar, and Step 26: Build a system to monitor the program in *Starting a Juvenile Drug Court: A Planning Guide*.

Conclusion

This document presents research-informed guidelines developed through an 18-month process of high-quality syntheses of research applicable to JDTCs. The guidelines present specific criteria that are related to JDTC outcomes. The unifying connection between the objectives and their guideline statements is that they are based on demonstrated effects on completing the JDTC successfully, reducing offending behaviors and further involvement in juvenile court for new offenses, and reducing substance use behaviors. These guidelines, therefore, might also apply to traditional juvenile courts that serve youth with substance use disorders.

Because the guideline statements are research informed, some areas will not be addressed until future research provides a sufficient basis to create a guideline. This allows for future development and introduction of additional guidelines as the body of JDTC research continues to grow. The full reports from the studies that built the research base for the guidelines and other additional resources on the development process are available at www.ojjdp.gov/Juvenile-Drug-Treatment-Court-Guidelines.html.

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