Transforming Juvenile Justice in Texas

A Framework for Action

Blue Ribbon Task Force Report

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TRANSFORMING JUVENILE JUSTICE IN TEXAS: A FRAMEWORK FOR ACTION

EXECUTIVE SUMMARY

Out of clutter, find simplicity.
From discord, find harmony.
In the middle of difficulty, lies opportunity.
~ Albert Einstein

The Texas Youth Commission (TYC) was created to care for, treat and educate the state's most serious and chronic juvenile offenders. In March of 2007, Rick Perry, Governor of Texas, placed the TYC under conservatorship to guide reform of the agency's correctional and rehabilitative systems following reports of sexual abuse of youth at TYC facilities.

In April of 2007, Ed Owens, then Interim Executive Director of TYC, asked me to form a Blue Ribbon Task Force charged with defining a new TYC rehabilitation system, including identifying evidence-based practices in the treatment and case management of adjudicated juvenile delinquents. With the unequivocal support of TYC administrators, including Mr. Owens, I expanded the scope of the Task Force to look more broadly at reforming the juvenile justice system in Texas.

Accordingly, the work of the Task Force was ultimately driven by two questions:

1. If we could re-design health care, education, treatment and case management at TYC correctional facilities, what would it look like?
2. If we could re-design the juvenile justice system in Texas, what would it look like?

A Blue Ribbon Task Force of national and regional experts was quickly convened. The Task Force met over the course of a two-day summit held on May 21 and 22, 2007, in Austin, Texas. We operated under a Consensus Model[1].

On day one of the two-day summit, the Task Force generated and subsequently operated under a number of agreed-upon guiding principles to form the recommendations in this report. The transformation of the juvenile justice system in Texas should be driven by the guiding principles enumerated below (see Table 1).

Suggested citation for this report: Springer, D. W. and colleagues (2007). *Transforming Juvenile Justice in Texas: A Framework for Action. Blue Ribbon Task Force Report.* Austin, TX: The University of Texas at Austin, School of Social Work.

[1] A Consensus Model is realized when each member of the Task Force is involved in making the recommendations in the report, and a recommendation is included in the report when everyone supports it and agrees to implement it given their respective roles. In keeping with a Consensus Model, each member of the Task Force is a co-author of this report. The conclusions and recommendations expressed in this report are those of the authors and do not necessarily represent the official position or policies of the Texas Youth Commission or any other agency of the state or federal government.

Table 1: Guiding Principles for Transforming the Juvenile Justice System in Texas

1. The continuum-of-care for youth has as its primary aims crime reduction and rehabilitation.
2. Congruent with the Texas Youth Commission (TYC) mission, TYC facilities incarcerate and treat only high-risk, serious, chronic juvenile offenders.
3. The continuum-of-care aims to minimize the penetration of youth into the juvenile and adult justice systems in order to decrease the flow of the juvenile-to-adult pipeline.
4. Services aim to decrease the number of youth who are incarcerated and to use the least restrictive and most home-like environment possible to rehabilitate youth.
5. The system maximizes cost effectiveness and uses taxpayers' money wisely.
6. The continuum-of-care promotes equal and equitable treatment for all youth.
7. Structures are in place to ensure that youth feel safe and are safe.
8. Referral and treatment decisions are formed by risk assessment that is multi-pronged, on-going, and includes practitioners, parental, and self-monitoring so that services are responsive to changing needs of the youth.
9. Services are flexible and tailored to meet the individual needs of the client system (e.g., strength-based, client-centered, family-focused, gender-sensitive, developmentally-congruent, disability-responsive, and culturally-grounded).
10. The entire juvenile justice system is set up to be child-centered and family-focused.
11. Parents and youth have easy access to advocacy organizations and attorneys to ensure that they are informed about their rights, and they have access to advocacy organizations and attorneys.
12. School-based and integrative community-based youth violence, delinquency and drug abuse prevention programs are prioritized.
13. The entire juvenile justice system is grounded with a clear focus on education.
14. A continuum of evidence-based treatment alternatives is implemented as an alternative to incarceration.
15. A regional management delivery system is implemented that supports the use of small community-based facilities, which allow juveniles to be kept as close as possible to their home communities.
16. Professional treatment and correctional staff are trained, retained, and supervised across the juvenile justice system through effective executive leadership.
17. Professional treatment and correctional staff are an appropriately educated workforce who are youth-focused and strength-based in their approach.
18. The entire juvenile justice system is driven primarily by evidence-based practices and policies.
19. The entire juvenile justice system is driven by clear measurable standards and grounded in a culture of accountability through the systematic monitoring and evaluation of programs and the treatment of juveniles.
20. Services aim to produce sustainable and meaningful changes in juveniles over time.

The members of the Task Force view the care of youth as a continuum-of-care to include before, during, and after confinement. Accordingly, this report is structured into three major sections: Before, During, and After. The Before section focuses on primary crime prevention/diversion, detention, and sentencing reform. The During section addresses the health care, education, treatment, and case management of adjudicated juvenile delinquents in correctional facilities. Finally, the After section coalesces around transition planning, reentry, aftercare, and parole.

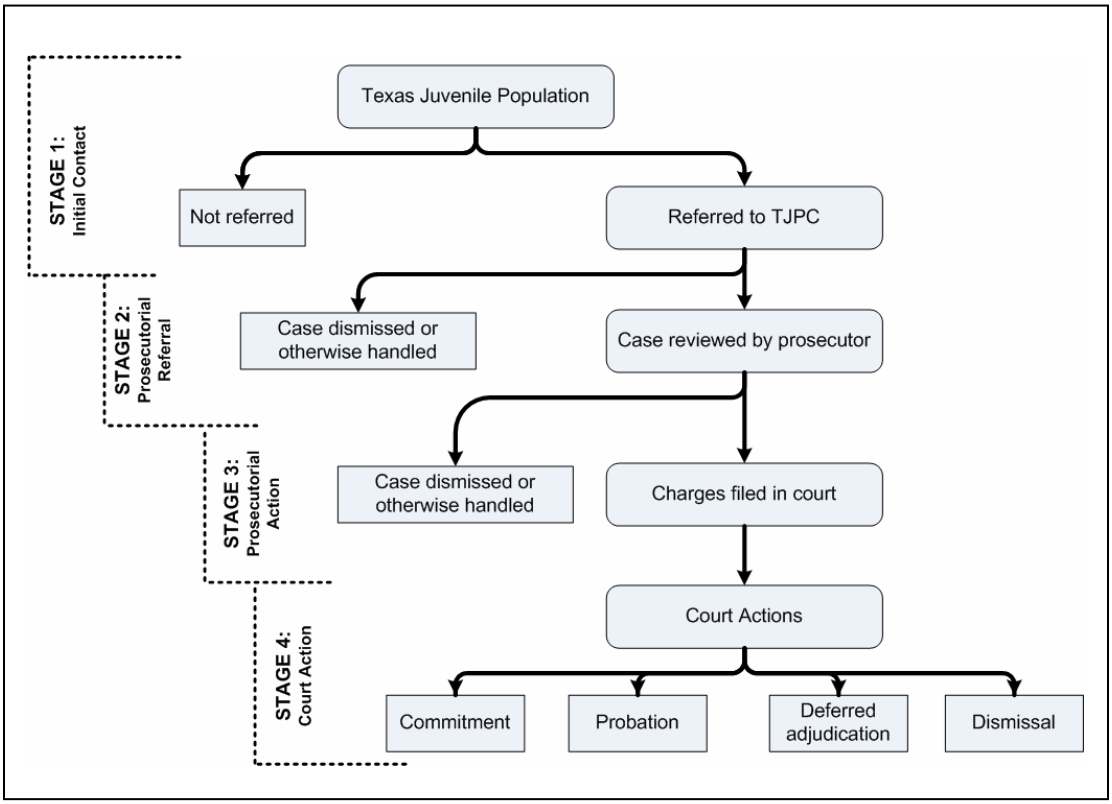
Preventative Care → Confinement Care → After Care

SHIFTING DEMOGRAPHICS OF TEXAS

Texas has undergone a shift in population demographics that demographers expect to continue over the next several years. Today, almost half (49%) of the Texas population is Anglo, over one-third (35%) is Hispanic, and nearly 12 percent is African American. By comparison, the current TYC population is 22% Anglo, 44% Hispanic, and 34% African American.

To examine such rates of disproportionality in the Texas juvenile justice system, Dr. Dottie Carmichael and her colleagues at the Texas A&M Institute for Policy Analysis examined differential rates of referral and progression through the juvenile justice system (see Figure 1). Using existing databases from the Texas Education Agency and the Texas Juvenile Probation Commission, virtually every Texas school child enrolled in grades 8 to 12 during the 1999 school year was monitored for juvenile justice involvement over a five-year period.

Figure 1. Multi-Stage Model of Progression through the Texas Juvenile Justice System[2]



They found that compared to Anglos, Hispanic juveniles have a significantly higher likelihood of progressing through all four stages of case processing from initial contact through court action (see Figure 1). African American youth have a higher likelihood of progressing through the first two stages, initial contact and prosecutorial referral.

[2] Source: Carmichael, D., Whitten, G., & Voloudakis, M. (2005). *Study of minority over-representation in the Texas juvenile justice system.* Submitted to the Office of the Governor, Criminal Justice Division. Public Policy Research Institute, Texas A&M University.

Dr. Carmichael and her colleagues concluded that efforts should be targeted toward minimizing the number of minority youth in high-risk categories. In other words, resources should be invested in prevention or early intervention programs to reduce involvement of minorities in school delinquency, enhance academic performance, support economically disadvantaged families, and develop effective interventions for juveniles with emotional or learning disabilities.

This critical issue of minority youth being overrepresented in the Texas juvenile justice system will only be amplified in the years to come if we do not change the entry of youth of color into the system. The Texas State Data Center projects that the majority of Texans by 2020 will be Hispanic, and that Hispanics will account for over 50 percent of all Texans by 2040. We must alter the pipeline from the juvenile justice to the adult criminal justice system for all youth, and especially for youth of color, through prevention and early intervention programs.

STOPPING THE JUVENILE- TO ADULT-PIPELINE: REDUCING CRIME AND SAVING MONEY

Incarcerating juveniles is very expensive, not only because of the costs of housing the youth, but also because of the correlation between juvenile incarceration and future incarceration as an adult. Research on youth sent to state institutions similar to TYC has shown that youth incarceration predicts future criminal behavior more so than gang affiliation, weapons possession, and family dysfunction. Preventing adolescents from continuing a criminal lifestyle would save the taxpayers of Texas millions of dollars. Each teen prevented from becoming a career criminal (including future adult offenders) could save between 1.7 and 2.3 million dollars *per* youth. The ultimate goal is to stop the cycle of violence that feeds the juvenile- to adult-pipeline in which so many youth and families are trapped (see Figure 2).

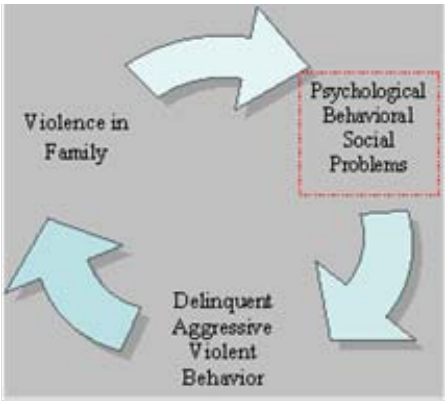


Figure 2. Cycle of Violence[3]

Knowing that youth who committed crimes are more likely to desist from criminal behavior if they remain in their home communities, the Illinois state legislature created Redeploy Illinois: Building on Success. This program appears to have saved the State of Illinois over $1,000,000 by giving counties financial support to provide comprehensive services to delinquent youth in their home communities who might otherwise be sent to the Illinois Department of Corrections. The Redeploy Amended Legislative Report projects that in the first year of Redeploy Illinois, the state will save $2,123,063 in funds that would have gone to incarcerating the youth, and that $1,411,000 will be spent on locally-based programs. The preliminary results of Redeploy Illinois indicates that along with saving money, when youth are appropriately evaluated, local community services reduce re-arrests and imprisonments, and increase the likelihood that youth will pay restitution, complete community service, and successfully complete probation.

[3] Source: Bender, K. (2007). *Interrupting the cycle of violence: Identifying gender-specific pathways from childhood victimization to juvenile delinquency.* The University of Texas at Austin, School of Social Work: Unpublished Dissertation Manuscript.

Several juvenile justice programs that serve as alternatives to incarceration decrease recidivism rates and save money for taxpayers. According to the Washington State Institute for Public Policy, there are currently 12 juvenile offender programs that save money for states and taxpayers (benefits minus costs). The savings range from $4,622 per participant to $77,798 dollars per participant. The programs that save more than $10,000 per participant include Multidimensional Treatment Foster Care, Adolescent Diversion Project, Family Integrated Transitions, Functional Family Therapy, Multisystemic Therapy, and Aggression Replacement Training. The cost effectiveness of these programs illustrates that there are programs for juvenile offenders that produce long-term economic benefits. Considering that approximately three-quarter of adult offenders have previously been in the juvenile justice system, this finding demonstrates the attractiveness of juvenile justice options as a means to reduce crime, which ultimately affects the need for prison construction and the ability to save Texas taxpayers' money.

Exhibit 1: Crime Rates and Youth Incarceration in Texas and California Compared: Public Safety or Public Waste?[4]

The Center on Juvenile and Criminal Justice (CJCJ) recently released a report comparing crime rates and youth incarceration in Texas and California. These are the nation's two most populous states, and are home to 22% of America's youth. Over the last two decades, Texas and California have taken diametrically opposite approaches to incarcerating juvenile offenders. From 1995 to 2006, Texas increased the number of youth that were incarcerated under the age of 18 by 48%. This was accomplished through sentencing practices that target non-violent, property, and drug offenders. By contrast, during the same period, California drastically reduced the total number of juveniles incarcerated in youth prisons by 75% by imprisoning only the most violent juvenile offenders. Our colleagues at CJCJ, in their report, examined the following question: Do higher incarceration rates reduce crime?

It is important to note that there are fundamental differences in the ages and types of the juveniles incarcerated in Texas and California. In Texas, 18% of the youth incarcerated in juvenile correctional facilities are younger than 15, compared to four-tenths of 1% in California. In 2006, nearly two-thirds of young offenders imprisoned in California were held for violent offenses, compared to a little more than one-quarter of the youth incarcerated in Texas. This means that on average, Texas imprisons larger numbers of younger offenders for less serious crimes, while California incarcerates older offenders for more serious crimes.

Interestingly, in examining the effects on crime, the trends over the last decade in Texas and California are *identical*. Youth crime rates in both states began a steady and consistent decline beginning in 1995 that continued through 2005. Texas's massive increase in youth incarceration produced no changes in youth crime rates relative to California. By reducing the proportion of non-violent juvenile offenders incarcerated for property and drug offenses, as well as the number of imprisoned youth overall, California experienced larger declines in rape, burglary, robbery, car theft, and arson.

These results suggest that juvenile crime control policies that emphasize incarceration and similar punitive measures need to be reconsidered, and that Texas's current youth incarceration policy is unjustified and unnecessary. The savings achieved by reduced incarceration could be reinvested in a range of community-based interventions.

[4] This comparison of crime rates and youth incarceration in Texas and California is excerpted with permission from: Males, M., Stahlkopf, C., & Macallair, D. (2007, June). *Crime rates and youth incarceration in Texas and California compared: Public safety or public waste?* San Francisco, CA: Center on Juvenile and Criminal Justice.

RESEARCH-BASED RECOMMENDATIONS

This report is a synthesis of opinions and perceptions of a group of people. Nevertheless, to the extent possible, the recommendations provided in this report are grounded in and driven by current research and evidence-based practice. This Task Force recommends implementing evidence-based programs throughout the continuum-of-care. Similar to evidence-based medicine, the goal of evidence-based juvenile justice programs is to improve the juvenile justice system by implementing programs that have been shown to work in reducing crime and rehabilitating youth. Determining whether a practice or policy is evidence-based is based upon outcome performance, rigorous evaluation, and cost-effectiveness analysis.

Dr. Mark Lipsey and Dr. Francis Cullen recently conducted a systematic review (meta-analysis) of hundreds of studies to examine the effectiveness of juvenile and adult correctional rehabilitation. Across the many studies that they reviewed, they found striking consistency on two key points. "First, every meta-analysis of studies that compare recidivism outcomes for offenders receiving greater versus lesser or no sanctions has found, at best, modest mean recidivism reductions for the greater sanctions and, at worst, increased recidivism for that condition. Second, every meta-analysis of large samples of studies comparing offenders who receive rehabilitation treatment with those who do not has found lower mean recidivism for those in the treatment conditions." In short, there is a large body of evidence that supports the conclusion that rehabilitation treatment is capable of reducing re-offense rates of convicted offenders, and that it has greater capability of doing so than correctional sanctions. We use research findings such as this to drive our recommendations. Table 2 provides our complete listing of recommendations across the Before, During, and After sections of the report.

One very important caveat needs to be underscored. Some recommendations in this report have already been enacted, in part or in full, by the Governor's office, the Texas legislature (i.e., SB 103), and/or the current TYC administration. My charge to the members of the Task Force was to operate as if they had a *tabula rasa,* to create the ideal system from the ground up. While we were thoughtful about historical trends and current momentum, we were mindful to not allow ourselves to feel constrained by these parameters. By listing recommendations in this report that have already been put in motion is by no means intended to minimize efforts already underway. Rather, we do not want good ideas to be lost with the passing of time, so we include ideas and strategies congruent with the guiding principles of the Task Force. In short, our vision and hope for this report is that it serves as a compass to guide the short-term and long-term transformation of the juvenile justice system in Texas.

David W. Springer, Ph.D., LCSW
Chair, Blue Ribbon Task Force

Table 2: List of All Recommendations Across Before, During, and After Sections of Report
BEFORE
Recommendation #1.1 **Emphasize keeping youth in the community.**
Recommendation #1.2 **Prioritize prevention for at-risk youth through integrated services including schools, faith-based institutions, community policing, and children and family services.**
Recommendation #1.3 **Prioritize youth education and vocational training that equip youth to be self-sufficient.**
Recommendation #1.4 **Fund community-based substance abuse and mental health programs to address the needs of at-risk youth so that these youth never enter the juvenile justice system.**
Recommendation #1.5 **Offer special programs for children of incarcerated parents to help them develop a path to positive adulthood.**
Recommendation #1.6 **Require counties to primarily use evidence-based practices through financial incentives.**
Recommendation #1.7 **Ensure that youth and their families have adequate legal representation.**
Recommendation #1.8 **Fund, develop, and use alternatives to incarceration where appropriate, including mental health courts and drug courts.**
Recommendation #1.9 **Restrict detention to only those youth who have committed violent crimes and who are at-risk of flight and/or re-offending.**
Recommendation #1.10 **Detain youth for the shortest time-period possible, in cases where detention is essential.**
Recommendation #1.11 **Deter counties from using detention as an alternative to TYC placement.**
Recommendation #1.12 **Use consistent and accurate (i.e., reliable and validated) standardized risk and need assessment instruments to inform hearings (detention and otherwise) of juvenile offenders**.
Recommendation #1.13 **Assure that youth in juvenile detention who are eligible for Children's Health Insurance Program (CHIP) or Children's Medicaid receive health coverage immediately upon release so that they experience no delay in accessing health care, particularly community mental health services.**
Recommendation #1.14 **Redirect money saved on decreasing detention to prevention and community-based programs.**
Recommendation #1.15 **Ensure that all youth in detention receive appropriate federal and state mandated education services. Enrollment for services should not be delayed**.
Recommendation #1.16 **Monitor the use and construction of local detention facilities.**
Recommendation #1.17 **Rely more on probation at the county level, with an emphasis on the use of evidence-based community-based interventions.**

Recommendation #1.18 **Avoid "Trail 'em. Nail 'em. and Jail 'em." supervision and surveillance strategies.**
Recommendation #1.19 **Consider expanding the use of specialized case loads for probation officers.**
Recommendation #1.20 **Carefully narrow the category of which juveniles may be sent to TYC.**
Recommendation #1.21 **Retain determinate sentencing but reserve it for the most serious youth.**
Recommendation #1.22 **Reform the certification of youth into the adult system so that anybody certified spends his or her youthful years (ages 14 to 19) in TYC prior to transfer to an adult correctional facility.**
Recommendation #1.23 **Implement a reverse transfer provision in order to provide judicial authority to send the case back to the juvenile system.**
Recommendation #1.24 **Improve information sharing between TYC and the Texas Department of Criminal Justice (TDCJ) to enable TDCJ to know which youth are being transferred pursuant to a determinate sentence.**
DURING
Recommendation #2.1 **Allocate adequate funding for facilities, rehabilitation and treatment programs, appropriate staffing ratios, education, and the training of employees.**
Recommendation #2.2 **Ensure that any appointed board and management receive adequate training in order to provide proper oversight and management of TYC facilities.**
Recommendation #2.3 **Formulate a Transitional Advisory Committee immediately.**
Recommendation #2.4 **Convene a Policymaking Board, regardless of structure, that is well-versed in the juvenile justice system, adolescent health and mental health treatment, law enforcement and education**.
Recommendation #2.5 **Create an entity within the state government or academia to provide objective research to state policymakers on juvenile and criminal justice issues, and to provide population and racial impact analyses of all proposed adult and juvenile justice legislation.**
Recommendation #2.6 **Create a system of accountability that allows an independent governmental office to investigate allegations of impropriety and to conduct routine inspections of facilities to assess conditions and the treatment of juveniles.**
Recommendation #2.7 **Support the newly established office of the Ombudsman and clarify the role of the Ombudsman.**
Recommendation #2.8 **Require that TYC facilities and programs be properly accredited and that the agency complies with a set of appropriate standards.**
Recommendation #2.9 **Administer a consumer satisfaction survey to youth currently housed in TYC facilities and at least one family member.**
Recommendation #2.10 **Make decisions on whether to admit youth to TYC facilities using objective, research-based risk**

assessment and classification.
Recommendation #2.11 **Adopt the Juvenile Assessment and Intervention System (JAIS) at all TYC facilities**.
Recommendation #2.12 **Create a regionalized system of care that supports the use of small facilities.**
Recommendation #2.13 **Separate low-risk and high-risk offenders from one another, and separate vulnerable offenders from potential aggressors.**
Recommendation #2.14 **Consider the particular needs of girls in the design of juvenile justice programs and facilities.**
Recommendation #2.15 **Provide flexible and individualized care for youth in TYC.**
Recommendation #2.16 **Provide graduated levels of care (i.e., services and restrictions) within the TYC system that are driven by risk assessment and classification.**
Recommendation #2.17 **Ground the juvenile justice system with a clear focus on education.**
Recommendation #2.18 **Begin aftercare planning within the first 30 days of a youth being placed at TYC.**
Recommendation #2.19 **Promote an integrated health care model - to include physical, behavioral, and mental health - across TYC facilities.**
Recommendation #2.20 **Provide dually diagnosed youth – those identified as simultaneously having substance use disorders and comorbid psychiatric mental health disorders – with *integrated* treatment**.
Recommendation #2.21 **Provide specialized treatment to juvenile sex offenders.**
Recommendation #2.22 **Provide specialized treatment to substance-abusing juvenile offenders.**
Recommendation #2.23 **Adopt cognitive-behavioral therapy (CBT) as a core element of effective treatment.**
Recommendation #2.24 **Engage families in treatment.**
Recommendation #2.25 **Maintain a safe place for youth that embraces a non-violent approach.**
Recommendation #2.26 **Develop goals to carefully ration, supervise, and document the use of seclusion, restraints, chemical control agents, and the use of force generally.**
Recommendation #2.27 **Evaluate cost-effectiveness of the TYC system and make decisions using the "best use of resources" principle.**
Recommendation #2.28 **Ensure that the staff are an appropriately educated workforce who are youth-focused and strength-based in their approach.**
Recommendation #2.29 **Properly screen applicants for jobs, but do not automatically eliminate ex-offenders**.
Recommendation #2.30 **Establish and maintain an adequate youth-to-staff ratio using national best practice standards, aiming for a 1:10 ratio.**

AFTER
Recommendation #3.1 **Emphasize a community reentry model upon *entry* to TYC.**
Recommendation #3.2 **Reduce lengths of stay at TYC.**
Recommendation #3.3 **Establish a detailed, comprehensive, individual- ized plan 2 to 3 months in advance to seamlessly transition the youth from the TYC facility.**
Recommendation #3.4 **Use Community Resource Coordination Groups (CRCGs) to facilitate transition planning.**
Recommendation #3.5 **Use a Structured Decision Making (SDM) approach to transition and re-integration.**
Recommendation #3.6 **Shift from a Parole Model to a Local Boards (or Reentry) Model of aftercare**.
Recommendation #3.7 **Encourage the 81st Texas Legislature to reconsider passing a mental health parity bill that would require health plans to cover all mental illnesses on equal terms with physical illness**.
Recommendation #3.8 **Create a system of accountability.**
Recommendation #3.9 **Shift the focus from a failure-based model to a strength-based model of aftercare**.
Recommendation #3.10 **Assess and monitor a youth's readiness to change his or her behavior, and tailor aftercare services accordingly.**

TRANSFORMING JUVENILE JUSTICE IN TEXAS: A FRAMEWORK FOR ACTION

I. BEFORE

WHAT IS THE PROBLEM?

The goal of primary prevention is to decrease crime and its impact on victims while concomitantly reducing state costs by addressing elements of youth in advance of the TYC system. Despite the fact that serious juvenile crime rates have been declining over the past decade, too many youth are being referred to TYC and not being kept in the local systems where services are more effective and less costly. Most youth housed in today's large, secure juvenile facilities (such as TYC) do not require such high levels of security, especially considering that research suggests that confining youth in these facilities is not only ineffective in improving functioning and is unnecessarily expensive, but actually makes the youth "worse off." Nearly two in three youth were committed to the TYC in 2006 for non-violent offenses. Moreover, large, centralized facilities remove youth from their community, which increases alienation and isolates troubled youth exclusively with other troubled youth.

We can spend nearly $100,000 to incarcerate a youth at TYC, or we can spend $645 to work with a youth and his or her family through the Services to At-Risk Youth (STAR) program, a proven prevention program that reduces family conflict, running away, and truancy. Indeed, schools and school districts play a critical role in the Texas juvenile justice system. Unfortunately, some schools create conditions in which low achieving and badly performing students are more likely to be detained and/or committed to the TYC. Information from a Texas Education Agency report indicates student discipline reports rose 52 percent between the 2000-2001 and 2005-2006 school years, from 1.7 million to 2.6 million. While some students may be removed from the general school program to an alternative school program because of serious violations of the school disciplinary code, many students are removed for problem behavior that should be resolved within the school. Further, the quality of alternative education placements is highly variable. Some alternative education settings become dumping grounds for youth who experience unmotivated teachers and staff, inadequate resources, and a culture of school failure. Data from the TYC for 2005-2006 show that the average youth committed at age 16 performs at about the 6th grade level in reading and the 5th grade level in math – well below that of their peers. Further, about 40 percent of committed youth have a history of special education services and their median performance on standardized measures of intelligence is in the low average range. While TYC does not report on prior school suspensions and grade-level retention of students, data from other states indicate that youth committed to juvenile corrections have a history of school suspensions, expulsions, and grade-level retentions.

Recommendations are given below for crime prevention/diversion, detention, sentencing and probation reform.[5]

[5] Recommendations in the Before section of the report are enumerated sequentially (e.g., #1.1, #1.2, and so on), as are recommendations in the During section (e.g., #2.1, #2.2) and After section (e.g., #3.1, #3.2) of the report.

RECOMMENDATIONS

PREVENTION/DIVERSION

One indisputable way to decrease the population of youth in TYC, to prevent future crime, and to minimize the traumatic impact on victims while simultaneously saving state funds is to prevent youth crime and reduce the likelihood of coming to the attention of TYC. Yet, many local communities lack the capacity to meet the needs of at-risk young offenders. This is, in part, because funding and services are fragmented and need to be integrated at the community level.

Recommendation #1.1
Emphasize keeping youth in the community. Community-based services (e.g., school- and faith-based programs, community policing, children and family services) are more effective and less costly than incarceration.

Research on the impact of large juvenile incarceration centers on reducing recidivism rates are at best equivocal, with as many as 50 to 70 percent of youth being rearrested within two years following their release. According to Kelly, Johnson, and Weitzer (2005), community-based programs generally contain lower recidivism rates than large state facilities for the following reasons: (1) they reduce crowding, (2) they cut the costs of operating juvenile detention centers, (3) they help the offender avoid associating with youth who have more serious delinquency issues, and (4) they maintain positive ties between the juvenile and his or her family and community. In a review of research on community-based interventions, Howell (1995) found community programs such as group homes and day reporting centers to be more effective than traditional correctional programs at reducing recidivism and improving community adjustment, even for violent adolescent offenders.

Considering the effectiveness of community-based interventions on reducing recidivism rates for adolescent offenders, the Governor and/or Legislature may want to consider directing the resulting savings from diversion efforts to additional prevention and community-based services. TYC should only incarcerate adolescent offenders who are at-risk for re-offending and absconding. These adolescents should be housed as close to their home communities as possible, enabling TYC to work with the adolescent's family and help the adolescent re-adjust to his or her community upon release from TYC. (See also Recommendation #2.12.)

Recommendation #1.2
Prioritize prevention for at-risk youth through integrated services including schools, faith-based institutions, community policing, and children and family services. Incorporate early identification of at-risk youth, as suggested by school disciplinary issues, assaults, bullying, truancy, and illiteracy. Early identification targets the enhancement of health (including hunger) programs, mental health and substance abuse treatment, and youth and family services that are gender-sensitive. It is critical to create a system-of-care that is racially-equitable and disability-responsive, with the goal to end the over-representation of youth of color and youth with disabilities in the Texas Youth Commission.

Patterns of school and school district referrals to police and juvenile courts for behavior that occurs in school and on school grounds should be carefully examined. Nationally, there has been a disturbing trend to "criminalize" school misbehavior. The pressure schools and school districts face to achieve Adequate Yearly Progress on No Child Left Behind (NCLB) standards has resulted in students with marginal skills and behavior problems being "pushed out" of the mainstream. When these students are out of school and in the community, they are at increased risk for involvement in juvenile courts and juvenile corrections and for involvement in crime. In Texas, schools have relied too heavily on the "ticketing" of students for violations of school rules, which sends students to local juvenile courts for hearings. Fortunately, House Bill 278 by Representative Jerry Madden prohibits ticketing at schools for non-penal code violations, so that students now must be in violation of penal code to be ticketed. This is an important step in keeping youth out of the juvenile justice system. Schools should use positive behavioral support systems, not the juvenile justice system, to impacts students' learning.

It is critical to create a system-of-care that is racially-equitable and disability-responsive, with the goal to end the over-representation of youth of color and youth with disabilities in the Texas Youth Commission.

Dr. Dottie Carmichael and her colleagues at the Texas A&M Institute for Policy Analysis recently found that one school disciplinary report is the most powerful predictor of future delinquency offenses in Texas. Furthermore, a recent study by Dr. Soyon Jung revealed that African American high-school students are approximately 3 times more likely and Hispanic students are 2 times more likely to receive an internal school suspension compared to White students (even after adjusting for gender and socioeconomic status). Schools and school districts should be required to report the number and reasons for referral of students to law enforcement and the courts as well as for students suspended and expelled. Reporting should provide the ethnic and racial background of students as well as special education status, and whether the students have been retained in grade.

House Bill 3202 by Rep. Jerry Madden will infuse state Texas Education Agency funding to local school districts to be used for youth assigned to disciplinary settings for the actions of assault, aggression, abuse and bullying. The bill calls for a 12 month case management system with use of "best practice" violence prevention, drug abuse prevention and delinquency prevention programs. Thus, targeting a program initiative to this specific group will have a significant impact on reduction of intake into the juvenile justice system. This information will help state and local policymakers, as well as school officials, make decisions about the use of resources and adequacy of school-based prevention efforts.

Recommendation #1.3
Prioritize youth education and vocational training that equip youth to be self-sufficient. For exemplary programs such as STAR to be effective, students need to attend school. Communities in Schools (CIS), the largest dropout prevention organization in the United States (including Texas), can play a critical role in this effort. In partnership with the local school system, CIS identifies the most critical needs of students and families, and then locates community resources, dedicated volunteers and agencies to serve in partnership with the public

schools (www.cisnet.org/about/who.asp). Organizations like CIS should be supported and utilized so that educational and vocational programs have the opportunity to work.

Recommendation #1.4
Fund community-based substance abuse and mental health programs to address the needs of at-risk youth so that these youth never enter the juvenile justice system. Approximately half of the youth currently in TYC are in need of such programs, and 50% of the youth on juvenile probation are not getting needed substance abuse and mental health services at the local level.

Recommendation #1.5
Offer special programs for children of incarcerated parents to help them develop a path to positive adulthood. Children of incarcerated parents are five to six times more likely to go to prison than their peers. We can and must do more to stop this cycle of violence.

Recommendation #1.6
Require counties to primarily use evidence-based practices through financial incentives. It is also important to reserve some funds for innovative interventions that include implementing rigorous evaluation. To accomplish the goal of reducing crime, decreasing victimization, and improving cost effectiveness, Texas will need to:

- Build capacity at the local level.
- Strengthen community bonds.
- Keep families involved, beginning with prenatal care and continuing throughout the life cycle.
- Shift funding (by decreasing incarceration rates) to proven community-based programs.
- Allot funding to counties based on youth population and require that counties bear the costs of sending youth to TYC.

After prevention, reforms should include the use of detention and sentencing, including the use of probation. For youth who come under the authority of the juvenile justice system but who are not sentenced to TYC, we recommend early triage and probation. This is critical because research consistently shows that low level offenders "get worse" by being incarcerated, which in turn results in more crime, an increase in the number of victims, and an increase in the amount of money needed to address crime.

With the goal of decreasing the number of youth with formal charges and increasing the use of community-based alternatives, early assessment and diversion is necessary. Immediate triage of cases early in the juvenile justice process should be pursued as the best way to divert a youth from TYC, while promoting cost-effectiveness and efficacy of services. This early assessment should begin with local law enforcement. Alternative programs should include county-based diversion programs and restorative justice programs for non-violent offenders. Victim-offender mediation (VOM) is the oldest, most widely developed, and most empirically grounded expression of restorative justice (see Exhibit 2). One meta-analysis (Nugent, Williams, & Umbreit, 2003) found an 18% reduction in crime for juvenile offenders that participated in VOM.

Exhibit 2: Brief Overview of Restorative Justice[6]
Restorative justice offers a different way of understanding and responding to crime. Instead of viewing the state as the primary one offended by criminal acts and placing the actual victims and the community, as well as offenders, in passive roles, restorative justice turns this arrangement around and recognizes crime as fundamentally directed against individual people. It is grounded in the belief that those most affected by crime should be the ones to be actively involved in resolving the conflict. Restorative justice is grounded in the following principles: (a) crime is a violation of a person by another person; (b) the harm suffered by victims must be paramount, and victims must be helped to move beyond their sense of vulnerability; (c) offenders must be encouraged to understand the harm they have caused and be given an opportunity to make amends; and (d) the community must be involved in holding the offender accountable, promoting a healing response to the needs of victims and offenders, and assuming responsibility for the social conditions that contribute to offender behavior.

DETENTION

Detention, or the local "jailing" of youth, as a major predictor of which youth eventually are sent to TYC should be improved to make it more useful and cost effective. The use of detention should also be curtailed.

Recommendation #1.7

Ensure that youth and their families have adequate legal representation. It is essential that youth and their families are represented by competent attorneys who are capable of providing effective representation in juvenile proceedings. However, attorneys should focus on diverting youth with disabilities and other special needs from the juvenile justice system by securing appropriate community-based services that would enable them to remain in their homes or be placed in less restrictive settings. Often these youth enter the juvenile justice system because of the failure to receive appropriate mental health and educational services in the community. To effectively represent these youth, public defenders and other attorneys would greatly benefit from the knowledge and skills of social workers who can provide assistance and support to these attorneys in diverting their clients from the juvenile justice system. Public defender offices should employ social workers to assist attorneys in achieving this goal of diversion.

Recommendation #1.8

Develop, fund, and use alternatives to incarceration where appropriate, including mental health courts and drug courts. Incarceration alone does little to break the cycle of illegal drug use and crime. Since treatment for substance abuse is a key component in preventing re-offenses, the need for alternative programs is evident. A promising and innovative approach to the growing substance abuse problem is the establishment of diversionary programs known as drug courts. Two main types of drug courts exist: those organized simply to speed up the processing of drug offenders and those that exist to provide treatment to offenders. The focus here is on treatment-oriented drug courts.

[6] Source: The text in Exhibit 2 is excerpted with permission from: Armour, M. P., & Umbreit, M. S. (2007). Victim-offender mediation and forensic practice. In D. W. Springer & A. R. Roberts (Eds.), *Handbook of forensic mental health with victims and offenders: Assessment, treatment, and research* (pp. 519-539). NY: Springer Publishing Co.

The drug court model creates an interface between the various components of the criminal justice and substance abuse treatment systems in order to use the coercive power of the court to promote abstinence and prosocial behavior. The team of professionals generally includes the state attorney, public defender, pre-trial intervention or probation staff, treatment providers, and the judge, who is considered to be the central figure on the team. The primary goals of drug courts are to reduce drug use and associated criminal behavior by engaging and retaining drug-involved offenders in programmatic and treatment services; to concentrate and coordinate expertise about drug cases in a single courtroom; to address other defendant needs through clinical assessment and case management; and to free judicial, prosecutorial and public defense resources for adjudicating non-drug cases.

Drug courts have been successful in closely supervising drug offenders in the community through frequent monitoring and close supervision including mandatory frequent drug testing, placing and retaining drug offenders in treatment programs, providing treatment and related services to offenders who have not received such services in the past, generating actual and potential cost savings and substantially reducing drug use and recidivism. (Mental health courts serve a similar function for offenders with mental health problems, although more research is needed on mental health courts to demonstrate their degree of effectiveness.)

Recommendation #1.9
Restrict detention to only those youth who have committed violent crimes and who are at-risk of flight and/or re-offending. Detention should not be used for misdemeanor offenses, except in extenuating circumstances. Detention should not be used as a sanction or placement, but as a means of holding a juvenile on a very short-term basis prior to adjudication or transfer to TYC, in cases where the juvenile's release to the community would pose unreasonable risks. The focus of detention should be to protect the community, not to punish kids.

Recommendation #1.10
Detain youth for the shortest time-period possible, in cases where detention is essential. Long-term detention of youth does not improve the functioning of youth, and therefore, does not improve the safety of communities in the long-run. It is critical that youth are integrated back into their communities as soon as possible so that services can truly be family-based and client-centered.

Long-term detention of youth does not improve the functioning of youth, and therefore, does not improve the safety of communities in the long-run.

Recommendation #1.11
Deter counties from using detention as an alternative to TYC placement. Implement/utilize community-based services to treat juvenile offenders. One strategy to eliminate detention as an alternative to TYC is to make fewer cases formal. Counties can deal with adolescents through community-based services without the case being formerly adjudicated, resulting in diversion from the juvenile justice system. (See also Recommendation #2.10.)

Recommendation #1.12
Use consistent and accurate (i.e., reliable and validated) standardized risk and need assessment instruments to inform hearings (detention and otherwise) of juvenile offenders. This will help ensure that detention decisions and sentencing decisions are more uniform across Texas, and that less serious offenders are not placed unnecessarily in overly secure settings. Such assessment instruments will also facilitate a juvenile's transition to TYC when necessary.

Recommendation #1.13
Assure that youth in juvenile detention who are eligible for Children's Health Insurance Program (CHIP) or Children's Medicaid receive health coverage immediately upon release so that they experience no delay in accessing health care, particularly community mental health services. This very effort is currently being piloted jointly through the Health and Human Services Commission, the Texas Youth Commission, and the Texas Juvenile Probation Commission. This pilot should be closely monitored and problems corrected so that statewide implementation can begin as soon as feasible, perhaps as early as the fall of 2007.

Recommendation #1.14
Redirect money saved on decreasing detention to prevention and community-based programs. The redirection of such funds should reside at the local county level.

Recommendation #1.15
Ensure that all youth in detention receive appropriate federal and state mandated education services. **Enrollment for services should not be delayed**. Require that schools and school districts promptly send students' transcripts and information about special education status and, if appropriate, Individualized Education Program information to detention centers within 5 school days of a youth's detention. Adequate funding and staff are needed to ensure that students receive full school days, including the array of mandated educational services. Additionally, youth with disabilities should be diverted from TYC whenever possible and referred instead to community-based services.

Recommendation #1.16
Monitor the use and construction of local detention facilities. In keeping with Recommendations 1.8 to 1.15, there may well be a need to monitor how local detention facilities are utilized. Because of the real risk that local detention facilities could spring up to fill a perceived gap in sentencing options for juveniles, and thereby undermine the goal of Texas's efforts at community-based diversion, Texas should require the development of a system for counties to seek state approval for expansion of detention facilities before state funds can be expended for juvenile probation programs. In short, we should avoid shifting incarceration to the local level.

In general, more stringent limits on using detention will reduce crime, decrease crime victimization, and decrease the victimization of low-risk offenders while saving taxpayers' dollars.

SENTENCING AND PROBATION REFORM

To further decrease the reliance on TYC, further decrease the risk of crime victimization, and more wisely use funding resources, Texas should reform its sentencing procedures and the use of probation. TYC should be reserved for the most serious youthful offenders; all others should be handled in their home communities through probation.

Recommendation #1.17
Rely more on probation at the county level, with an emphasis on the use of evidence-based community-based interventions. Probation should be community-based with services in the youth's home environment, with particular emphasis on evidence-based interventions. Emphasis should be placed on programs that significantly decrease recidivism rates and save money. For a thorough list of such programs, see Exhibits 3 and 4[7]. (Exhibit 3 serves as a guide for interpreting the findings in Exhibit 4.)

Exhibit 3: Interpreting Exhibit 4 – Reducing Crime with Evidence-Based Options: What Works, and Benefits & Costs

Exhibit 4 summarizes the findings from a recent systematic review of the evaluation research literature by the Washington State Institute for Public Policy. Overall, the researchers reviewed and meta-analyzed the findings of 571 comparison-group evaluations of adult corrections, juvenile corrections, and prevention programs.

For each category of programs that they analyzed, the results in Exhibit 4 reflect the evidence-based effect that one would expect for the "average" program. For example, the results indicate that the average adult drug court reduces the recidivism rate of participants by 8% and that the average juvenile drug court reduces the recidivism rate of participants by 3.5%. Some drug courts, of course, achieve better results than this, some worse. At the bottom of Exhibit 4, they also list a number of programs for which the research evidence is inconclusive at this time.

In column (1) of Exhibit 4, our colleagues at the Washington State Institute for Public Policy show the expected percentage change in crime outcomes for the program categories that they reviewed. This figure indicates the average amount of change in the crime outcomes – compared to no treatment or treatment as usual – that can be achieved by a typical program in each category of programs. A negative value indicates the magnitude of a statistically significant reduction in crime. A zero percent change means that, based on their review of the evidence, a typical program does not achieve a statistically significant change in crime outcomes. A few well-researched programs even have a positive sign indicating that crime is increased with the program, not decreased. In addition to reporting the effect of the programs on crime outcomes, column (1) also reports (in parentheses) the number of studies on which the estimate is based.

As Exhibit 4 reveals, we find a number of programs demonstrate statistically significant reductions in crime outcome. We also find other approaches do not achieve a statistically significant reduction in recidivism. Thus, the first lesson from this evidence-based review is that some programs work and some

[7]Source: Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates.* Olympia: Washington State Institute for Public Policy. Full report available on line: www.wsipp.wa.gov/rptfiles/06-10-1201.pdf

do not. A direct implication from these mixed findings is that public policies that reduce crime will be ones that focus resources on effective evidence-based programming while avoiding ineffective approaches.

As an example of how to interpret the information provided in Exhibit 4, consider a program for juvenile offenders named "Functional Family Therapy," or FFT. The FFT program involves an FFT-trained therapist working for about three months with a youth in the juvenile justice system and his or her family. The goal is to increase the likelihood that the youth will stay out of future trouble. Seven rigorous evaluations of this program were located and meta-analyzed, revealing that the average FFT program with quality control can be expected to reduce a juvenile's recidivism rates by 15.9%. This analysis indicates that, without the program, a youth has a 70% chance of recidivating for another felony or misdemeanor conviction after a 13-year follow-up. If the youth participates in FFT, then we would expect the recidivism rate to drop to 59% - a 15.9% reduction.

Exhibit 4 also contains estimates of the benefits and costs of many of the program categories analyzed. Within three broad groupings – programs for adult offenders, programs for juvenile offenders, and prevention programs – many of the options are ranked by their assessment of each program's "bottom line" economics for reducing crime. For programs that have an evidence-based ability to affect crime, they estimate benefits from two perspectives: taxpayers' and crime victims'. For example, if a program is able to achieve statistically significant reductions in recidivism rates, then taxpayers will spend less money on the criminal justice system. Similarly, if a program produces less crime, then there will be fewer crime victims. The estimates shown in columns (2) and (3) of Exhibit 4 display the estimates of victim and taxpayer benefits, respectively. Column (4) shows cost estimates of many programs.

Finally, column (5) shows "bottom line" estimates of the net gain (or loss). These figures are the net present values of the long-run benefits of crime reduction minus the net up-front costs of the program. This provides the best overall measure each type of program can be expected to achieve per program participant. An examination of column (5) provides an important finding from this analysis. There are some programs for juvenile offenders that produce especially attractive long-run economic returns.

For the Functional Family Therapy example, we find that the program costs, on average, $2,325 per juvenile participant. The costs are higher because it is a one-on-one program between a FFT therapist and the youth and his or her family. The 15.9% reduction in recidivism rates that we expect FFT to achieve generates about $34,146 in life-cycle benefits, measured in terms of the taxpayer and crime victim costs that are avoided because of the reduced long-run level of criminal activity of the youth. Thus, the net present value of this juvenile justice program is expected to be $31,821 per youth.

This finding, and others like it, coupled with the raw number of adult offenders in prison in Texas that have previously been in Texas' juvenile justice system, demonstrates the attractiveness of juvenile justice options as a means to affect the long-run need for prison construction in Texas.

Source – the text in Exhibit 3 to help interpret the findings in Exhibit 4 is excerpted with permission from: Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates.* Olympia: Washington State Institute for Public Policy. Full report available on line: www.wsipp.wa.gov/rptfiles/06-10-1201.pdf

Exhibit 4

Reducing Crime With Evidence-Based Options: What Works, and Benefits & Costs

Washington State Institute for Public Policy **Estimates as of October, 2006** **Notes:** **"n/e"** means not estimated at this time. **Prevention program costs** are partial program costs, pro-rated to match crime outcomes.	**Effect on Crime Outcomes** Percent change in crime outcomes, & the number of evidence-based studies on which the estimate is based (in parentheses) (1)	**Benefits and Costs** (Per Participant, Net Present Value, 2006 Dollars) **Benefits to Crime Victims** (of the reduction in crime) (2)	**Benefits to Taxpayers** (of the reduction in crime) (3)	**Costs** (marginal program cost, compared to the cost of alternative) (4)	**Benefits (total) Minus Costs** (per participant) (5)
Programs for People in the Adult Offender System					
Vocational education in prison	-9.0% (4)	$8,114	$6,806	$1,182	**$13,738**
Intensive supervision: treatment-oriented programs	-16.7% (11)	$9,318	$9,369	$7,124	**$11,563**
General education in prison (basic education or post-secondary)	-7.0% (17)	$6,325	$5,306	$962	**$10,669**
Cognitive-behavioral therapy in prison or community	-6.3% (25)	$5,658	$4,746	$105	**$10,299**
Drug treatment in community	-9.3% (6)	$5,133	$5,495	$574	**$10,054**
Correctional industries in prison	-5.9% (4)	$5,360	$4,496	$417	**$9,439**
Drug treatment in prison (therapeutic communities or outpatient)	-5.7% (20)	$5,133	$4,306	$1,604	**$7,835**
Adult drug courts	-8.0% (57)	$4,395	$4,705	$4,333	**$4,767**
Employment and job training in the community	-4.3% (16)	$2,373	$2,386	$400	**$4,359**
Electronic monitoring to offset jail time	0% (9)	$0	$0	-$870	**$870**
Sex offender treatment in prison with aftercare	-7.0% (6)	$6,442	$2,885	$12,585	**-$3,258**
Intensive supervision: surveillance-oriented programs	0% (23)	$0	$0	$3,747	**-$3,747**
Washington's Dangerously Mentally Ill Offender program	-20.0% (1)	$18,020	$15,116	n/e	n/e
Drug treatment in jail	-4.5% (9)	$2,481	$2,656	n/e	n/e
Adult boot camps	0% (22)	$0	$0	n/e	n/e
Domestic violence education/cognitive-behavioral treatment	0% (9)	$0	$0	n/e	n/e
Jail diversion for mentally ill offenders	0% (11)	$0	$0	n/e	n/e
Life Skills education programs for adults	0% (4)	$0	$0	n/e	n/e
Programs for Youth in the Juvenile Offender System					
Multidimensional Treatment Foster Care (v. regular group care)	-22.0% (3)	$51,828	$32,915	$6,945	**$77,798**
Adolescent Diversion Project (for lower risk offenders)	-19.9% (6)	$24,328	$18,208	$1,913	**$40,623**
Family Integrated Transitions	-13.0% (1)	$30,708	$19,502	$9,665	**$40,545**
Functional Family Therapy on probation	-15.9% (7)	$19,529	$14,617	$2,325	**$31,821**
Multisystemic Therapy	-10.5% (10)	$12,855	$9,622	$4,264	**$18,213**
Aggression Replacement Training	-7.3% (4)	$8,897	$6,659	$897	**$14,660**
Teen courts	-11.1% (5)	$5,907	$4,238	$936	**$9,208**
Juvenile boot camp to offset institution time	0% (14)	$0	$0	-$8,077	**$8,077**
Juvenile sex offender treatment	-10.2% (5)	$32,515	$8,377	$33,064	**$7,829**
Restorative justice for low-risk offenders	-8.7% (21)	$4,628	$3,320	$880	**$7,067**
Interagency coordination programs	-2.5% (15)	$3,084	$2,308	$205	**$5,186**
Juvenile drug courts	-3.5% (15)	$4,232	$3,167	$2,777	**$4,622**
Regular surveillance-oriented parole (v. no parole supervision)	0% (2)	$0	$0	$1,201	**-$1,201**
Juvenile intensive probation supervision programs	0% (3)	$0	$0	$1,598	**-$1,598**
Juvenile wilderness challenge	0% (9)	$0	$0	$3,085	**-$3,085**
Juvenile intensive parole supervision	0% (10)	$0	$0	$6,460	**-$6,460**
Scared Straight	+6.8% (10)	-$8,355	-$6,253	$58	**-$14,667**
Counseling/psychotherapy for juvenile offenders	-18.9% (6)	$23,126	$17,309	n/e	n/e
Juvenile education programs	-17.5% (3)	$41,181	$26,153	n/e	n/e
Other family-based therapy programs	-12.2% (12)	$15,006	$11,231	n/e	n/e
Team Child	-10.9% (2)	$5,759	$4,131	n/e	n/e
Juvenile behavior modification	-8.2% (4)	$19,271	$12,238	n/e	n/e
Life skills education programs for juvenile offenders	-2.7% (3)	$6,441	$4,091	n/e	n/e
Diversion progs. with services (v. regular juvenile court)	-2.7% (20)	$1,441	$1,034	n/e	n/e
Juvenile cognitive-behavioral treatment	-2.5% (8)	$3,123	$2,337	n/e	n/e
Court supervision vs. simple release without services	0% (8)	$0	$0	n/e	n/e
Diversion programs with services (v. simple release)	0% (7)	$0	$0	n/e	n/e
Juvenile intensive probation (as alternative to incarceration)	0% (5)	$0	$0	n/e	n/e
Guided Group Interaction	0% (4)	$0	$0	n/e	n/e
Prevention Programs (crime reduction effects only)					
Nurse Family Partnership-Mothers	-56.2% (1)	$11,531	$8,161	$5,409	**$14,283**
Nurse Family Partnership-Children	-16.4% (1)	$8,632	$4,922	$733	**$12,822**
Pre-K education for low income 3 & 4 year olds	-14.2% (8)	$8,145	$4,644	$593	**$12,196**
Seattle Social Development Project	-18.6% (1)	$1,605	$4,341	n/e	n/e
High school graduation	-10.4% (1)	$1,738	$2,851	n/e	n/e
Guiding Good Choices	-9.1% (1)	$570	$2,092	n/e	n/e
Parent-Child Interaction Therapy	-3.7% (1)	$268	$784	n/e	n/e

Program types in need of additional research & development before we can conclude they do or do not reduce crime outcomes:

Programs needing more research for people in the adult offender system		**Comment**
Case management in the community for drug offenders	0% (13)	Findings are mixed for this broad grouping of programs.
COSA (Faith-based supervision of sex offenders)	-22.3% (1)	Too few evaluations to date.
Day fines (compared to standard probation)	0% (1)	Too few evaluations to date.
Domestic violence courts	0% (2)	Too few evaluations to date.
Faith-based programs	0% (5)	Too few evaluations to date.
Intensive supervision of sex offenders in the community	0% (4)	Findings are mixed for this broad grouping of programs.
Medical treatment of sex offenders	-21.4% (1)	Too few evaluations to date.
Mixed treatment of sex offenders in the community	0% (2)	Too few evaluations to date.
Regular parole supervision vs. no parole supervision	0% (1)	Too few evaluations to date.
Restorative justice programs for lower risk adult offenders	0% (6)	Findings are mixed for this broad grouping of programs.
Therapeutic community programs for mentally ill offenders	-20.8% (2)	Too few evaluations to date.
Work release programs (from prison)	-4.3% (4)	Too few recent evaluations.
Programs needing more research for youth in the juvenile offender system		
Dialectical Behavior Therapy	0% (1)	Too few evaluations to date.
Increased drug testing (on parole) vs. minimal drug testing	0% (1)	Too few evaluations to date.
Juvenile curfews	0% (1)	Too few evaluations to date.
Juvenile day reporting	0% (2)	Too few evaluations to date.
Juvenile jobs programs	0% (3)	Too few recent evaluations.
Juvenile therapeutic communities	0% (1)	Too few evaluations to date.
Mentoring in juvenile justice	0% (1)	Too few evaluations to date.

Recommendation #1.18
Avoid "Trail 'em. Nail 'em. and Jail 'em." supervision and surveillance strategies. The purpose of supervision is not simply to catch youth violating probation; rather, it is to provide case management[8] and treatment so that more serious options such as incarceration can be avoided. Strengthen local health, education, and social service agency supports to probation and parole officers to ensure access to needed treatment, educational, and workforce programs.

Recommendation #1.19
Consider expanding the use of specialized case loads for probation officers. In particular, specialized case loads should be considered for female juvenile offenders and for youth with disabilities so that probation officers are able to truly tailor services to meet these offenders' unique needs.

Recommendation #1.20
Carefully narrow the category of which juveniles may be sent to TYC. Limit TYC placement to high-risk or chronic felons. Every juvenile under consideration for a TYC placement should be given emergent risk and comprehensive needs assessments. This strategy would also ensure more uniformity in sentencing patterns and use of TYC resources across jurisdictions.

TYC should not accept any juvenile for whom such assessments do not indicate a high-risk of re-offense, and TYC must be able to accommodate a youth's disability.

Recommendation #1.21
Retain determinate sentencing[9] but reserve it for the most serious youth. As long as determinate sentencing is available only for the most serious offenses and there is no widening of the net as to which juveniles are eligible for transfer to the adult system, this can be an effective option for juvenile judges. Also, in order for this sentencing option to be most effective, there has to be a realistic potential for the juvenile to be released directly from TYC assuming his or her behavior and progress while in TYC is conducive to release. Juveniles facing the possibility of decades-long periods of incarceration need such an incentive in order to make their time in TYC meaningful and to encourage good behavior and participation in programming.

Recommendation #1.22
Reform the certification of youth into the adult system so that anybody certified spends his or her youthful years (ages 14 to 19) in TYC prior to transfer to an adult correctional facility. Regardless of their offense, youth of this age have specific needs (especially educational, programmatic, emotional, medical, recreational, and dietary) that cannot be adequately addressed in the adult system. Moreover, they are at severe risk of abuse in the adult system because of their age. Youth should be sent to TYC to accommodate those needs until such time that they are adults and can safely be placed in adult prisons. It is particularly

[8] Effective *case management* includes at least six primary functions: (a) identification and outreach to people in need of services; (b) assessment of specific needs; (c) planning for services; (d) linkage to services; (e) monitoring and evaluation; and (f) advocacy for the client system.
[9] Determinate sentencing is a system whereby juveniles who have committed one of a number of serious crimes are given a fixed sentence that begins in TYC and takes them into adulthood and, upon reaching age 19, are evaluated either for release directly from TYC to TDCJ parole or for transfer to TDCJ institutional care (i.e., prison) to complete their sentence.

important to decrease the disproportionate number of youth of color serving time in adult correctional institutions. A disproportionate percentage of African American and Hispanic youth are being processed as adults, particularly older adolescents committed for drug-related offenses. Texas might also consider looking to the states of Illinois, Connecticut, and Delaware for guidance, as these states have recently taken steps to reduce the number of youth tried as adults.

Recommendation #1.23
Implement a reverse transfer provision in order to provide judicial authority to send the case back to the juvenile system. The current system allows juvenile judges to transfer a case to adult criminal court. The criminal judge, however, has no way to return the case to the juvenile court if, upon further review of the evidence, it becomes clear that the juvenile is not appropriate for certification. The Texas Legislature should pass a law that allows criminal judges to transfer juveniles to the juvenile court in appropriate cases.

Recommendation #1.24
Improve information sharing between TYC and the Texas Department of Criminal Justice (TDCJ) to enable TDCJ to know which youth are being transferred pursuant to a determinate sentence, and in which programs they participated while at TYC.

Avoid "Trail 'em. Nail 'em. and Jail 'em." supervision and surveillance strategies. The purpose of supervision is not simply to catch youth violating probation; rather, it is to provide case management and treatment.

II. DURING

WHAT IS THE PROBLEM?

The challenges for the Texas Youth Commission have been highlighted in recent months through countless media accounts and during the 80th Texas Legislative session. Conservator Jay Kimbrough's May 2007 report noted many of these challenges, including: overcrowding at TYC facilities; too great an emphasis on punishment, with insufficient resources for education and treatment; a fragmented health care delivery system; non-violent offenders being housed at TYC facilities; high caseloads and high turnover rates among staff; a shortage of correctional officers; too many incidents of violence at TYC facilities; youth being sentenced to TYC facilities that are too large and too far away from their home communities; dorm designs that make it difficult to monitor youth; and lack of accountability and transparency, including facility staff with too much control over the complaint process.

Generally, the recommendations enumerated in this section of the report are driven by a cumulative response to the above concerns and two overarching questions. First, "how do we keep our communities safe?", and second, "what would one expect (or accept) for his or her own child?"

The following guiding principles would engender a system acceptable for all parents or caregivers. They are also responsive to the community, including those that may have been victimized as well as professionals in public education, law enforcement, prosecutors and the judiciary. (1) The environment within TYC should be safe, health-promoting, and facilitate the appropriate educational and moral development of youth; (2) Youth should spend the least amount of time possible in the TYC system; (3) The TYC environment should be as least restrictive as possible (i.e., placements in settings ranging from the most integrated to the most segregated); (4) Staffing capacity should be commensurate with the size and needs of the population; (5) Evidence-based policies and programs should be implemented; (6) TYC should be child-focused, family-centered, and non-violent; (7) Communication must be effective; (8) TYC should be grounded in positive youth development where education and treatment, rather than punishment, is the primary work of the TYC; (9) Youth with disabilities should be identified and accommodated; and (10) Youth and families should have easy access to attorneys and advocacy groups.

Incarceration rates for juvenile delinquents in Texas are too high compared to the rest of the country and their adverse consequences on the youth, the victims and the state's budget are far too costly. The most recent data reported by the U.S. Department of Justice show that the Texas rate of commitment of youth to juvenile correction, 243 youth per 100,000 youth, is well above the national average of 219 per 100,000 youth. When compared to other states with an upper age of juvenile court jurisdiction at 16, Texas's rate is only exceeded by Louisiana which has a commitment rate of 246 youth per 100,000 youth.

The following recommendations address strategies to improve funding, governance, sentencing, accountability, policies and procedures, TYC centers, security, cost effectiveness, management, and services.

RECOMMENDATIONS

FUNDING AND GOVERNANCE

Recommendation #2.1
Allocate adequate funding for facilities, rehabilitation and treatment programs, appropriate staffing ratios, education, and the training of employees.

Recommendation #2.2
Ensure that any appointed board and management receive adequate training in order to provide proper oversight and management of TYC facilities. Consideration for appointment to the board should be from entities and persons with backgrounds that have direct interests in youth misconduct and rehabilitation. Training for executives, board, and staff should be child-centered. In this spirit, we recommend bringing in representatives from the National Juvenile Court Services Association (www.njcsa.org) to provide consultation on a range of issues, from the correctional climate to training.

Recommendation #2.3
Formulate a Transitional Advisory Committee. The Transitional Advisory Board's role, perhaps composed of representatives from this Juvenile Justice Blue Ribbon Task Force, should simply be to assure that the principles and recommendations set forth in this section of the report are clearly articulated and delivered to the newly created policymaking board (see Recommendation #2.4). This group should be sunsetted when a policymaking board is named.

Recommendation #2.4
Convene a Policymaking Board, regardless of structure, that is well-versed in the juvenile justice system, adolescent health and mental health treatment, law enforcement and education. Board members and executive level personnel must visit facilities at least once per year and have recurring management and ethics training. The best interest of the youth needs to be the primary focus at all levels of executive leadership.

Recommendation #2.5
Create an entity within the state government or academia to provide objective research to state policymakers on juvenile and criminal justice issues, and to provide population and racial impact analyses of all proposed adult and juvenile justice legislation. This research component should be independent, system-wide, and ongoing, perhaps being housed in a university setting. Two exemplar centers can be found in California (Center for Evidence-Based Corrections at UC-Irvine) and Washington (Washington State Institute for Public Policy).

ACCOUNTABILITY

Recommendation #2.6
Create a system of accountability that allows an independent governmental office to investigate allegations of impropriety and to conduct routine inspections of facilities to assess conditions and the treatment of juveniles. One model for this is to have the Office of the Inspector General (OIG) report directly to the Governor, and to have the Ombudsman report directly to the OIG. The need to conduct routine inspections is also important. It is insufficient to only look into complaints, as complaints may never be made and may never come to the agency's attention.

Ombudsman → OIG → Governor

Recommendation #2.7
Support the newly established office of the Ombudsman and clarify the role of the Ombudsman. The Ombudsman should have an intake system that is not cumbersome, but rather promotes access and transparency. He or she will need adequate funding to realize the potential of this important position.

Recommendation #2.8
Require that TYC facilities and programs be properly accredited and that the agency complies with a set of appropriate standards. TYC should obtain accreditation again from the American Correctional Association (ACA) (www.aca.org). (TYC has previously been accredited by ACA.) There are other sources that TYC may want to consider for additional guidance and/or accreditation (i.e., the National Commission on Correctional Health Care, Southern States Association of Colleges, and the Council of Juvenile Correction Administrators).

Recommendation #2.9
Administer a consumer satisfaction survey to youth currently housed in TYC facilities and at least one family member. There is one such survey, originally developed by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and later streamlined by the National Council on Crime and Delinquency (NCCD), which takes about 35 minutes to administer. It is available on an electronic notebook, and in Spanish. A random sample of youth could be drawn from TYC facilities so that a baseline could be established now, and these data could be used to set management goals. The survey should allow management to assess emerging concerns about particular facilities, as well as programs or staff within facilities. This survey should be administered by individuals who are independent of TYC, such as university graduate students supervised by a faculty member. The results should be reported through the Office of the Ombudsman, and made publicly available.

CENTERS/FACILITIES/SERVICES

Recommendation #2.10

Make decisions on whether to admit youth to TYC facilities using objective, research-based risk assessment and classification. (See also Recommendation #1.20.) Risk assessment should drive decision-making about treatment (i.e., treatment matching). A recent meeting of juvenile justice assessment experts dubbed the "Consensus Conference" produced recommendations for screening and assessment of mental health needs in the juvenile justice system. Following the RAND Corporation expert consensus guidelines approach, the group asked juvenile justice staff about current and best practices in assessment. The Consensus Conference urges personnel in the juvenile justice system to screen for issues presenting immediate risk for harm within 24 hours of system intake. The early screen for "emergent risk" targets screening for (1) risk of self-harm, (2) risk of harm to others, (3) immediate mental health crises, (4) current medications, (5) recently ingested substances, and (6) recent mental health treatment (see Figure 3 – Screening and Assessment Emergent Risk Model).[10] The initial health assessment should include a medical and dental assessment that is performed by personnel with the appropriate training and credentials to conduct the assessment using standing delegation orders and protocols developed by a multidisciplinary health team (mental, dental, medical). For youth committed to correctional care, treatment needs with recommendations should be identified and comprehensive psychological, forensic, and educational/workforce development assessments conducted.

Keeping youth in institutional settings on the basis of treatment or educational needs, rather than risk, is unwarranted and inefficient.

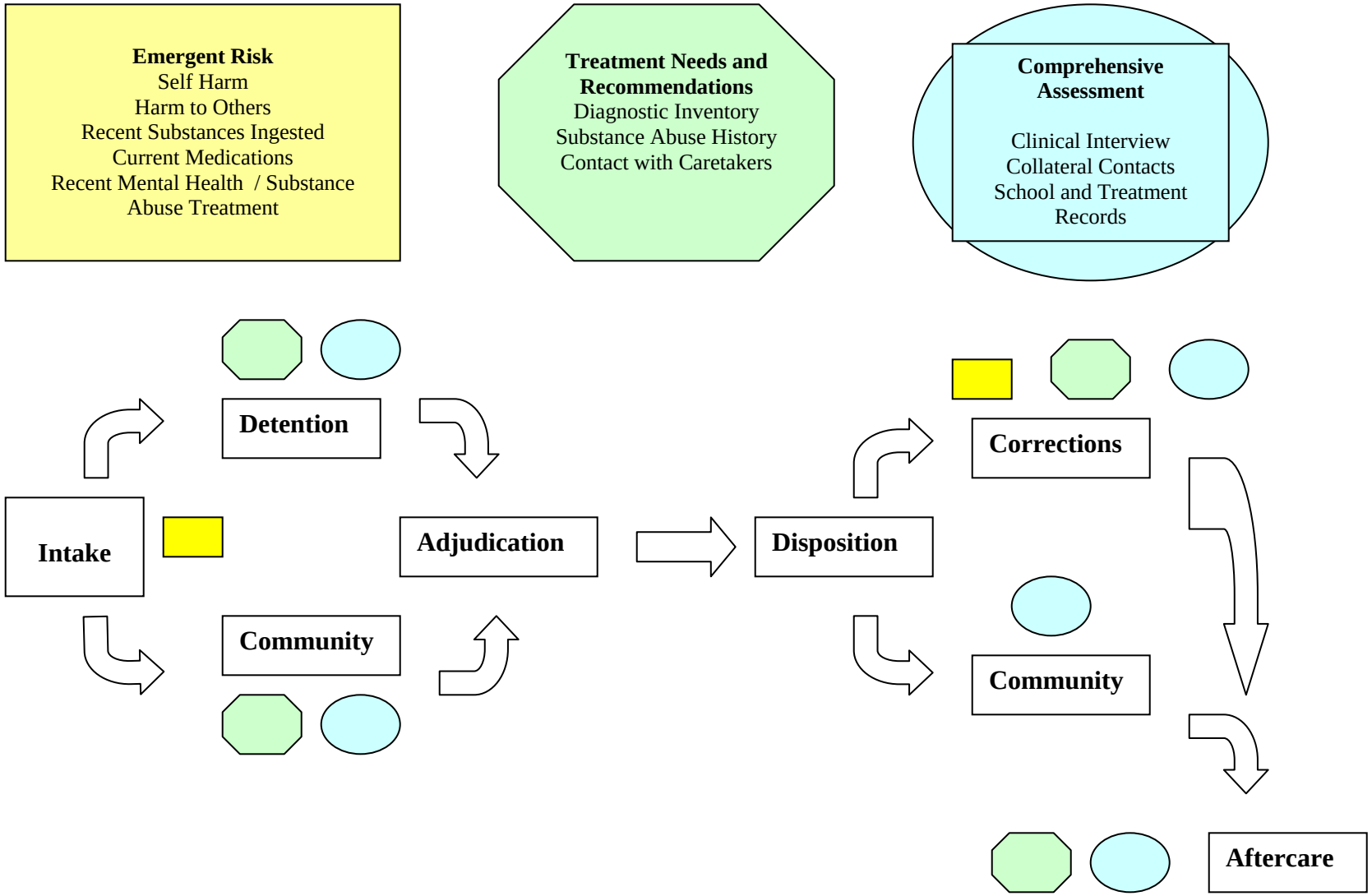
The type of emergent risk screening portrayed in Figure 3 should be used at all TYC facilities. Delinquent youth should be placed in a secure institutional environment on the basis of their potential risk to themselves or the community. Keeping youth in institutional settings on the basis of treatment or educational needs, rather than risk, is unwarranted and inefficient. Research demonstrates that it is more costly to keep youth in institutions than to supervise them in their own home environments. It is less costly and more effective if they are provided alternative services, such as day treatment and therapeutic foster care.

Recommendation #2.11

Adopt the Juvenile Assessment and Intervention System (JAIS) at all TYC facilities. JAIS, a low-cost, comprehensive assessment and treatment planning package is being used around the country, including Florida and California (www.nccd-crc.org/nccd/n_cj_jabout.html). Once initiated, it could be implemented within 45 to 60 days to drive risk assessment, placement, and treatment at TYC facilities. Such a model would result in individualized, objective, treatment matching. JAIS provides proven casework strategies for handling different types of offenders, with conclusive data on outcomes in institutional, parole, probation, and re-entry initiatives.

[10] Source: Potter, C. C., & Jenson, J. M. (2007). Assessment of mental health and substance abuse treatment needs in juvenile justice. In A. R. Roberts & D. W. Springer (Eds.), *Social work in juvenile and criminal justice settings* (3rd ed.) (pp. 133-150). Springfield, IL: Charles C Thomas.

Figure 3: Screening and Assessment Emergent Risk Model



Recommendation #2.12

Create a regionalized system of care that supports the use of small facilities. A regional system provides enhanced monitoring of credentialing, oversight, and training. Such a regional TYC system should emphasize a variety of settings, including day treatment, therapeutic foster care, and small residential facilities. Placements should be based on factors such as age, gender, individual needs, disability, and proximity to a youth's home.

Developing an effective system of care requires that youth be held and served as close to their home community as possible. Ideally, every region should have access to beds that are secure as well as multiple less restrictive environments and services; such as functional family therapy, foster homes, wraparound services, multisystemic therapy (MST), and day treatment (refer to Exhibit 4 for additional evidence-based and cost-effective services). Such a continuum of care allows for individualizing the service delivery system. Moving the youth along the continuum and working with his/her family and community is more efficient, more effective, and less costly.

One question that needs to be addressed at this point is how to transition the existing system of institutional care to one that emphasizes community-based alternatives and regional structures of care. (This question could be answered, in part, through a feasibility study.) The current institutions will obviously continue to exist for a while. The long-term strategy, however, is to create regional service centers in the different regions of the state, and those centers, as they grow and mature and enrich their service delivery systems, will reduce the state's reliance on institutions. Texas organizes its health, mental health, and developmental disability service delivery system using a regional structure. The State's public health and social service infrastructure is specifically comprised of 11 regions designed to support the effective provision of essential services at the local level. Using a similar structure should be feasible for the juvenile justice system.

Institutions can also be assigned to the different regions. If they are too large, some institutions can serve more than one region. Over time, the regional system will become stronger and should take over the operations. Such a strategy helps transfer the power and responsibility from the central institutional system to the regions. Transferring the authority and responsibility locally from the state can go a long way towards finding local solutions, local interventions, and reintegration of the youth into his or her community. It is important to note that some youth will still need institutional systems that are centralized; however, their numbers will be much fewer than the current number of youth in TYC.

The Missouri Division of Youth Services (DYS) has received attention in the media and among juvenile justice experts as a system that stands out for its ability to provide successful intensive treatment across residential facilities, group homes, and aftercare services. Accordingly, a brief overview of DYS seems warranted here, as it is important to unpack the critical elements of such a regionalized approach (see Exhibit 5). According to a study by DYS in 2003, approximately 11 to 29 percent of youth released from DYS custody in 1999 had recidivated within the following three years, and 8 percent of those released were sentenced to adult prison or short-term 120 adult confinement programs during the following three years (Roberts & Bender, 2008).

Exhibit 5: Brief Overview of the Missouri Division of Youth Services (DYS)

Each region of the Missouri Division of Youth Services (DYS), in addition to small residential program capacities sufficient to handle youth of varied risk-levels, has at least one day treatment program for youth released from DYS. While all juveniles released go to day treatment. The emphasis is to get youth back into mainstream services (e.g., public schools) rather than keeping them segregated with other delinquent youth.

The extensive services provided appear to be a result of keeping programs small in size and involving family members throughout the treatment process. Highly trained staff are available 24 hours a day and M.S.W. family therapists promote family involvement throughout residential treatment and home-based aftercare. The residential facility, targeting adjudicated youth with felony charges, and the group home programs, targeting status offenders, share a focus on treatment and rehabilitation in small settings as opposed to a focus on punishment. Residential treatment facilities offer extensive group therapy as well as multisystemic family therapy. A strength of this program is the use of day treatment transitional programs to bridge the residential setting to returning to the community.

DYS provides "aftercare" services for each committed youth lasting a minimum of 4 months, but often longer. The aftercare supervision is done by the youth's case worker, who is assigned upon commitment and who, therefore, has worked with the youth and his or her family throughout the period of commitment. (In our estimation, this is a key strength of this program, as DYS personnel have developed lengthy, relatively intimate relations with the youth's family during the residential period that then supports aftercare efforts considerably better than normal.)

In addition to case management, aftercare supervision is supported by "trackers," contract personnel who are responsible for basic monitoring of youth following release. This enables the case manager to focus on treatment goals and needs and leaves the monitoring activities to someone with less clinical training.

Regions have discretionary funds with which they can purchase services for selected youth whose needs or circumstances are not sufficiently covered by the routine services available in the region. So, if a particular youth is discharged and needs a very specialized kind of intervention or care, arrangements can be made to purchase those services with these discretionary funds.

Most DYS commitments are for indefinite terms.

Institutional staff at DYS facilities have college degrees and are compensated proportionately. In other words, the basic human capital available to run these facilities and work with these youth is different from the average correctional system.

At the most basic level, DYS facilities are set up to create a different environment, one that seeks to "normalize" the impact of institutional placement. When one enters one of their residential facilities, it simply does not feel like a correctional facility. There are no huge fences covered with razor wire. The entryways, while they usually have a metal detector that visitors go through, do not have sallyport-type entries for visitors. The main living areas feel like large living rooms (one secure center near Kansas City has a big fireplace, lovely couches and chairs in the main room). This is true even for their most secure facilities, including those that house offenders who have committed murders.

Using the DYS regionalized system as a framework, we highlight in Table 3 below what in our estimation are fundamental elements of effective regionalization.

Table 3: Fundamental Elements of Effective Regionalization

Regionalization is armored by a set of beliefs and philosophies of which all decisions and interventions must align.

Fundamentals

- Decentralized decision making that provides agency-wide ownership of the direction, philosophy and goals.
- Clear mission, vision, and values; mission-driven leadership.
- Leadership defined by supervision vs. function.
- Organization chart reflects regional structure (i.e., lean central office staff with sole goal to support the regions; flattened hierarchy; clear line of authority to and within the regions; clear line of authority at the program level between management, group leaders and the frontline staff).
- Decentralized budgets.
- Regional capacity to conduct training (staff at all levels of the organization receive the training necessary to skillfully perform their job duties).
- Check and balance systems at the program, regional and central office levels.
- Standardized reporting system; reviewed and supported by direct observation.
- Statewide Advisory Board and localized Community Liaison Councils.

Structure and Service Delivery

Each region has a similar continuum of community-based and residential services. Support functions of supervision, planning, evaluation, and training necessary for effective and efficient delivery of programmatic and contractual services are well maintained.

Fundamentals

- Regionalized continuum of services. Regardless of the security level, an overall emphasis is placed on meeting the individualized psychosocial, educational, vocational, and medical needs of the youth in a humane, structured, supportive, and therapeutic environment.
- Small residential programs with high staff to student ratios.
- Youth receive services in close proximity to their homes and families.
- Programs and services fit the needs of the youth and requirements of the law.
- Families are involved, engaged and active participants in the treatment process.
- All services are coordinated with and cognizant of the family.

Team Philosophy and Structure

The residential programs are divided into teams of 10-12 youth. The youth are assigned to one team, there to remain until completion of the residential treatment.

Fundamentals

- Stable and consistent teams with an assigned team leader.
- Consistent team assignment and leadership.
- 24-hour eyes, ears, heart and "brains" on supervision.
- Employees are empowered and supported to make decisions.
- Focus on continuous improvement.
- Ongoing training and staff development.

Integrated Service Delivery System at the Site Level

Fundamentals

- Rehabilitative treatment model vs. correctional model.
- Empowered leadership and empowered team.
- Treatment and educational program components work in harmony.
- Staff teams and program leaders are the brokers of supplemental services (e.g., supplemental services must align with agency mission, goals and objectives).

Case Management

The Case Manager serves as the primary advocate for youth and their family. To provide continuity and consistency, each youth remains with the same case manager throughout his/her commitment. Case managers are assigned to specific geographic areas of the state.

Fundamental Responsibilities

- Develop Individualized Treatment Plans (ITP's) for all youth assigned to their respective caseloads.
- Communicate with his/her supervisor and staff team to discuss the particulars of each case and formulate specific treatment interventions for the youth.
- Utilize an objective screening tool to determine the appropriate service.
- Works in cooperation with the family and service providers to determine when the youth is ready for release.
- Make the final recommendation for release and discharge.

Intensive Case Monitors (Tracking)

Trackers help the case managers maintain a high level of supervision on youth activities and they are a central component of the youth's successful transition back into the community.

Fundamental Responsibilities

- Monitor and supervise youth in the community.
- Maintain contact with designated youth through face-to-face meetings, home visits, phone calls and collateral contacts with others professionals who work directly with the youth.
- Regularly report progress and concerns to the case manager.

Recommendation #2.13
Separate low-risk and high-risk offenders from one another, and separate vulnerable offenders from potential aggressors. To effectively ensure this separation, see Recommendations 2.10, 2.11, and 2.12 above.

Recommendation #2.14
Consider the particular needs of girls in the design of juvenile justice programs and facilities. Considering that girls are the fastest growing segment of the juvenile justice population (OJJDP, 2000) and that they often have different problems and needs than boys, it is important that the Texas juvenile justice system in general, and TYC in particular, implement gender-specific policies, programs, and practices.

While the field of juvenile justice is in desperate need of interventions designed specifically for females, few specific interventions exist and most existing programs have not been evaluated empirically (American Bar Association, 2001). Instead, a variety of interventions including behavioral, cognitive, affective/dynamic, and systems perspectives are used in gender-specific programs (Bloom & Covington, 2001). Although this variety exists, research *has* identified a number of common features of juvenile justice programming that should be considered in adapting juvenile justice systems to meet the unique needs of female offenders.

Gender-specific programming includes two important aspects: 1) content (treatment that addresses the issues impacting females' delinquency), and 2) context (an environment that is safe, connected and congruent with girls' needs) (Bloom & Covington, 2001).

Content

The following factors are especially prevalent and influential in the lives of female delinquents and should be addressed in female programming:

Trauma. Research demonstrates that one of the most prevalent and distinct issues common to female offenders is physical and sexual abuse, and corresponding posttraumatic-stress disorder (PTSD). Individual, group, and family counseling with masters-level professionals should be provided to address past trauma and help youth address such issues as domestic violence, family abuse, and coping methods (Patino, Ravoira, & Wolf, 2006). In developing group counseling programs, homogeneous groups should be used for females that have experienced similar traumas (Bloom & Covington, 2001).

Research demonstrates that one of the most prevalent and distinct issues common to female offenders is physical and sexual abuse, and corresponding posttraumatic-stress disorder (PTSD).

M**ental Health.** It is important to identify strategies for the re-allocation of resources to provide mental health services as all levels of the continuum from secure short-term, acute psychiatric placements to community mental health services. Mental health treatment should address the interconnectedness of mental health symptoms, past trauma, addiction, and delinquent behaviors (Patino et al., 2006).

Substance Abuse. Substance abuse plays a prominent role in female offending. Reports indicate that substance-abusing females are found in the criminal justice system four to ten times more than in the general population (Bloom & Covington, 1998). Substance abuse treatment resources should be available for all females whose criminal behavior is related to their chemical dependency (Patino et al., 2006; ISFOPG, 1995).

Relationships. Relationships with others are particularly important to the healthy development of female adolescents. Programs should help females to establish trusting positive relationships with staff, family members and other trusted females already present in their lives, including friends, relatives, neighbors or teachers. These individuals should be engaged in the treatment process (Patino et al., 2006). Family members, in particular, need to participate in treatment to build skills for successful parenting and conflict resolution in order for youth to be successful in their home communities. In addition to treatment, females need relationships with positive female role models and mentors. Mentoring relationships should be fostered and encouraged within the juvenile justice program (Bloom & Covington, 1998; ISFOPG, 1995).

Pregnancy and parenting skills. Females should receive specialized medical care including gynecological services and pregnancy/STD prevention programming. For those females who have children or are pregnant, parenting skills training should be made available (Beckman, 1994; Belknap et al., 1997).

Traditional and Non-Traditional Educational and Vocational Programming. Most females benefit greatly from formal education as well as training in other non-traditional areas such as relationship building, healthy boundaries, decision making, assertiveness, and anger management. Trainings should prepare females to function in their communities in educational or vocational settings of interest to them as well as social settings (Patino et al., 2006).

Context

In addition to including content relevant to female delinquency, gender-specific programs should take place within an environment that includes the following attributes:

Proximity. Programs, whether residential or community-based, should be provided in the communities where girls live. Proximity allows for building relationships through family visitation and family therapy, and girls can develop skills necessary for addressing the challenges within their home communities (Patino et al., 2006).

Safety. Female programs should be provided in a safe, trusting and supportive environment (Bloom & Covington, 1998). Programs should be free of physical, emotional, and sexual harassment and re-victimization (Beckman, 1994). This includes establishing and enforcing appropriate boundaries and rules of conduct without resorting to the use of physical force.

Continuum of Services. Regardless of what point girls are in the system (minimum to maximum risk), mental health and substance abuse services should be available to female delinquents. Gender-specific services need to be available to girls at *all* program levels, from prevention to incarceration to aftercare services. Females should not have to be placed in more

secure settings simply to gain access to treatment or services (Petino et al., 2006). Furthermore, collaboration and coordination between service providers and aftercare services is especially important for females as this supports taking a relational approach to treatment (Austin, Bloom, & Donahue, 1992).

Least restrictive environment. Females are disproportionately arrested for less serious crimes, and despite their low risk level, are placed in more restrictive settings (American Bar Association, 2001). It is important that only girls who pose a public safety risk be placed in residential programs, while recognizing that some of these girls may be at risk in their home environments (e.g., from abuse or neglect). Accommodations may need to be made for them, short of putting them in a detention or TYC setting. The least restrictive programming environment available should be used whenever possible, and placement in more secure placements should be based solely on level of concern for public safety and treatment needs (Bloom & Covington, 1998).

Informed Staff. Staff working with females should be educated about female development and service needs. Staff should reflect the client population in terms of gender, race/ethnicity, sexual orientation and language spoken. Staff or successful peers should serve as positive role models and mentors and create opportunities for female delinquents to develop trusting relationships with them. It is important for staff members and facilitators to empower girls rather than using power over them (Bloom & Covington, 2001).

Connection. The environment should foster connections between staff members and female delinquents and should emphasize an interaction style comfortable to females, including relationship building, empowerment to express feelings, mutual power rather than authoritarian leadership (Bloom & Covington, 1998).

Many of the factors discussed above were supported in a recent review of over 100 community programs for women. This review found the most successful programs did not utilize a medical model of treatment that strives to cure offenders. Instead, successful programs employed an empowerment model that aimed to help women develop coping skills, improve decision making, and develop behavioral responses to meet their own needs. Within the empowerment approach, successful programs addressed a broad range of issues, including victimization, substance use, pregnancy, parenting, mental health, and relationships. Furthermore, programs associated with positive outcomes provided safe environments with clear expectations, diverse staff (including former offenders), accountability for behavior, and connection to aftercare services (Austin et al., 1992).

Adapting current services to be gender-responsive requires several changes to program content and context. The National Council on Crime and Delinquency (NCCD) has developed short-term and longer-term recommendations for providing gender-specific services to girls in the juvenile justice system (see Table 4).

Table 4. Gender-Specific Recommendations for Female Juvenile Offenders[11]

Short-term Recommendations

1. Reduce beds in residential delinquency programs by creating community treatment programs for at-risk girls.
2. Implement a uniform, gender-responsive screening and assessment process utilizing an instrument that identifies risk level, intervention needs, and supervision strategies.
3. Provide appropriate resources for the development and implementation of uniform gender-responsive training for all staff working with girls along the entire juvenile justice continuum as part of the required training.

Longer-term Recommendations

1. Provide specialized service options for pregnant and parenting girls.
2. Deliver health services such as gynecological care, prenatal and post-partum care for pregnant girls, and health education that address HIV and other sexually transmitted infections and diseases.
3. Offer specialized services to address family conflict and associated risk.
4. Implement aftercare and transitional services to ensure success for girls.
5. Provide traditional/non-traditional education and vocational programs that are gender-specific.
6. Explore the implementation of a female offender probation unit which would entail the reorganization of caseloads so all girls on probation would be supervised under one unit and probation officers would have all-girl caseloads.

In keeping with the gender-specific treatment recommendations outlined in Table 4, the NCCD recommends creating community treatment programs for at-risk girls, thus reducing the need for beds in residential delinquency programs. Funding for new programs would need to be shifted from residential programs over time to avoid disrupting existing placement options while the new programs are being established.

Specific new program initiatives for TYC officials to consider include:
• *Create a pilot project for girls with self destructive and aggressive behaviors, mood disorders, and substance abuse.* Using the Family Integrated Transitions Program model developed by the Division of Public Behavioral Health and Justice Policy at the University of Washington would provide an alternative to residential placement for girls who have committed non-law violations or misdemeanors.
• *Combine PACE with Dialectical Behavioral Therapy and day treatment* for girls who are now being sent to commitment for non-law violations and misdemeanors.
• *Pilot a community-based project for girls with mental health and abuse issues* that works with families to address girls' multiple risk factors using the Multisystemic Therapy model.
• *Adopt the Seeking Safety Therapy (SS)* program for girls with co-morbid substance abuse and PTSD (Najavits, Gallop, & Weiss, in press). (See also Exhibit 6).

[11] Source: Patino, V., Ravoira, L., & Wolf, A. (2006). *A rallying cry for change: Charting a new direction in the State of Florida's response to girls in the juvenile justice system.* Oakland, CA: National Council on Crime and Delinquency.

Recommendation #2.15
Provide flexible and individualized care for youth in TYC. Institutionalized care tends to be rigid and provides little opportunity to individualize and tailor the care for the youth. In reality, upon release from TYC facilities, many of these youth need a system that can give them increased supervision or even increased restrictions if they show signs of getting in trouble. This requires a more flexible system of care that regularly interacts with their community. The JAIS described in recommendation 2.11 could support this sort of flexible and individualized care, as would allowing advocacy and support groups to provide on-site services to incarcerated youth.

Recommendation #2.16
Provide graduated levels of care (i.e., services and restrictions) within the TYC system that are driven by risk assessment and classification (see recommendations 2.10 and 2.11 above for more detail).

Recommendation #2.17
Ground the juvenile justice system with a clear focus on education. The importance of education opportunities for court involved youth cannot be overstated. Academic competence and educational attainment is inversely correlated with re-arrests and re-offending among youth.

There is a clear nexus between school failure and school exclusion and the increased risk for a youth's involvement in juvenile corrections. Nationally, data suggest that while school violence has remained relatively constant and/or has declined since 1995, the rate at which students are excluded from school via suspensions and/or expulsions has increased dramatically. The youths who are subject to increased numbers of disciplinary infractions are disproportionately minority students and students enrolled in special education programs. Some attribute this to "zero tolerance" policies that sweep up kids involved in serious disciplinary infractions, as well as youth whose transgressions in the past were handled by the assistant principal. In addition to involving local police in the "criminalization" of school misbehavior, schools set students up for involvement in the juvenile justice system by placing them out of school and providing limited, if any, alternatives. (See also Recommendations #1.2 and 1.3.)

Given that the median reading achievement level was 6th grade for youth at TYC (four years behind their peers), and congruent with NCCB and IDEA, all youth should be offered a scientifically-based reading program.

Incarcerated youth and youth under the supervision of the juvenile court or probation have a right to education services comparable to their peers who are not in trouble.[12] The problems are particularly acute for students with disabling conditions and for English language learners. In addition, recent national data suggest that the number of youth with special education needs in juvenile corrections is 3 to 5 times the number found in the public schools. Forty percent (40%) of youth at TYC facilities currently are eligible for federal special education programming (see Texas Education Agency [TEA] rule that governs the provision of special education services in pre- and post adjudication facilities - 19 Tex. Admin. Code 89.115).

[12] More than 23 states have experienced class-action litigation that included, in part, problems with the inadequate education services.

Recommendation #2.18
Begin aftercare planning, addressed more fully in the next section of the report, within the first 30 days of a youth being placed at TYC. Treatment should follow the youth and limit the function of the institutional placement.

Recommendation #2.19
Promote an integrated health care model - to include physical, behavioral, and mental health - across TYC facilities. The goal should be to improve health, both physical and mental, for youth and promote maintenance of health following TYC involvement. In an effort to make health care available to youth in rural communities, the potential application of technology (i.e., telehealth) should be supported, not in lieu of providing on-site medical care, but rather as an adjunct to it.

In keeping with an integrated health care model, it is important to underscore the importance of adopting a bio-psycho-social perspective. In other words, a traditional or strict medical model for managing health care, particularly mental health and substance abuse issues, is not recommended. Health services are best delivered when there is appropriate and systematic coordination across disciplines, including medical, psychiatry, psychology, education, and social work. The services do not necessarily have to be delivered by one provider, but the delivery of services should be coordinated. Additionally, whenever possible, parents or caregivers should be actively involved in providing consent for health care.

According to the American Academy of Pediatrics' (AAP) Committee on Adolescence, adolescents entering correctional care facilities may be at higher risk than their non-incarcerated counterparts for a multitude of general health problems, including sexually transmitted diseases, drug use and abuse, issues regarding pregnancy, HIV or AIDS, and pre-existing mental health problems. Since the early 1970s, the AAP has published policy statements about health care for correctional care facilities. The AAP is also one of more than 30 organizations represented on the Board of the National Commission on Correctional Health Care, a not-for-profit organization comprised of representatives from the fields of corrections, law, law enforcement, medical, dental, and mental health care. The primary purpose of this organization is to work with correctional facilities to assist in improving their systems for providing health care. The commission produces national standards for correctional health services, offers a voluntary accreditation program, and publishes official position statements.

Youth incarcerated in TYC facilities should be provided with health care services as recommended by the AAP, and at least equivalent to those accepted as community standards of care commonly accepted in the community. Additionally, integrated health care in TYC facilities should comply with the American Correctional Association's Performance Based Juvenile Healthcare Standards (www.aca.org). TYC health care services should include age and gender appropriate periodic health examinations for health maintenance as well as recommended screening and testing for behavioral, dental, and medical issues (this would include preventive dental care and vaccinations for vaccine preventable illnesses).

One additional factor to consider in delivering health care and other treatment services to youth is that the neurobiology make-up of the adolescent brain is different than that of the adult brain. Applying adult models of criminal justice to delinquent youth is inappropriate, at best, and insufficient and negligent, at worst, as adolescents' neurodevelopment is still in process and not yet fully developed as an adult brain. Adolescents' brains continue to grow and mature into their mid-20s. The pre-frontal cortex, responsible for the hallmarks of adult behavior, such as impulse control, the regulation of emotions and moral reasoning, is the last part of the brain to mature. As a result, adolescents – in comparison to adults – utilize fewer parts of the brain to recognize others' emotions and to determine appropriate responses, often reacting to events instinctively. This developing yet immature wiring suggests that adolescents require a justice system sensitive to their unique developmental needs.

Applying adult models of criminal justice to delinquent youth is inappropriate, at best, and insufficient and negligent, at worst, as adolescents' neurodevelopment is still in process and not yet fully developed as an adult brain.

Recommendation #2.20

Provide dually diagnosed youth – those identified as simultaneously having substance use disorders and comorbid psychiatric mental health disorders – with *integrated* treatment. Integrated treatment, which involves treating both disorders concurrently, is considered most effective in comparison to serial treatment (treating one disorder before the other) or parallel treatment (treating both disorders simultaneously by separate clinicians).

Bender, Springer, and Kim (2006) conducted a systematic review on the effectiveness of current empirically supported treatments for dually diagnosed adolescents. Studies included in this review were those that met the following selection criteria established by the researchers: (1) randomized clinical trials, allowing researchers to determine effectiveness; (2) treatment for dually diagnosed disorders, meaning treatment for both substance abuse and mental health disorders concurrently; (3) peer reviewed in past 10 years, to provide the most current literature available; (4) treatments designed for youth with already existing dual diagnoses, excluding prevention studies; (5) studies published in English; and (6) treatment for youth ages 12-18, narrowing studies to those of adolescents only. The search identified seven interventions for dually diagnosed adolescents reported across six different studies that met this selection criteria. These included: Multisystemic Therapy (MST; Henggeler, Pickrel, & Brondino, 1999), Interactional Group Treatment (IT; Kaminer, Burleson, Blitz, Sussman, Rounsaville, 1998; Kaminer & Burleson, 1999), Family Behavior Therapy (FBT; Azrin, Donohue, & Teichner, 2001), Individual Cognitive Problem-Solving (ICPS; Azrin, Donohue, & Teichner, 2001); Cognitive Behavior Therapy (CBT; Kaminer, Burleson, & Goldberger, 2002), Ecologically Based Family Therapy (EBFT; Slesnick & Prestopnik, 2005), and Seeking Safety Therapy (SS; Najavits, Gallop, & Weiss, in press).

The results were broken down by three specific treatment outcomes: externalizing disorders (e.g., conduct disorder, aggression), internalizing disorders (e.g., depression, anxiety), and substance abuse. The results were analyzed and interpreted using a statistic called an effect size. This statistic is commonly used in clinical outcome research. Effect size statistics portray the strength of association found in any study, no matter what outcome measure is used, in terms that

are comparable across studies (Rubin & Babbie, 2008). Thus, they enable us to compare the effects of different interventions across studies that use different types of outcome measures. These treatment effects are interpreted as *large, moderate, or small*, which is simply a way to more easily interpret the effect size.

Table 5 shows those treatments that had large, moderate, and small effects at follow-up on externalizing, internalizing, and substance abuse outcomes. The table also indicates the follow-up time period, allowing the reader to interpret the effect in the context of the time period in which it was measured.

Externalizing Disorders. Externalizing effect sizes were large for the MST, FBT, and ICPS groups. Of interest is that youth receiving MST and ICPS showed moderate to large improvements in externalizing outcomes at posttest and these effects improved further to large effects at follow-up.

Table 5. Treatments Organized by Effect Size and Treatment Outcome for Dually Diagnosed Adolescents.

	Dual Diagnosis Outcomes		
Effect Size	Externalizing	Internalizing	Substance Abuse
Large	MST** FBT** ICPS**	IT**** CBT[1]**** FBT** ICPS** CBT[2]***	FBT** ICPS** CBT[2]*** PET***
Moderate	EBFT** SS*	PET*** EBFT**	EBFT** CBT[1]**** SS*
Small		SS*	MST** IT****

Asterisks indicate period of time between pretest and follow-up; *Pre to 3-month follow-up, **Pre to 6-month follow-up, ***Pre to 9-month follow-up, ****Pre to 15-month follow-up. [1]CBT from Study 2 (Kaminer et al., 1998); [2]CBT from Study 4 (Kaminer et al., 2002).

Internalizing Disorders. Internalizing effect sizes were large for the IT, CBT, FBT, and ICPS groups. The effects of all four of these interventions improved over time after treatment ended. Especially impressive among these treatments is the sustainability of internalizing outcomes for IT and CBT; youth in these groups demonstrated substantial changes even when evaluated as long as 15 months after treatment ended.

Substance Abuse. Lastly, substance abuse effect sizes were large for the FBT, ICPS, PET, and CBT groups. Worth noting is that newer, less established treatments such as EBFT and SS also had moderate effect sizes at posttest and sustained moderate reductions in substance abuse at follow-up.

While analysis identifying effective treatment modalities for individual outcomes is helpful, one challenge of treating dually diagnosed youth is their likely diagnosis with several or all of these conditions. Reviewing these results, FBT and ICPS appeared to be the only interventions to produce large treatment effect sizes across externalizing, internalizing, and substance abuse domains. Furthermore, the large effect sizes for these two treatments were evident at 9-months post-treatment demonstrating sustainability of effects over time.

After examining the common factors among treatments with demonstrated effectiveness, Bender and colleagues developed ten preliminary treatment guidelines for dually diagnosed adolescents (see Table 6). These guidelines might serve as a barometer, perhaps providing a general gauge of how to tailor treatment for dually diagnosed juvenile offenders.

Table 6. Ten Preliminary Treatment Guidelines for Dually Diagnosed Adolescents[13]

1. Assessment is multi-pronged, ongoing, and includes practitioner, parental and self monitoring so that treatment is responsive to the changing needs of the client.
2. Treatment strategically enhances engagement and retention.
3. Treatment plans are flexible and allow for client choice and voice.
4. An integrated treatment approach is used to address both mental health and substance related disorders concurrently.
5. Treatment is developmentally and culturally sensitive to match the unique needs of the client system.
6. Treatment is ecologically grounded and systems oriented, including important individuals to the client such as family members, friends, and school personnel.
7. Treatment taps several domains of the client's functioning to enhance the client's problem solving and decision-making skills, affect regulation, impulse control, communication skills, and peer and family relations.
8. Treatment is goal-directed, here-and-now focused, and strength-based.
9. Treatment requires active participation by all members involved, and includes homework assignments.
10. Interventions aim to produce sustainable changes over the course of treatment.

For detained youth and those leaving detention, collaboration between mental health, substance use, and juvenile justice service providers appears especially important in reducing delinquency. This type of collaboration requires graduate level clinicians with specialized training in patterns of behavior of dually diagnosed youth, which suggests a need for training clinicians on collaborative case management and techniques for integrating treatment for dually diagnosed juvenile offenders.

[13] Source: Bender, K., Springer, D. W., & Kim, J. S. (2006). Treatment effectiveness with dually-diagnosed adolescents: A systematic review. *Brief Treatment and Crisis Intervention, 6*(3), 177-205.

Recommendation #2.21

Provide specialized treatment to juvenile sex offenders. Programming should be based on currently accepted practices including the field's knowledge of approaches to assess and evaluate youth with general delinquent behavior, as well as current literature and research related to evaluating and treating youth who sexually offend. One recent meta-analysis by Reitzel and Carbonell (2006) found that programs for juvenile sex offenders resulted in a 46% reduction in recidivism.

Current practices suggest that treatment is guided by the risk, need and responsivity principles. *Risk* refers to matching intensity of treatment to the risk level of the youth, with the highest risk youth receiving the most intense services. The *need principle* refers to targeting specific dynamic risk factors that are related to recidivism, both sexual recidivism and general delinquent recidivism. *Responsivity* refers to delivering treatment in a style that the youth can learn from. In practice, this means adjusting program design and delivery based on a youth's developmental, learning, and social/emotional characteristics. In other words, we ask not what program packages are most effective, but what characteristics are common to effective programs (Lipsey & Cullen, in press).

Consistent with the research and current practices within the field of juvenile sex offender treatment, programming should not assume certain cycles of abuse or triggers to offending, nor that all adolescent sex offenders need traditional relapse prevention approaches. Rather, the program should recognize that there are multiple pathways to offending and utilize an evolved view of relapse prevention that embraces the role of approach goals in striving towards overall prosocial functioning.

The program's supervisory staff should be knowledgeable of current approaches to adolescent sex offender treatment and familiar with approaches to general delinquent behavior. All staff involved in the program need appropriate levels of specialized training related to juvenile sex offenders, in addition to training focused on delinquent youth. The program should be cognitive behavioral in nature with a skills building focus, and have the capacity to address sex offender and general delinquent dynamic risk factors in addition to youth's other health, mental health, and educational needs. The current research also suggests that an effective treatment program is one that attends to therapist style and is most effective when treatment is delivered in a way that stresses respect and hope, versus earlier approaches to adolescent sex offenders which tended to be rather confrontational in nature.

The evaluation process should include recognized risk assessment instruments for both sex offending risk and general risk for delinquent reoffending. It is important to differentiate sex offender specific risk factors and factors unlikely linked to sexual reoffending (see Table 7). Accordingly, a progress rating scale that focuses on sex offender specific dynamic risk factors should be utilized throughout the youth's treatment. Sex offender specific tools to consider using include the Juvenile Sex Offender Assessment Protocol II (JSOAP-II) and the Estimate of Risk of Adolescent Sexual Offence Recidivism (ERASOR). A useful general delinquent and violence scale is the Youth Level of Service/Case Management Inventory (YLS/CMI). Release planning should be initiated when the youth enters the system and should be based on appropriateness for a lower level of care and not on "program completion."

Table 7. Differentiating Risk Factors Linked and Unlinked to Sexual Offending	
Sex Offender Specific Risk Factors	**Factors Unlikely Linked to Sexual Reoffending**
Male Victims Young Victims Diverse Deviant Behavior Prior Legally Charged Offenses Multiple Victims Poor Social Skills/Social Isolation Attitudes Supportive of Offending Difficulties Managing Emotions Sexual Deviation/Preoccupation	Denial Empathy for Specific Victim Degree of Force Used in Offense Degree of Intrusiveness of Offense General Psychological Problems Low Motivation at Intake

The program should have the capacity to involve the family in the treatment process, as appropriate. For youth who have a release goal of returning home, appropriate family work will need to occur prior to the youth's release, with specific guidelines for youth under consideration of being returned to a home where children reside. Upon release, interventions should be offered in collaboration with probation officers who will provide supervision, link youth to appropriate treatment and interventions in the community, monitor compliance to safety guidelines and therapeutic recommendations, and assist in evaluation of risk levels and progress.

Recommendation #2.22

Provide specialized treatment to substance-abusing juvenile offenders. Adolescent substance abuse and juvenile delinquency are interrelated and complex problems. Research indicates a significant association between adolescent alcohol and other drug (AOD) use/abuse and delinquency. Incarcerated adolescents are three times more likely to have partaken in substance use in the past year than other adolescents, and juvenile offenders are more likely to have substance use problems. Because of the association between substance abuse and juvenile delinquency, the reduction of AOD use is critical to treating and preventing juvenile delinquency.

Accordingly, we provide a matrix from the University of Washington Alcohol and Drug Abuse Institute that summarizes the evidence-based practices for treating substance use disorders (see Exhibit 6; matrix available from http://www.adai.washington.edu/ebp/matrix.pdf). Below, we briefly discuss one of the treatments from this exhibit, Multisystemic Therapy (MST), which is highlighted as an approach for adolescent offenders.

Multisystemic Therapy (MST) is noted as being effective for adolescent offenders for a range of AOD-related issues. MST is an intensive family- and community-based treatment that has been applied to a wide range of serious clinical problems, including substance use, chronic and violent criminal behavior, sexual offending, and serious health problems.

MST works with youth, family members, and all pertinent systems in which the youth is involved including peers, school, extended family, family supports, the neighborhood, community groups, and other involved agencies such as child welfare or juvenile justice. Early in treatment, specific measurable overarching goals and functionally meaningful outcomes are set

in collaboration with the family, and as appropriate, other stakeholders. MST overarching goals are broken down into measurable weekly goals. Any person or agency that may influence attainment of these goals is engaged by the therapist and caregiver with specific interventions designed to encourage actions that will facilitate goal achievement.

Strong engagement with the family is essential for successful outcomes, and the MST treatment model incorporates strategies to encourage cooperative partnering. Families are treated with respect and are assumed to be doing the best they can. Other youth-associated systems are viewed as vital partners in the treatment process.

MST is provided via a home-based model of service delivery, and the use of such a model has been crucial to the high engagement and low dropout rates obtained in MST outcome studies (Henggeler, Pickrel, Brondino, & Crouch, 1996). Henggeler, Sheidow, and Lee (2007) summarize the critical service delivery characteristics utilized in MST:

1. Low caseloads to allow intensive services: A MST team consists of 2-4 full-time therapists, a .50 time supervisor per team, and appropriate organizational support. Each therapist works with 4-6 families at a time. The therapist is the team's main point of contact for the youth, family and all involved agencies and systems.
2. Delivery of services in community settings (e.g., home, school, neighborhood center) to overcome barriers to service access, facilitate family engagement in the clinical process, and provide more valid assessment and outcome data.
3. Time-limited duration of treatment (4-6 months) to promote efficiency, self-sufficiency, and cost effectiveness.
4. 24 hour/day and 7 day/week availability of therapists to provide services when needed and to respond to crises. MST is proactive, and plans are developed to prevent or mitigate crises. Crisis response can be taxing, but most families are appreciative, and a supportive response can enhance engagement. Moreover, the capacity to respond to crises is critical to achieving a primary goal of MST programs – preventing out-of-home placements.

Federal entities such as the Surgeon General (U.S. DHHS, 1999; U.S. Public Health Service, 2001), National Institute on Drug Abuse (1999), National Institutes of Health (2004), Center for Substance Abuse Prevention (2001), and President's New Freedom Commission on Mental Health (2003); and consumer organizations (e.g., National Alliance for the Mentally Ill, 2003; National Mental Health Association, 2004) have identified MST as either demonstrating or showing considerable promise in the treatment of youth criminal behavior, substance abuse, and emotional disturbance. These conclusions are based on the findings from 15 published outcome studies (14 randomized, one quasi-experimental) with youths presenting serious clinical problems and their families. Henggeler, Sheidow, and Lee (2007) summarize the research findings across several trials with violent and chronic juvenile offenders, where MST produced 25% to 70% decreases in long-term rates of rearrest, and 47% to 64% decreases in long-term rates of days in out-of-home placements.

Evidence Based Practices for Treating Substance Use Disorders

Practice		Population																			Drug Problem										
Click on intervention title for a detailed description. *Manual availability:* *D = Download free from web* *F = Free print copy (order)* *$ = Cost to purchase print copy* *N = No specific manual*	*Manual: see note at left*	*Adolescents*	*Adults*	*African American*	*Am Indian/Alask Native*	*Asian/Pacific Islander*	*Children/Youth*	*College Student*	*Co-Occurring Patients*	*GLBT*	*Hispanic/Latino*	*HIV+/Hep C/STD*	*Homeless*	*IV Drug User*	*Low-income/Unemployed*	*Men*	*Offenders*	*Opiate Subst Clients*	*Polydrug Users*	*Pregnant Women*	*Women*	*Not Specific to One Drug*	*Alcohol Dependence*	*Alcohol Problem Drinking*	*Amphetamines*	*Cocaine / Crack*	*Heroin / Opiates*	*Marijuana*	*Methamphetamine*	*Polydrug Use*	*Prescription Meds*	*Tobacco*
Cognitive and/or Behavioral Interventions																															
12-Step Facilitation Therapy	$6		X																			X			X						
Anger Management for Substance Abuse and Mental Health Clients: Cognitive Behavioral Therapy	F/D		X						X							X					X	X									
Behavioral Couples (Marital) Therapy	F		X													X		X	X		X	X	X			X	X				
Behavioral Self-Control Training	N		X													X					X			X							
Behavioral Therapy for Adolescents	N	X																				X									
Brief Alcohol Screening and Intervention for College Students (BASICS): A Harm Reduction Approach	$30							X																X							
Brief Cognitive Behavioral Intervention for Amphetamine Users	D		X																X						X						
Brief Intervention	D	X	X					X																X							X
Brief Marijuana Dependence Counseling (BMDC)	F/D		X	X							X																	X			
Brief Strategic Family Therapy (BSFT)	D	X	X								X											X									
Cannabis Youth Treatment	F/D	X																										X			
Cognitive Behavioral Coping Skills Therapy	$6		X																				X								
Combined Behavioral & Nicotine Replacement Therapy	F/D		X																												X

Practice		Population																			Drug Problem										
Click on intervention title for a detailed description. *Manual availability:* *D = Download free from web* *F = Free print copy (order)* *$ = Cost to purchase print copy* *N = No specific manual*	*Manual: see note at left*	*Adolescents*	*Adults*	*African American*	*Am Indian/Alask Native*	*Asian/Pacific Islander*	*Children/Youth*	*College Student*	*Co-Occurring Patients*	*GLBT*	*Hispanic/Latino*	*HIV+/Hep C/STD*	*Homeless*	*IV Drug User*	*Low-income/Unemployed*	*Men*	*Offenders*	*Opiate Subst Clients*	*Polydrug Users*	*Pregnant Women*	*Women*	*Not Specific to One Drug*	*Alcohol Dependence*	*Alcohol Problem Drinking*	*Amphetamines*	*Cocaine / Crack*	*Heroin / Opiates*	*Marijuana*	*Methamphetamine*	*Polydrug Use*	*Prescription Meds*	*Tobacco*
Combined Scheduled Reduced Smoking & Cognitive Behavioral Therapy	N	X	X																												X
Community Reinforcement Approach (CRA) with Vouchers	D		X											X								X			X	X				
Contingency Management (Without CRA)	N		X	X										X	X			X								X	X				
Day Treatment with Abstinence Contingencies and Vouchers	N		X										X													X					
Dialectical Behavior Therapy	N		X						X												X	X									
Downward Spiral	$20		X					X									X					X									
Family Support Network (FSN) for Adolescent Cannabis Users	F/D	X																										X			
Group Drug Counseling for Cocaine Addiction: The Collaborative Cocaine Treatment Study Model	D		X													X				X						X					
Holistic Harm Reduction Program (HHRP+)	D		X	X								X		X				X								X	X				
Individual Cognitive-Behavioral Therapy	D		X																			X				X					
Individual Drug Counseling to Treat Cocaine Addiction	D		X													X					X	X				X					
Lower-Cost Contingency Management	N		X															X					X				X	X				
Matrix Intensive Outpatient Program for the Treatment of Stimulant Abuse	$25-$60	X	X																										X			
Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users	F/D	X																										X			

Practice		Population																			Drug Problem										
Click on intervention title for a detailed description. *Manual availability:* *D = Download free from web* *F = Free print copy (order)* *$ = Cost to purchase print copy* *N = No specific manual*	*Manual: see note at left*	*Adolescents*	*Adults*	*African American*	*Am Indian/Alask Native*	*Asian/Pacific Islander*	*Children/Youth*	*College Student*	*Co-Occurring Patients*	*GLBT*	*Hispanic/Latino*	*HIV+/Hep C/STD*	*Homeless*	*IV Drug User*	*Low-income/Unemployed*	*Men*	*Offenders*	*Opiate Subst Clients*	*Polydrug Users*	*Pregnant Women*	*Women*	*Not Specific to One Drug*	*Alcohol Dependence*	*Alcohol Problem Drinking*	*Amphetamines*	*Cocaine / Crack*	*Heroin / Opiates*	*Marijuana*	*Methamphetamine*	*Polydrug Use*	*Prescription Meds*	*Tobacco*
Motivational Enhancement Therapy (MET) for Problem Drinkers	$6		X																			X	X								
Multidimensional Family Therapy (MDFT)	F/D	X		X																							X		X		
Multisystemic Therapy (MST)	$40	X															X				X										
Node-Link Mapping: Mapping New Roads to Recovery: Cognitive Enhancements to Counseling	D/$15	X	X																		X										
Relapse Prevention Therapy	D	X	X																		X	X			X						
Seeking Safety: A Psychotherapy for Trauma/PTSD and Substance Abuse	D/$20	X	X						X						X	X	X				X	X									
Supportive-Expressive Psychotherapy	$27		X						X									X								X	X				
Time Out! for Me: An Assertiveness and Sexuality Workshop Specially Designed for Women	D/$19		X																	X	X										
Time Out! for Men: A Communications Skills and Sexuality Workshop for Men	D/$19		X													X					X										
Treating Tobacco Use and Dependence. Clinical Practice Guideline	D/F	X	X				X		X							X				X	X										X
Pharmacological Therapies*																															
Acamprosate (Campral)	$6		X																			X									
Buprenorphine (Suboxone and Subutex)	F/D		X																							X					
Combined Behavioral & Nicotine Replacement Therapy	F/D		X																												X

Practice		Population																			Drug Problem											
Click on intervention title for a detailed description. *Manual availability:* *D = Download free from web* *F = Free print copy (order)* *$ = Cost to purchase print copy* *N = No specific manual*	*Manual: see note at left*	*Adolescents*	*Adults*	*African American*	*Am Indian/Alask Native*	*Asian/Pacific Islander*	*Children/Youth*	*College Student*	*Co-Occurring Patients*	*GLBT*	*Hispanic/Latino*	*HIV+/Hep C/STD*	*Homeless*	*IV Drug User*	*Low-income/Unemployed*	*Men*	*Offenders*	*Opiate Subst Clients*	*Polydrug Users*	*Pregnant Women*	*Women*	*Not Specific to One Drug*	*Alcohol Dependence*	*Alcohol Problem Drinking*	*Amphetamines*	*Cocaine / Crack*	*Heroin / Opiates*	*Marijuana*	*Methamphetamine*	*Polydrug Use*	*Prescription Meds*	*Tobacco*
Methadone Maintenance Treatment	N		X													X					X						X					
Naltrexone (for Alcohol)	$6		X																				X									
Naltrexone (for Opiates)	N		X														X										X					

*Washington State law requires that a behavioral therapy component is provided to patients receiving pharmacological therapies for substance use disorders.

CITATION: University of Washington Alcohol and Drug Abuse Institute. Evidence-Based Practices for Treating Substance Use Disorders: Matrix of Interventions, August 2006.
URL: http://adai.washington.edu/ebp/matrix.pdf

Recommendation #2.23

Adopt cognitive-behavioral therapy (CBT) as a core element of effective treatment. The broad category of cognitive-behavioral therapies includes those therapeutic interventions designed to alter both a youth's cognitions and behaviors related to their poor conduct or offending. Cognitive behavioral therapy is an umbrella category for contingency management, cognitive behavioral treatment, guided-group interaction/positive peer culture, and milieu therapy (Pearson, Lipton, Cleland, & Yee, 2002); however, two subcategories are evident. First, behavioral modification is the administration of positive reinforcement when an appropriate behavior is exhibited by a person. For example, when a youth offender completes a classroom exercise without engaging in disruptive behaviors, such as talking out of turn, then the instructor will provide the youth with a reward, such as a favored activity. Essentially, reinforcement is meant to draw youths toward appropriate behaviors by rewarding them (Pearson, Lipton, Cleland, & Yee, 2002). The second subcategory is cognitive behavioral treatments. Cognitive behavior treatments are those interventions that target behavioral processes and lead to changes in a ways of thinking (Pearson, Lipton, Cleland, & Yee, 2002). Social skills training, problem-solving education, and role modeling are all forms of cognitive behavioral treatments. Cognitive behavioral treatments can be coupled with other forms of treatment to enhance the range of interventions offered to juvenile offenders. For example, practitioners can include cognitive-behavioral treatments with family therapies to bring about changes in a youth's and family's functioning.

In their meta-analysis examining the effects of cognitive-behavioral therapy (CBT) programs for offenders, Landenberger and Lipsey (2005) found CBT to be equally effective with both adult and juvenile offenders. CBT was especially useful in reducing recidivism in high-risk offenders and was effective across secure and community settings. Two particular facets of CBT, the anger control and interpersonal problem-solving components, were associated with much larger effect sizes than were victim impact and behavior modification components. Other meta-analyses have found similar support for cognitive-behavioral interventions with juvenile offenders (Wilson, Bouffard, & MacKenzie, 2005), with some studies citing particular support for cognitive-behavioral rather than purely behavior modification treatment (Pearson, Lipton, Cleland, & Yee, 2002).

In short, TYC should consider adopting CBT approaches as part of the core treatment package.

Recommendation #2.24

Engage families in treatment. It is a truism that families should play a critical role in a juvenile offender's treatment. Research has demonstrated that involving families in the treatment of young offenders decreases the likelihood of further criminal behavior and reduces adolescent incarceration rates. In order to systematically analyze the literature on the effects of including family treatment to services for young offenders, Latimer (2001) conducted a meta-analysis with 35 experimental research studies. Compared to young offender programs that do not include family involvement, Latimer found that family intervention treatment significantly reduces the recidivism rate of young offenders.

There are many forms of family therapy from which to choose. Austin, Macgowan, and Wagner (2005) conducted a rigorous evaluation of family-based interventions for adolescent substance abuse populations. The purpose of the systematic review was to examine the level of efficacy and effectiveness of the most current family-based interventions. Austin and his colleagues found that two family-based interventions in particular were the most effective among the family-based interventions: Multidimensional Family Therapy and Brief Strategic Family Therapy (BSFT). We briefly summarize the latter below.

Brief Strategic Family Therapy. BSFT was developed in response to an increase in Hispanic adolescent drug use in the 1970's (Robbins et al., 2003), and has since become the primary model used to work with Hispanic families with behavior problem youth, including alcohol and other drugs (AOD). BSFT is based on three central constructs: systems, structure/patterns, and strategy. BSFT proponents believe that a family is a system comprised of individuals whose behaviors affect other family members. Structure and patterns refer to the set of repetitive patterns of interactions that are idiosyncratic to a family. A maladaptive family structure contributes to behavior problems such as conduct disorder and AOD use. Strategy is the third central construct on which BSFT is based. Therapists that adhere to BSFT use family interventions that are practical, problem-focused, and deliberate, and they move the family toward desired objectives (Robbins et al., 2003). Therapy sessions, which involve the entire family, are generally once a week for 8-12 weeks and last between an hour and an hour and a half.

Robbins et al. (2003) highlight three key assumptions to BSFT: (1) changing the family is the most effective way of changing an individual; (2) changing an individual and then returning him or her to a detrimental or negative environment does not allow the individual changes to remain in place; and (3) changes in one central or powerful individual can result in changes in the rest of his or her family.

SECURITY

Recommendation #2.25

Maintain a safe place for youth that embraces a non-violent approach. The classification system needs to address the security and safety of the juveniles while confined in TYC. To this aim, decisions for housing juveniles need to include, among other things, the age and vulnerability of the juvenile. Factors increasing a juvenile's vulnerability to assault include age, physical size, feminine appearance or demeanor (in a male), developmental disabilities, sexual identity, and commission of certain sexual offenses. To assure that the levels of disciplinary (and especially violent) acts are kept to a minimum, monitoring of assault offenses at the dorm, facility and agency level must be maintained. Superintendents of facilities must use the information to identify trouble spots, and move aggressive juveniles to more secure settings. Juveniles who have been targeted or who are vulnerable should be moved to safer environments, but should not be placed in highly restrictive settings except in unusual circumstances. Any juvenile who has complained of threats or assaults against him or her should be immediately separated from the juveniles against whom he or she has complained. Agency administrators must use this information to assure that institutional administrators are monitoring the level of violence occurring in their facilities and are taking proper action.

Recommendation #2.26

Develop goals to carefully ration, supervise, and document the use of seclusion, restraints, chemical control agents, and the use of force generally. There is convincing evidence that lowering the size of living units and enriching staff resources at facilities like TYC can reduce violence within the facilities and promote better rehabilitative outcomes. Lowering the size of living units to no more than 50 wards has been shown to substantially improve correctional management and advance treatment goals. This research has been influential for the design of juvenile correctional facilities across the nation, and was important to establishing professional standards (e.g., ACA standards) on the appropriate size of living units.

At root, the new TYC executive leadership at Central Office in Austin needs to foster a "new organizational culture" that does not accept ward violence or staff use of force. Organizational culture change is aided by a new clarity of policy and procedure, but this must be strongly reinforced by ongoing training, as well as daily reaffirmation of the values of the new culture. It is admittedly very difficult for Central Office staff to effectively control the behavior of staff who work in institutions that are hundreds of miles from Austin. It is hard enough for superintendents to control the behavior of staff in their own institutions, especially in the evenings and hours of lower staffing. There is no substitute for continuous and regular communications of organizational values and expectations. There must also be opportunities for staff to learn and participate in the new culture.

The TYC executive leadership has recently been traveling around the state to visit each TYC facility. We strongly encourage this pattern to continue. Frequent visits by Central Office staff to each of the facilities is a must. Instituting a very intensive schedule of routine facility visits could be a crucial step to building and strengthening the hold of a new TYC organizational culture throughout the entire system.

COST-EFFECTIVENESS

Recommendation #2.27

Evaluate cost-effectiveness of the TYC system and make decisions using the "best use of resources" principle. In financial terms, this means identifying a range of policy and treatment choices that replace lower rate-of-return investments with strategies that produce higher rates of return on the taxpayer's dollar (see Exhibit 2, as well as recommendations 2.10, 2.11, and 2.12).

MANAGEMENT

Recommendation #2.28

Ensure that the staff are an appropriately educated workforce who are youth-focused and strength-based in their approach. Properly equip all TYC employees with sufficient education, training and credentials. In keeping with the shifting demographics underscored in the executive summary at the beginning of this report (i.e., with a current TYC population of 22% Anglo, 44% Hispanic, and 34% African American), it is also essential that the executive leadership team of TYC is representative of the Hispanic and African American youth being treated.

This recommendation carries with it broader implications for health and mental health workforce development in the State of Texas. According to independent and recent reports by the Hogg Foundation for Mental Health and the Texas Health Care Policy Council, there are shortages across the majority of the health-related and helping professions, particularly in rural and under served urban areas of Texas. This critical issue requires sustained attention and strategic planning.

Recommendation #2.29
Properly screen applicants for jobs, but do not automatically eliminate ex-offenders. Decisions about whether to retain or fire ex-felons or ex-misdemeanants should be made on a case-by-case basis, and should include consideration of the type of pre-existing offense and the amount of time lapsed since the offense was committed.

Recommendation #2.30
Establish and maintain an adequate youth-to-staff ratio using national best practice standards, aiming for a 1:10 ratio.

There is convincing evidence that lowering the size of living units and enriching staff resources at facilities like TYC can reduce violence within the facilities and promote better rehabilitative outcomes.

Factors increasing a juvenile's vulnerability to assault include age, physical size, feminine appearance or demeanor (in a male), developmental disabilities, sexual identity, and commission of certain sexual offenses.

III. AFTER

WHAT IS THE PROBLEM?

There are several notable challenges related to the aftercare of youth released from TYC, including extended lengths of stay, misallocated and insufficient aftercare services, and a deteriorating "failure-based" parole system. Regarding extended lengths of stay in TYC, research shows that more time incarcerated is associated with higher recidivism rates. Furthermore, along with increasing the chances of recidivating, extending the length of stay for youth is very expensive, costing $60,000 per year for each youth.

Research indicates that proper aftercare provides the most utility per dollar spent and decreases recidivism rates. Despite the likelihood that aftercare services will decrease recidivism, the Task Force has identified several corresponding challenges in the Texas juvenile justice system: while TYC has specialized caseloads serving certain groups of offenders (females, sex offenders, VIO A offenders, determinate sentence offenders, and youth with a high level of mental health needs) in specific geographic regions (Austin, Dallas, Ft. Worth, Houston, Harlingen, and San Antonio), the capacity for specialized caseloads needs to be expanded; transitional planning could be enhanced with additional resources; there are no alternative reporting sites; TYC's day treatment programs have been eliminated; there are insufficient intermediate restriction sanction beds and independent living beds; and TYC does not provide aftercare risk-assessment (a parole risk-assessment instrument has been designed, but not implemented).

The "failure-based parole system" is deteriorating. Parole officers are mainly charged with surveillance, which is not conducive to the goal of re-entry. The parole officers are hard-working individuals committed to youth. These shortcomings are system-based, and should not be placed on the shoulders of the parole officers. Considering that parole officers generally have caseloads anywhere from 35 to 45 youth, they should be applauded for the successful outcomes that they do achieve with youth offenders.

It is vital that the juvenile justice system in Texas creates a system of accountability and improves collaborative work between probation and other agencies that service similar populations. It is in this spirit that the following recommendations are made.

RECOMMENDATIONS

Recommendation #3.1
Emphasize a community reentry model upon *entry to* TYC. To this end, successful reentry into the community should become the central theme of a youth's entire stay within the TYC system. From the moment of the youth's arrival *to* TYC, an individualized service plan must be constructed that outlines the timeline for his/her release into the community. Each youth should also have a plan for aftercare services upon release from TYC. The aftercare process should focus on youth learning to live and be successful with their family and within their community.

From the moment of the youth's arrival *to* TYC, an individualized service plan must be constructed that outlines the timeline for his/her release into the community.

Recommendation #3.2
Reduce lengths of stay at TYC. All steps to reduce the length of stay at TYC should be undertaken, and all aspects that lengthen stay should be scrutinized. More intensive and individualized treatment services should be implemented at TYC to decrease the length of stay. Moreover, the state should shorten or eliminate time-adds and shorten minimum length of stay benchmarks.

Recommendation #3.3
Establish a detailed, comprehensive, individualized plan 2 to 3 months in advance to seamlessly transition the youth from the TYC facility. The plan must address community, family, education, special needs, and health care. The length of aftercare should be based upon meeting individualized benchmark behaviors established by the treatment plan and built with the input of all invested parties.

Recommendation #3.4
Use Community Resource Coordination Groups (CRCGs) to facilitate transition planning. CRCGs, which were created by the 70th Texas Legislature in 1987, and reauthorized again through the 77th Legislature, have as their primary purpose to establish a system of interagency coordination of services to children and youth and their families (and now adults) who often "fall through the cracks" due to having complex needs that require coordination across multiple agencies. Child or youth- serving CRCGs are available to all 254 Texas counties, although adult-serving CRCGs are still being implemented around the state. While there is one CRCG model with guiding principles, each local CRCG is customized according to the resources within that community and the creativity of the members that serve on the group. The strength of this flexible network is evidenced by a number of CRCGs serving as a catalyst in developing a stronger systems-of-care that incorporates a wraparound services delivery approach for a youth and his or her family. Thus, these existing provider networks can be tapped to help divert youth from a restrictive juvenile justice settings or to re-integrate youth back into their community. Currently there are over 160 local CRCGs that include child and youth-serving CRCGs, adult-serving groups (CRCGAs), or a combined group that serves any age of individual and families (CRCGF). Of note, there is no dedicated state funding directed to the operation of local CRCGs, therefore, the success of this interagency process is contingent upon the leadership

and innovation of the collective membership. According to 2006 data from the State Office of CRCGs, the highest rates of referrals into local CRCGs statewide are independent school districts followed by local juvenile probation departments. Thus, it is conceivable that CRCGs could also be used on the front-end to amplify diversion efforts.

Recommendation #3.5

Use a Structured Decision Making (SDM) approach to transition and re-integration. Structured Decision Making® (SDM) is an assessment, classification, and case management model designed to help agencies reduce recidivism among youth referred to the juvenile justice system (see Table 8). An SDM approach to transition can help correctional agencies maximize the use of limited resources and ensure public safety by tailoring transition efforts to different sub-groups in the correctional population. Factors to consider in transition and re-integration strategies include the youth's level of risk, treatment needs, length of stay in TYC, and the strength of the youth's community support system.

Table 8. Model Transition Process for Youth Completing Placement in TYC[14]

Risk of Offending	**Length of Stay**		
	Less than 6 months	**6 to 12 months**	**More than 12 months**
Low	1. ISP: 30 days 2. Reassess risk and supervise accordingly	1. ISP: 60 days 2. Reassess risk and supervise accordingly	1. Day Treatment: 30 days 2. ISP: 30 days 3. Reassess risk and supervise accordingly
Moderate	1. ISP: 30 days 2. Reassess risk and supervise accordingly	1. Day treatment: 30 days 2 .ISP: 30 days 3. Reassess risk and supervise accordingly	1. Transition facility: 30 days 2. ISP: 30 days 3. Reassess risk and supervise accordingly
High	1. Day treatment: 30 days 2. ISP: 60 days 3. Reassess risk and supervise accordingly	1. Transition facility: 30 days 2. ISP: 60 days 3. Reassess risk and supervise accordingly	1. Transition facility: 30 days 2. ISP: 60 days 3. Reassess risk and supervise accordingly
Very High	1. Day treatment: 60-90 days 2. ISP: 90 days 3. Reassess risk and supervise accordingly	1. Transition facility: 30 days 2. Day treatment: 30-60 3. ISP: 90 days 4. Reassess risk and supervise accordingly	1. Transition facility: 60 days 2. Day treatment: 30-60 days 3. ISP: 90 days 4. Reassess risk and supervise accordingly

[14] Source: National Council on Crime and Delinquency (NCCD) (2007): *Reforming juvenile justice SDM components: Youth transition and community re-integration protocols.* Oakland, CA: NCCD.

The higher the risk level, and the greater the length of stay in TYC, the greater the need for a gradual and extended step-down process. For example, using the SDM transition process outlined in Table 5, a youth who has been incarcerated for less than 6 months but who is deemed at high-risk of re-offending would receive day treatment for 30 days, Intensive Supervision Probation (ISP) for 60 days, followed by a reassessment of risk and supervision as needed.

Recommendation #3.6
Shift from a Parole Model to a Local Boards (or Reentry) Model of aftercare. Money saved on incarceration should then be re-allocated to the county level so that local organizations can offer aftercare services needed by youth. Local boards of community stakeholders should determine and submit for TYC's approval the necessary budget for community-based services. TYC should then develop an RFP process to contract for aftercare services from probation departments, individual providers, or nonprofit organizations. The community-based model will enable the shift from "surveillance and control" to "services and success."

Recommendation #3.7
Encourage the 81st Texas Legislature to reconsider passing a mental health parity bill that would require health plans to cover all mental illnesses on equal terms with physical illness. Texas is a "partial parity" state. While health plans must provide coverage for certain specified illnesses like schizophrenia, plans do not have to cover many mental disorders, such as eating disorders. Parity is one building block toward a system where every youth can access the mental health services he or she needs.

Recommendation #3.8
Create a system of accountability. Evidence-based practices should be infused within TYC facilities, but also incorporated into family- and community-based care. This may require an assessment of service delivery gaps. The current institutional culture must be diverted towards a new reentry model via proper financial incentives.

Recommendation #3.9
Promote a strength-based rather than a failure-based model of aftercare. Such a shift can be accomplished, in part, by replacing traditional parole with aftercare services, and distributing these aftercare services to community-based entities. These community-based providers (e.g., nonprofit and faith-based organizations, probation departments) should be allowed to subcontract in remote areas of the state with mentors, coaches, teachers, or churches to provide parole services. In this proposed system, parole officers would be responsible for brokering and monitoring time-limited aftercare services for youth to ensure that services are evidence-based, strength-based, client-centered, family-focused, gender-sensitive, disability-responsive, developmentally-congruent, and culturally-grounded.

Recommendation #3.10
Assess and monitor a youth's readiness to change his or her behavior, and tailor aftercare services accordingly. A youth's readiness to change, or stage-of-change, is in keeping with a client-centered approach to service delivery. Adopting aftercare strategies that are congruent with a stage-of-change model will help ensure that youth are only re-incarcerated for violent and serious offenses (see Exhibit 7 and Figure 4).

Exhibit 7. Stages of Developing and Maintaining Change with Individuals, Families, Organizations, and Communities in an Ecological Context (IFOCEC) Model

Youth present with different levels of readiness for change. Some are ready to fully engage in treatment, while others adamantly deny that there is anything wrong with the way they are living. Many juvenile offenders, at least initially, fall into the latter category. The stages-of-change model takes this into consideration when planning and delivering services.

As shown in Figure 4, the stages-of-change model can be expanded beyond the individual to examine readiness for change among families, organizations, and communities that may be the targets of change. Just as some juvenile offenders are more ready to change than others, organizations and communities will have differential level of readiness to change regarding how they deal with juvenile delinquency. This expanded model is named the Individuals, Families, Organizations and Communities in an Ecological Context (IFOCEC) Model.

The IFOCEC Model focuses on how individuals and populations adapt and maintain behavioral change. The success of behavior change lies in proactively applying stage-matched interventions across multiple systems, which will increase participation, retention, and progress, and impact change rates in entire populations at risk for unhealthy behaviors - in this case, juvenile offenders.

The IFOCEC Model posits six stages of change: 1) *Precontemplation*, in which there is no intention or motivation to change one's behavior; 2) *Contemplation*, in which there is awareness of a problem and a desire to overcome it, but no commitment to take the actions necessary to accomplish change; 3) *Preparation*, involving a decision to take action sometime in the near future, but without a specific plan for accomplishing this goal; 4) *Action,* in which the individual makes changes in behavior and/or lifestyle and sustains those from one day to six months; 5) *Maintenance*, involving activities necessary to maintain change and avoid relapse; and 6) *Evaluation,* focusing on assessing results and obtaining feedback. Individuals who prematurely terminate treatment are mostly in the precontemplation stage, while those who remain consistent in treatment are in the maintenance stage, and those who terminate appropriately are typically in the action stage.

In addition, though this model has been used to describe changing undesirable behaviors like juvenile delinquency and drug use, we propose that it can also be thought of in terms of a strength perspective to identify protective factors in preventing and mitigating delinquent behavior. For example, an adolescent may never seriously contemplate adopting drug use behaviors because of micro influences (such as family support and supervision), mezzo influences (such as community youth activities and church and cultural activities), and macro influences (such as respect for laws punishing drug use).

Note that the IFOCEC model in Figure 4 is presented using spirals. Clients do not simply pass through these stages in a linear fashion. A juvenile offender that has successfully completed one treatment program may relapse or reoffend, and revisit an earlier stage (e.g., slipping from the action stage to the contemplation stage). Anyone who has ever tried to quit smoking or lose weight can attest to the reality of this spiral effect. Likewise, aftercare planning should account for this spiral effect, as should corresponding decisions about parole revocation and re-incarceration of juvenile offenders. Emphasizing a youth's readiness for change, and matching services accordingly to maximize the likelihood for change, is congruent with a rehabilitative juvenile justice framework.

A treatment approach called *Node-Link Mapping* is particularly useful to enhance treatment readiness. Simpson and his colleagues (Pitre, Dansereau, Newbern, & Simpson, 1998; Simpson, Chatham, & Joe, 1993; Simpson, Dansereau, & Joe, 1997) at Texas Christian University have developed a series of treatment readiness interventions as part of the NIDA-supported CETOP (Cognitive Enhancements for the Treatment of Probationers) Project. These interventions are designed specifically for use with offenders early in the treatment process (precontemplation or contemplation), and can be used in groups of up to 35 participants.

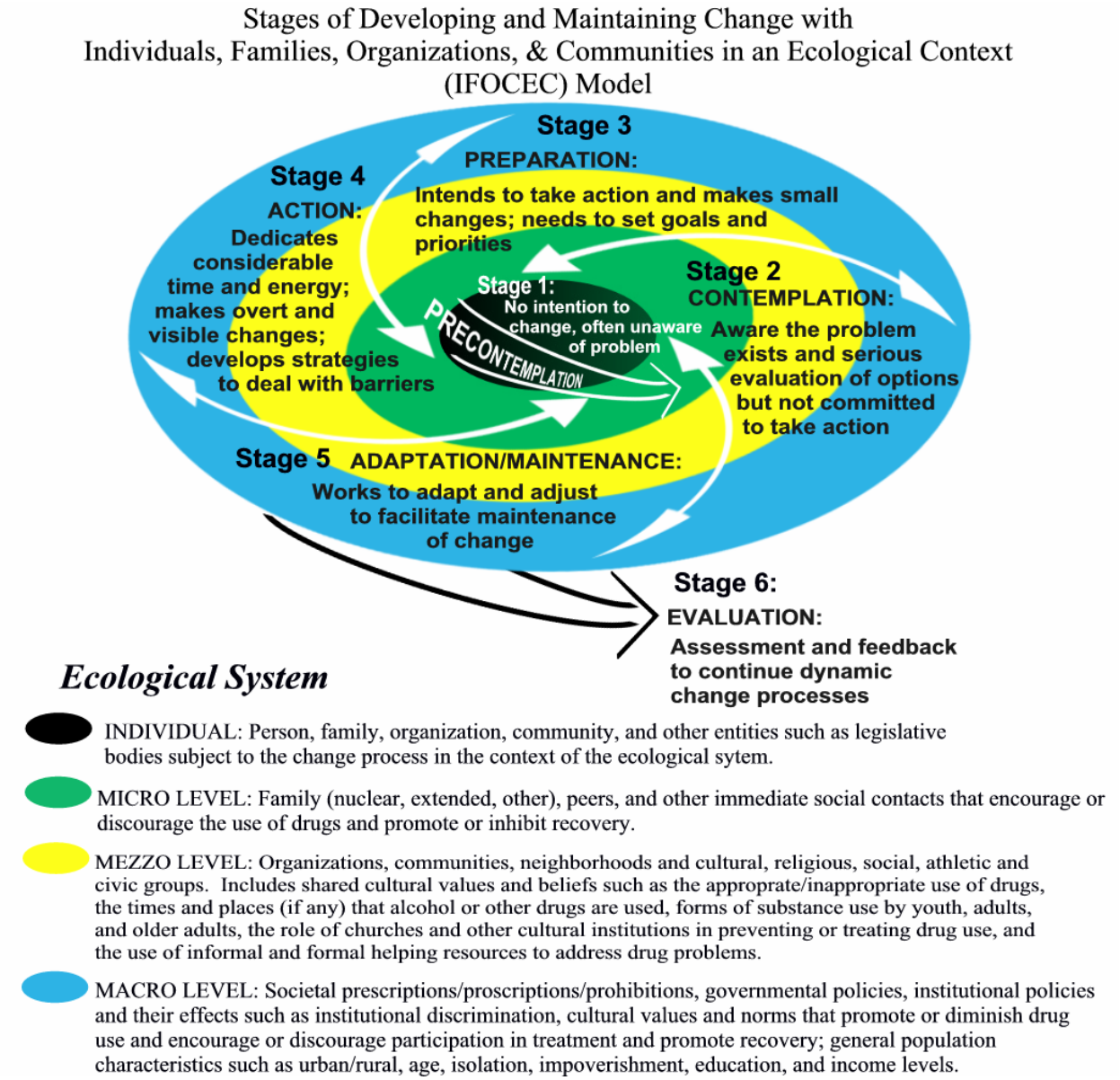
Essentially, node-link mapping is a visualization tool, in which elements of ideas, feelings, actions or knowledge contained within "nodes" (circles, squares) are connected to each other by "links" (lines) that are named to specify relationships between the nodes. These maps are usually drawn by practitioners in collaboration with their clients during group or individual sessions.

Node-link mapping has produced modest positive treatment effects across studies. (Recall that node-link mapping was listed as en evidence-based treatment for substance-abusing adolescents in Exhibit XX.) Mapping appears to increase counseling efficiency, help clients focus their attention, facilitate the development of the therapeutic relationship, and increase counseling efficiency (cf. Czuchry, Dansereau, Dees, & Simpson, 1995; Dansereau, Joe, & Simpson, 1995; Pitre, Dansereau, & Simpson, 1997). An examination by client subgroups indicates that the following types of individuals benefit the most strongly from mapping-enhanced counseling: clients with attention difficulties (Czuchry, Dansereau, Dees, & Simpson, 1995; Dansereau, Joe, & Simpson, 1995); African American and Mexican American clients (Dansereau, Joe, Dees, & Simpson, 1996); and clients who do not have a high school degree or GED certificate (Pitre, Dansereau, & Joe, 1996) (cited in Pitro, Dansereau, & Simpson, 1997).

Treatment Readiness Manuals are available through Lighthouse Institute, which is a part of the Chestnut Health Systems, for a charge of $15 to $20 per manual (see more information at http://www.chestnut.org). The manuals are also available for downloading from the website of the Institute of Behavioral Research (IBR) of the Texas Christian University (TCU) (http://www.ibr.tcu.edu), where Simpson and his colleagues are based.

Figure 4:

Individuals, Families, Organizations & Communities in an Ecological Context (IFOCEC) Model[15]



[15] The IFOCEC Model was developed by faculty (Dr. Clayton Shorkey and Dr. Diana M. DiNitto) and a former graduate student (Ryan Koch) at The University of Texas at Austin, School of Social Work. Barber (1995) initially integrated the ecological meta-theory with the Transtheoretical Model (TTM) and Stages-of-Change Model developed by Prochaska, DiClemente, and Norcross (1992), upon which the IFOCEC Model is based.

CONCLUSION: A NEW REFORM MOVEMENT?

The juvenile justice system in Texas is at a crossroad. We are facing a critical turning point, which presents a unique opportunity to shape Texas history. More often than not, reform movements are triggered by high-profile cases of abuse or neglect, or critical reports from outside entities such as the media. In recent years, there have been many such high-profile cases and critical reports: Nathaniel Abraham, Lionel Tate, Columbine, and Jonesboro.

In Missouri, a reform movement was launched in the early 1970s following a federal report critical of one of the state's large training schools. Louisiana's reform movement was launched through state legislation and the involvement of the Annie E. Casey foundation in 2003, in the wake of exposes of rampant violence in facilities, lawsuits, and the death of an incarcerated child. After a major lawsuit and years of criticism for harsh, violent, neglectful conditions in California Youth Authority facilities, including the widespread practice of placing youth in small cages while they attended counseling sessions and school, the California juvenile justice system announced reform plans. In early 2005, the California Youth Authority issued a statement announcing that "The California Youth Authority is completely broken and can't be fixed."

It has been suggested by many that the same holds true for the Texas juvenile justice system. The leaders, citizens, and advocates of Texas no doubt have the resolve to reform the state's juvenile justice system. In fact, this reform movement has already started.

Collectively, the recommendations and strategies laid out in the Before, During, and After sections of this report may well enable the State of Texas to fully realize this reform movement already underway, and thus lower its juvenile crime rate, reduce the victimization of citizens, more efficiently and effectively spend its pecuniary resources, and enable these youth to be productive contributors to the State of Texas.

The leaders, citizens, and advocates of Texas no doubt have the resolve to reform the state's juvenile justice system. In fact, this reform movement has already started.

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