



STATEWIDE TECHNICAL ASSISTANCE PROJECT: DEVELOPING STATEWIDE TREATMENT STANDARDS FOR JUVENILE DRUG COURTS IN NORTH DAKOTA

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Abstract

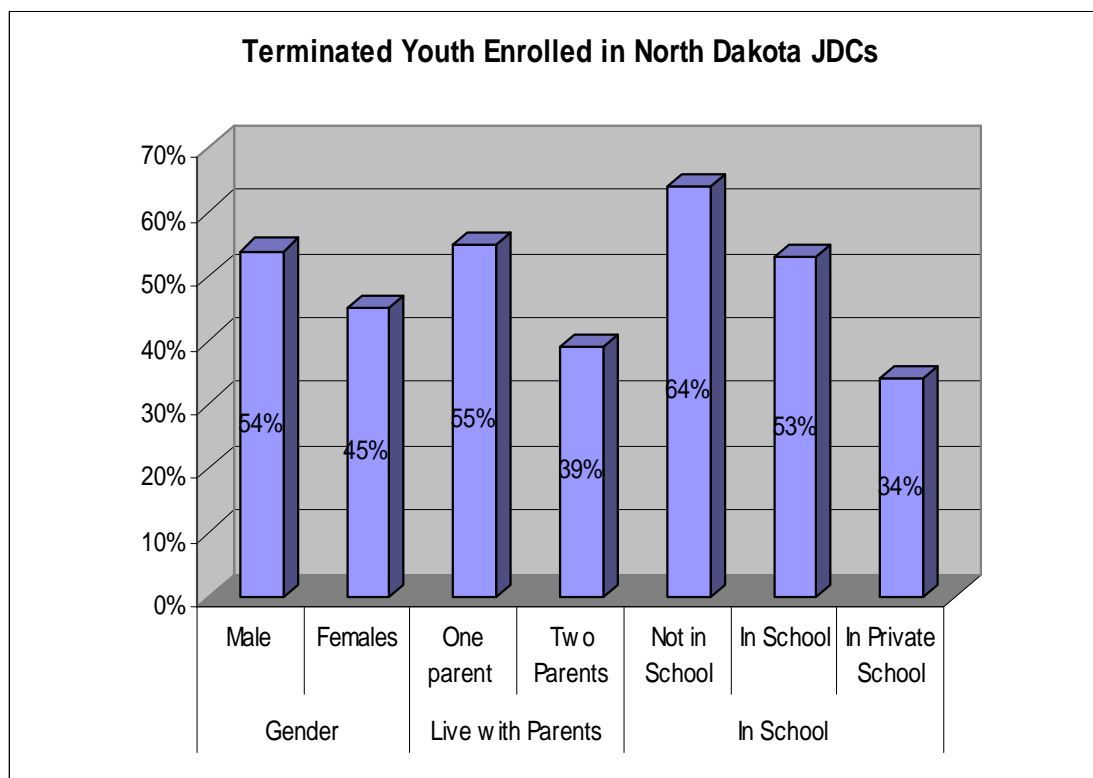
This Bulletin describes the experience of working with five drug court teams (four operational and one planning/implementation team) in North Dakota to develop statewide treatment standards for its juvenile drug courts. The experience included two consensus-building meetings that utilized a social validation approach. During the first meeting, participants were exposed to three critical areas: elements of an effective juvenile drug court as suggested by research literature; elements of an effective substance abuse treatment program and the National Institute on Drug Abuse (NIDA) 13 suggested principles for an evidence-based substance abuse treatment program; and Multisystemic Therapy (MST) enhanced with Contingency Management (CM) as a model of an evidence-based substance abuse treatment that has obtained favorable outcomes in the context of a juvenile drug court setting. After critical area presentations, the larger group broke into individual drug court groups to determine whether the covered elements and principles would be appropriate for their drug court. The larger group then reconvened to reach agreement on those elements that would serve as statewide standards for the North Dakota Juvenile Drug Court. The larger group agreed upon 19 statewide treatment standards for juvenile drug courts. The second meeting focused on each court's assignment to produce a document indicating how they planned to achieve the 19 statewide treatment standards agreed upon during the first meeting. If an individual court already had certain statewide treatment standards, then each court indicated how it would sustain its current achievements. We believe that we were successful in North Dakota and that this model could be replicated successfully in other states.

Reasons for the Project

Unfavorable differential treatment outcomes related to recidivism for one of North Dakota's Juvenile Drug Court (North Dakota's JDC) served as the primary impetus for this Statewide Technical Assistance Project. Such outcomes were surprising inasmuch as 80% of treatment for North Dakota's JDCs is provided by one agency: its state Human Services Centers. It was hypothesized that the treatment philosophy for the agency with unfavorable treatment outcomes might differ from the treatment philosophy of the other JDCs.

A secondary impetus for this project was results from an outcome evaluation (Thompson, 2006), which examined the outcomes of 96 youth who were enrolled in North Dakota JDCs. Alarming, 47 (49%) of the enrolled youth were terminated from JDC and failed to graduate. Simple statistics indicated that terminated youth were more likely to come from the previously mentioned agency with unfavorable outcomes (55%) than other agencies (48.5%). Additionally, terminated youth were more likely: males (54%) than females (45%); Native Americans (58%) than other ethnic

groups (e.g., 48% for Caucasian participants); to live with one parent (55%) than two parents (39%); to not be in school (64%) than in school (46%); to have dual diagnoses (53%) than a single diagnosis (34%); to be enrolled in public school (53%) than private school (34%); and to have slightly more juvenile court referrals (6.2) than youth who graduated from JDC (5.7).



To address the likelihood of different treatment philosophies between the aforementioned agency and other agencies and to reduce the alarming number of terminated youth, a plan was devised to bring all of North Dakota JDCs together at a central meeting site, and inviting a JDC and substance abuse treatment expert to assist North Dakota JDCs over the course of two-consensus building meetings to develop statewide treatment standards for North Dakota JDCs. Prior to describing these two-consensus building meetings, a brief description of treatment in North Dakota JDCs and the participants who attended the two consensus building meetings is provided.

Description of Treatment in North Dakota Juvenile Drug Courts

North Dakota JDCs' treatment consists of two phases: primary and aftercare (Thompson, 2006). Three levels of primary treatment are available depending upon the needs of JDC participants. Residential treatment is the most intense level and requires youth to attend a group session two times a day with a licensed addiction counselor. Intensive out patient treatment is the next most intense level and requires youth to attend sessions three times a week. Finally, low intensive out patient treatment is the least intense level of treatment and requires youth to attend one to two sessions a week. Primary treatment lasts from six to twelve weeks depending on the level of care. After completing primary treatment, youth are transitioned to aftercare treatment. Aftercare treatment consists of a weekly group or individual sessions for 1 to 1 ½ hours per session over the course of 16-20 weeks.

Participants

Twenty five representatives from the five North Dakota JDCs (i.e., Bismarck, Minot, Grand Forks, Fargo, and Williston) and state level officials attended the meeting. Participants included a North Dakota State Supreme Court Judge, a juvenile drug court state level representative, a state level funder, JDC judges, coordinators, treatment providers, probation officers, prosecutors, and defense counsel. ■

First Consensus Building Meeting

On November 15-16, 2007, the first consensus meeting occurred over two days in Bismarck, North Dakota. During the first consensus building meeting, elements of an effective juvenile drug court, elements and principles of an effective adolescent substance abuse treatment, and features of Multisystemic Therapy (MST) enhanced with Contingency Management (CM), which served as a model of an evidence-based substance abuse treatment that has obtained favorable outcomes in the context of a JDC setting, were explored.

Elements of an Effective Juvenile Drug Court

The second section of the first consensus building meetings consisted of the entire group discussing two important factors that could derail effective adolescent substance abuse treatment and could lead to youth and their families being terminated from JDC (i.e., engagement and group treatment), reviewing 13 principles that are suggested by the National Institute on Drug Abuse (NIDA) as effective principles for an effective adolescent substance abuse treatment program, and elements of an effective adolescent substance abuse program as suggested by research literature.

Regarding engagement, researchers have asserted that treatment cannot progress unless key members of a family (e.g., adult caregivers of a substance abusing youth) are actively participating and engaged in the treatment process as evidenced by helping to define problems, setting goals, and implementing interventions to achieve treatment goal (Cunningham & Henggeler, 1999). That is, brilliant interventions developed by a clinician are of little value unless a strong alliance between key family members and clinician exists. Research findings related to the importance of engagement, signs of high engagement, signs of low engagement, barriers to engagement, and strategies to overcome barriers to engagement were reviewed. For example, the following common barriers that JDCs may fail to fully address, which might account for youth and families being terminated prematurely from JDCs, were discussed: culturally and gender-specific programming needs; families' practical needs; adult caregivers' mental and primary health needs; adult caregivers feeling blamed by JDCs for their child's lack of progress; and adult caregivers not agreeing to treatment goals as indicated by adult caregivers not carrying out treatment recommendations. Overall, the group agreed that engagement is crucial to treatment success and that a lack of engagement is likely a contributing factor to substance abusing youth and their family being terminated from JDCs.

Although group treatment is one of the most common forms of treatment used by the North Dakota JDCs and can provide access to treatment to a large number of youth, it is potentially another factor that might contribute to youth and their families being terminated from JDCs. Researchers have indicated that placing youth in substance abuse treatment groups may actually have a harmful effect (Dishon, & McCord, 1999). As a result of being placed in group treatment, substance abusing youth can end up forming friendships and associations with other substance abusing youth, which can result in an increase in drug use and other criminal activities. Although the entire group understood the harm associated with group treatment, changing North Dakota JDCs' use of group treatment will require time and effort given their JDCs' current high level of group treatment use.

Next, the entire group reviewed principles of an effective adolescent substance abuse treatment program that were developed by NIDA. In 1999, NIDA conducted an extensive review of the treatment outcome research literature in the areas of adolescent and adult substance abuse. To enable organizations, institutions, and programs, such as JDCs, to select effective substance abuse treatment providers, NIDA published and disseminated 13 principles of effective treatments (NIDA, 1999). These principles include the following:

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to the multiple needs of the individual, not just his/her drug use.
4. An individual's treatment and service plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
6. Counseling and other behavioral therapies are critical components of an effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with co-existing mental health disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change the long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases, and counseling to help clients modify or change behaviors that place themselves or others at risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Next the entire group discussed more adolescent substance abuse treatment review literature that suggested elements of an effective adolescent substance abuse treatment program. Several reviews have documented an emerging evidence base of promising adolescent substance abuse treatments (e.g., Bukstein, 2000; Liddle & Dakof, 1995; McBride et al., 1999; NIDA, 1999; Stanton & Shadish, 1997; Waldron, 1997; Winters, 1999; Sheidow & Henggeler, in press).

For example, NIDA (1999) cited three models as scientifically based approaches to adolescent drug treatment, including MST (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), multidimensional family therapy (Liddle et al., 2001), and contingency management (Azrin et al., 1996). Similarly, Stanton and Shadish (1997) have highlighted the promise of several family-based approaches and favorable substance use outcomes have recently been observed for functional family therapy (Waldron, Slesnick, Turner, Brody, & Peterson, 2001). MST has also been extensively validated and cited as an effective treatment for youth with violent and serious criminal behavior and substance abuse (McBride, VanderWaal, VanBuren, & Terry, Y., 1999; Center for Substance Abuse Prevention, 2001; Surgeon General's report on youth violence [U.S. Department of Health and Human Services, 2001]).

Some key elements across MST and other models cited by researchers are emphases on: family treatment, individualizing treatment to address specific factors across various systems in the youth's ecology that give rise to the youth's drugs use, addressing multiple needs of families and other barriers that prevent treatment success, addressing cultural and gender needs, and prohibiting group treatment. ■

MST-CM as a Model of an Evidence-Based Substance Abuse Treatment

The third section of the first consensus building meeting involved the entire group discussing features of and research related to MST-CM, which served as a model of an evidence-based substance abuse treatment that has obtained favorable outcomes in the context of a JDC setting.

Features of MST. MST clinical procedures are detailed in two volumes (Henggeler & Borduin, 1990; Henggeler et al., 1998). MST is based on a social ecological model of behavior (Bronfenbrenner, 1979), which is highly consistent with findings on the correlates of adolescent substance use. An underlying assumption of MST is that adolescents' clinical problems develop within the context of their social ecology, which includes the family (immediate and extended family members), peers, school, and neighborhood. Within this framework, MST uses evidence-based intervention techniques (e.g., behavior therapy, cognitive behavioral therapy, pragmatic family therapy, and community reinforcement voucher approach) to address individual, family, and system factors that are associated with treatment goals, including substance use. These interventions, however, are implemented in a programmatic context that differs substantially from the contexts in which most mental health and substance abuse services are delivered. In addition to adhering to a social ecological conceptual framework, MST programs (a) have intensive quality assurance protocols to optimize treatment fidelity and outcomes (Henggeler & Schoenwald, 1999), (b) use a home-based model of service delivery to overcome barriers to service access, (c) focus interventions on building caregiver capacity to be effective with their youth (in contrast with a child-focused approach), and (d) assume accountability for engaging families in treatment and for achieving treatment goals.

Engagement and retention in treatment. Although treatment retention rates have traditionally been quite low in the area of drug treatment (Stark, 1992), MST retention in a study (Henggeler, Pickrel, & Brondino, 1999) with juvenile offenders who met formal diagnostic criteria for substance abuse (56%) or dependence (44%) was excellent. Fully 100% (58 of 58) of families in the MST condition were retained for at least two months of services, and 98% (57 of 58) were retained until treatment termination at approximately four months post referral.

Alcohol and drug use outcomes. Five randomized clinical trials of MST have evaluated alcohol and drug related outcomes. Substance-related outcomes were examined in two randomized trials of MST with violent and chronic juvenile offenders (Borduin et al., 1995; Henggeler, Melton, & Smith, 1992), and these substance-related findings were published in a single report (Henggeler et al., 1991). Findings in the first study (Henggeler et al., 1992) showed that MST significantly reduced adolescent reports of a combined index of alcohol and marijuana use at post treatment. In the second study (Borduin et al., 1995), substance-related arrests at a four-year follow-up were 4% in the MST condition versus 16% in the comparison condition. In a recent meta-analysis of family-based treatments of drug abuse (Stanton & Shadish, 1997), the MST effect sizes were among the highest of those reviewed.

In a third randomized clinical trial, the effectiveness and transportability of MST were examined with 118 juvenile offenders meeting DSM-III-R criteria for substance abuse or dependence and their families (Henggeler, Pickrel, & Brondino, 1999). MST reduced self-reported alcohol and marijuana use at post treatment but not at follow-up. The fourth randomized trial evaluated MST as an alternative to emergency psychiatric hospitalization (Henggeler, Rowland, et al., 1997, 1999); outcomes are currently being examined at six-month and 12-month follow-ups regarding biological and self-report indices of substance use.

Cost savings. Within the context of the randomized trial with substance abusing or dependent juvenile offenders (Henggeler, Pickrel, & Brondino, 1999), the incremental costs of MST were examined and related to observed reductions in days of incarceration, hospitalization, and residential treatment at approximately one year post referral (Schoenwald, Ward, Henggeler, Pickrel, & Patel, 1996). Results showed that the incremental costs of MST were nearly offset by the savings incurred as a result of reductions in days of out-of-home placement during the year.

Improving MST substance-related outcomes – Adapting the model. Although the MST outcomes for reducing substance use are generally favorable, the one trial that focused specifically on juvenile offenders who met diagnostic criteria for substance abuse or dependence did not evidence the types of outcomes that have typically been obtained in MST studies for other key outcomes (e.g., criminal activity). That is, biological indices of drug use did not confirm the self-reported reductions at post treatment, and the reductions in self-reported substance use demonstrated at post treatment were not maintained at follow-up.

In light of the high prevalence of substance abuse among populations of juvenile offenders and youths with serious emotional disturbance, an adaptation was sought to enhance the effectiveness of MST in treating substance abuse. In reviewing the literature, the work of Arzin and his colleagues (Arzin et al., 1996) and Higgins and Budney and their colleagues (Budney & Higgins, 1998; Budney, Higgins, Radonovich, & Novy, 2000; Higgins & Budney, 1993; Higgins, Wong, Badger, Ogden, & Dantona, 2000) seemed to present considerable potential to be integrated into MST. Higgins and Budney and their colleagues have developed a treatment for adult cocaine abuse, the Community Reinforcement Approach (CRA) that has strong empirical support and is theoretically compatible with the MST model. Key features of the CRA include (a) the consistent tracking of substance use through frequent urine screens, with vouchers used as rewards for clean drug screens; (b) functional analyses to identify triggers for drug use; (c) self management plans consisting of cognitive behavioral interventions that focus on addressing the emotional, behavioral, and environmental triggers to drug use for the individual; and (d) development of drug avoidance skills. Arzin and his colleagues have developed an effective CM program for adolescent substance abusers (Arzin et al., 1996) that rewards adolescents for non drug use. Hence, in contrast with traditional MST that has focused primarily on broader environmental risk and protective factors, the CRA and CM models focus very specifically on substance use per se.

The integration of MST and key components of the CRA and CM models (henceforth referred to as MST-CM) has been evaluated in one quasi-experimental study and a fifth randomized trial.

Neighborhood Solutions for Neighborhood Problems. This quasi-experimental neighborhood-level intervention project (Randall, Swenson & Henggeler, 1999) examined the degree to which a neighborhood can be empowered through the provision of evidence-based services to address problems identified by neighborhood residents. Neighborhood residents and stakeholders identified adolescent drug dealing, adolescent drug abuse, child prostitution, and school expulsion and suspension as the most pressing child- and family-related problems in the neighborhood. MST-CM was used to effectively to treat 13 substance abusing adolescents (Swenson, Henggeler, Taylor, & Addison, 2005). Results from weekly urine screens indicate that all the youth had negative drug screens for cocaine, and 85% of the youth had negative drug screens for cannabis at seven weeks post-treatment.

Drug court study. In the fifth randomized clinical trial that is most relevant to this report, the National Institute of Drug Abuse and National Institute of Alcohol Abuse and Alcoholism funded a randomized trial to determine whether the integration of an intensive evidenced-based treatment model (i.e., MST alone and MST-CM) enhances the possibly favorable outcomes of juvenile drug court (Henggeler et al., 2006). One hundred and sixty one juvenile offenders who met diagnostic criteria for substance abuse or dependence were randomly assigned to one of four groups: family court with local community substance abuse treatment, JDC with local community substance abuse treatment, JDC with MST, and JDC with MST-CM. One year assessment data on adolescent substance use, criminal behavior, and days in out-of-home-placement supported a pretreatment hypothesis that JDC with local community substance abuse treatment was more effective than family court with local community substance abuse treatment. The relative reductions in antisocial behavior, however, failed to translate into corresponding decreases in rearrest or incarceration, possibly due to the greatly increased surveillance of youth in JDC.

Regarding substance use, the results indicated that the use of evidence-based treatments within JDC significantly improved youth substance related outcomes. For example during the first four months of drug court participation 70% of urine screens in the JDC with local community substance abuse treatment group were positive for drug use. In comparison only 28% and 18% for JDC with MST and JDC with MST-CM, respectively, were positive for drug use. Follow-up analysis over the succeeding eight months showed similar results with JDC with local community substance abuse treatment, JDC with MST, and JDC with MST-CM conditions (45%, 7%, and 17% respectively). Overall, the findings support the viability of JDC and indicate that CM can accelerate substance-related treatment gains when integrated into MST protocols. ☐

Small Group Exercise

After reviewing the critical elements, the larger group broke into individual drug court groups to determine whether the covered elements, principles, and features of MST would be appropriate for their drug court. The larger group then reconvened to reach agreement on those critical elements, principles, and features of MST that would serve as statewide standards for North Dakota Juvenile Drug Court. Eighty percent agreement was the required as the cutoff point for an element, principle, or feature of MST to be considered a potential statewide standard. Below are the treatment standards along with definitions/descriptions of the standards upon which the North Dakota JDCs agreed.

North Dakota Juvenile Drug Courts Treatment Standards

1. Identification of substance abuse needs (assessment).
A standardized assessment tool is being used to determine if youth are meeting DSM criteria for substance abuse or dependency as part of their eligibility criteria for admission to Juvenile Drug Court.
2. Pre-Juvenile Drug Court (JDC) meeting occurs with entire drug court team.
The JDC team is meeting prior to JDC to review all cases.
3. JDC convened.
JDC is occurring weekly.
4. JDC team develops a comprehensive individualized treatment plan.
Individual plans are developed for each youth to address the specific reasons why the youth is using drugs. For example, one youth might be using drugs due to his or her association with negative peers. Thus, this youth's plan will focus, in part, on monitoring, supervision, and disrupting the youth's association with negative peers. Another youth might be using drugs to self-medicate his or her depression or anxiety. Thus, this youth's plan will, in part, focus on getting the youth on medication and medication compliance. The JDC team will avoid developing one size fit all type of treatment plans.
5. Collaboration with family to address youth needs.
The youth's adult caregivers are active participants in the development of the youth's treatment goals, implementation of treatment plans, and deliverer of rewards and punishments.
6. Evidence-based treatment is used.
Evidence-based treatments, such as Multisystemic Therapy, Multidimensional Family Therapy, and Contingency Management, are being used to address youth's drug use.
7. Mental and primary health care needs are addressed.
Comorbid mental health conditions and physical health conditions are being addressed.
8. JDC team monitors youth progress with a weekly staffing and random drug testing.
Youth progress is monitored during weekly JDC staff meetings, and random drug screens are being administered youth. The frequency of random drug screens is determined by type of drug(s) each youth uses.

9. Feedback is given to the judge at the hearing, and judge delivers rewards/sanctions

The JDC judge receives feedback from the JDC team on each youth's progress. The Judge delivers rewards and sanctions to youth during JDC. Efforts are made to empower the youth's adult caregivers by the Judge asking the youth's adult caregivers what the youth's reward or punishment should be given the youth's performance this week. Prior to court, the JDC team has prepped the youth adult caregivers to answer the judge's questions appropriately.

10. Frequency of court appearances decreases with favorable behavior changes.

As youth advance in drug court phases, the frequency of their appearances decreases.

11. Practical needs are addressed.

Practical needs are addressed.

12. Follow-up assessment is done.

Six, 12, or 18-month assessments on youth's drug use, rearrests, and placement are completed.

13. Continued care is addressed.

Youth who require additional outpatient services following JDC are referred to appropriate services. Whenever possible, JDC treatment providers will attend transitional meetings.

14. Specific and measurable program goals are used.

Outcome data related to drug use, graduation rates, rearrests, and placement are collected.

15. Ongoing state training occurs.

Ongoing JDC training needs are identified by JDC teams and state agencies and are addressed.

16. Group treatment is prohibited.

Group treatment is not used.

17. Culturally and gender-specific programming are part of the treatment.

For each youth, an assessment of cultural specific needs is conducted. For example, if a youth comes from a culture where it is considered inappropriate for an adult female caregiver to take the lead in disciplining a male youth, efforts will be made to find other adult male relatives to assist with disciplining the male youth. Individual assessment will also be conducted to determine specific gender related needs, and these needs will be addressed.

18. Caregiver is viewed as key to long-term success.

Because caregivers are the key to long-term success, caregivers will be included in the development of the youth's treatment goals, implementation of treatment plans, and deliver of rewards and punishments. Additionally, ongoing assessments of barriers that prevent caregivers from parenting effectively will be completed, and such barriers will be addressed.

19. Multiple issues addressed with family.

Family issues (e.g., parental mental health, poor monitoring and supervision, poor caregiver links with schools, negative peers and other siblings in the family offering a youth drugs, lack of prosocial activities, family practical needs) will be assessed and addressed.

In between the first and second consensus building meetings, North Dakota JDCs were mailed the 19 treatment standards upon which they agreed, and were instructed to produce a document indicating how they planned to achieve the 19 statewide treatment standards agreed upon during the first meeting. If an individual court already had certain statewide treatment standards, then each court indicated how it would sustain its current achievements. All four operational North Dakota JDCs completed the assignment. The one planning/implementation North Dakota JDC team was not required to complete the assignment but actively participated in both consensus building meetings. ☐

Second Consensus Building Meeting

On March 6-7, 2008, the entire group reconvened over two days in Bismarck, North Dakota to review documents developed by the four operational North Dakota JDCs that indicated how they planned to achieve the 19 statewide treatment standards agreed upon during the first meeting. As previously stated if an individual court already had certain statewide treatment standard, then the JDC indicated how it would sustain its current achievements. A total of 22 participants attended the second consensus building meeting. During the meeting, each of the four operational JDCs presented how they were meeting or were planning on meeting the previous agreed upon 19 standards. Following each individual JDC's presentation, the larger group commented on the individual JDC's presentation. After all individual JDC's presentations were concluded and discussed by the larger group, the JDC and substance abuse treatment expert summarized and discussed with the larger group North Dakota JDC standards that were currently being implemented in North Dakota JDCs to varying degrees and those standards that would require the North Dakota JDCs to further improve its current practices to implement.

Results of the Assignment and Presentations

The North Dakota JDCs reported that 12 of the previously mentioned 19 standards are being implemented. These 12 standards are listed below *(Please note that each standard is listed with the original number it had on the complete list of 19 standards)*.

North Dakota Juvenile Drug Courts Treatment Standards Currently Implemented

1. Identification of substance abuse needs (assessment).
A standardized assessment tool is being used to determine if youth are meeting DSM criteria for substance abuse or dependency as part of their eligibility criteria for admission to Juvenile Drug Court.
2. Pre-Juvenile Drug Court (JDC) meeting occurs with entire drug court team.
The JDC team is meeting prior to JDC to review all cases.
3. JDC convened.
JDC is occurring weekly.
7. Mental and primary health care needs are addressed.
Comorbid mental health conditions and physical health conditions are being addressed.
8. JDC team monitors youth progress with a weekly staffing and random drug testing.
Youth progress is monitored in weekly JDC staff meetings, and random drug screen are being administered youth. The frequency of random drug screens is determined by type of drug(s) each youth uses.
9. Feedback is given to the judge at the hearing, and judge delivers rewards/sanctions
The JDC judge receives feedback from the JDC team on each youth's progress. The Judge delivers rewards and sanctions to youth during JDC. Efforts are made to empower the youth's adult caregivers by the Judge asking the youth's adult caregivers what the youth's reward or punishment should be given the youth's performance this week. Prior to court, the JDC team has prepped the youth adult caregivers to answer the judge's questions appropriately.
10. Frequency of court appearances decreases with favorable behavior changes.
As youth advance in drug court phases, the frequency of their appearances decreases.
11. Practical needs are addressed.
Practical needs are addressed.
12. Follow-up assessment is done.
Six, 12, or 18-month assessments on youth's drug use, rearrests, and placement are completed.
13. Continued care is addressed.
Youth who require additional outpatient services following JDC are referred to appropriate services. Whenever possible, JDC treatment providers will attend transitional meetings.
14. Specific and measurable program goals are used.
Outcome data related to drug use, graduation rates, rearrests, and placement are collected.
15. Ongoing state training occurs.
Ongoing JDC training needs are identified by JDC teams and state agencies and are addressed.

North Dakota Juvenile Drug Courts Treatment Standards Yet to Be Fully Implemented

North Dakota JDCs indicated that 7 of the aforementioned 19 treatment standards are yet to be fully implemented. These 7 standards are listed below.

4. JDC team develops a comprehensive individualized treatment plan.

Individual plans are developed for each youth to address the specific reasons why the youth is using drugs. For example, one youth might be using drugs due to his or her association with negative peers. Thus, this youth's plan will focus, in part, on monitoring, supervision, and disrupting the youth's association with negative peers. Another youth might be using drugs to self-medicate his or her depression or anxiety. Thus, this youth's plan will, in part, focus on getting the youth on medication and medication compliance. The JDC team will avoid developing one size fit all type of treatment plans.

5. Collaboration with family to address youth needs.

The youth's adult caregivers are active participants in the development of the youth's treatment goals, implementation of treatment plans, and deliverer of rewards and punishments.

6. Evidence-based treatment is used.

Evidence-based treatments, such as Multisystemic Therapy, Multidimensional Family Therapy, and Contingency Management, are being used to address youth's drug use.

16. Group treatment is prohibited.

Group treatment is not used.

17. Culturally and gender-specific programming are part of the treatment.

For each youth, an assessment of cultural specific needs is conducted. For example, if a youth comes from a culture where it is considered inappropriate for an adult female caregiver to take the lead in disciplining a male youth, efforts will be made to find other adult male relatives to assist with disciplining the male youth. Individual assessment will also be conducted to determine specific gender related needs, and these needs will be addressed.

18. Caregiver is viewed as key to long-term success.

Because caregivers are the key to long-term success, caregivers will be included in the development of the youth's treatment goals, implementation of treatment plans, and deliver of rewards and punishments. Additionally, ongoing assessments of barriers that prevent caregivers from parenting effectively will be completed, and such barriers will be addressed.

19. Multiple issues addressed with family.

Family issues (e.g., parental mental health, poor monitoring and supervision, poor caregiver links with schools, negative peers and other siblings in the family offering a youth drugs, lack of prosocial activities, family practical needs) will be assessed and addressed.

Summary and Next Steps

A perusal of the standards that have been implemented and the standards that are yet to be implemented fully suggests that North Dakota JDCs are extremely strong in procedural elements of an effective JDC. However, North Dakota JDCs are not as strong in the area of elements of effective and evidence-based adolescent substance abuse treatment programs that are suggested in the research literature, such as family therapy focused treatments as opposed to group treatment. Given the tremendous growth that the North Dakota JDCs has achieved since the inception of their first JDC less than ten years ago, moving towards more evidence based treatments is extremely achievable. To this end, the 19 standards that North Dakota JDCs developed will be reviewed in subsequent state level meetings of North Dakota JDCs leadership to ensure that current standards that are being implemented will be maintained and to ensure that plans are being developed and implemented to assist North Dakota JDCs in achieving the remaining standards that are yet to be fully implemented. ■

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About the National Drug Court Training and Technical Assistance Initiative: Statewide Technical Assistance Project

Since 2002, the Bureau of Justice Assistance has awarded funds to the National Center for State Courts to provide technical assistance services to state-level agencies such as the Administrative Office of the Courts and the Alcohol and Drug Abuse Agency to:

1. Enhance the leadership of statewide drug court efforts;
2. Improve coordination and collaboration between the drug court agencies; and
3. Increase the likelihood of the institutionalization of drug courts into the mainstream of court operations.

Pursuant to these awards, the National Center for State Courts has provided technical assistance services to states that include:

1. On-site technical assistance;
2. Off-site technical assistance; and
3. A series of topical publications on integrating drug courts into mainstream court operations.

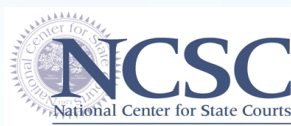
This Statewide Technical Assistance Bulletin is the seventh in the series of publications.

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