



**Report to the Legislature**

# **Chemical Dependency Disposition Alternative**

**Chapter 338, Laws of 1997, Section 27  
RCW 13.40.165 and 70.96A.520**

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Department of Social and Health Services  
Juvenile Rehabilitation Administration  
Division of Treatment and Intergovernmental Programs  
P.O. Box 45720  
Olympia, Washington 98504-5720  
(360) 902-8105  
Fax: (360) 902-8108

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## EXECUTIVE SUMMARY

The Chemical Dependency Disposition Alternative (CDDA) became effective July 1, 1998, (RCW 13.40.165). CDDA provides juvenile courts with a sentencing option for youth who abuse or are dependent on chemical substances, allowing judges to order youth into substance abuse treatment instead of confinement. The court may revoke the alternative or impose sanctions for youth who fail to meet the program requirements under RCW 13.40.165.

RCW 70.96A.520 requires that:

*“The department shall prioritize expenditures for treatment provided under RCW 13.40.165. The department shall provide funds for inpatient and outpatient treatment providers that are the most successful, using the standards developed by the University of Washington under section 27, Chapter 338, Laws of 1997.” In addition, section 28, Chapter 338, Laws of 1997 requires that “the department shall, not later than January 1 of each year, provide a report to the Governor and the Legislature on the success rates of programs funded under this section.”*

To comply with this legislation, JRA contracted with the University of Washington (UW) in 1999 to conduct an outcome evaluation to support JRA’s annual reports to the Governor and Legislature on CDDA success rates. The contract with the UW was completed in 2004.

The January 2004 CDDA report submitted by JRA to the Governor and Legislature presented the UW’s final evaluation of CDDA outcomes. The UW concluded that the CDDA program had the greatest impact on committable youth and recommended that to enhance the impact and effectiveness of CDDA:

1. Substance abuse treatment providers be required to adhere to the protocol for CDDA treatment services.
2. A method to monitor treatment providers’ adherence to CDDA guidelines for treatment services be established.
3. Additional fiscal resources be provided to the CDDA program to ensure that youth in CDDA receive needed family therapy services.
4. The CDDA Advisory Committee (Committee) be reconvened to address the above issues.
5. Additional study of committable youth in CDDA with a longer follow-up period be implemented.

In response to the UW’s recommendations, JRA developed an action plan which was included in the January 2004 report to the Legislature (see Attachment 1). In addition, JRA reconvened the Committee to identify evidence-based treatment interventions to enhance the quality of CDDA services across the state and increase involvement of families in CDDA treatment programs.

This is a transition report that summarizes the implementation activities for the CDDA program from 1998 to the present. The UW has completed its outcome evaluation as noted above and future CDDA reports submitted by JRA will continue to provide information on CDDA success rates.

## **CDDA Outcomes**

From July 1, 2003, through June 30, 2004, a total of 445 youth were placed on CDDA local sanction<sup>1</sup>. On July 1, 2003, there were approximately 424 CDDA local sanction youth remaining on supervision from the previous fiscal year. Out of the 860 local sanction youth served in FY 2004, 76 youth (9 percent) had their local sanction sentence revoked.

From July 1, 2003, through June 30, 2004, a total of 96 youth were placed on CDDA committable status<sup>2</sup>. On July 1, 2003, there were approximately 93 committable youth remaining on supervision from the previous fiscal year. Out of these 189 youth served in FY 2004, 62 (33 percent) had their committable sentence revoked and were sent to a JRA institution.

## **Conclusions**

Based on the UW recommendations, the Committee's next steps, and the FY 2004 completion data, JRA and the juvenile courts will continue to pursue a plan to introduce evidence-based family treatment into services provided under CDDA.

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<sup>1</sup> Locally sanctioned youth are youth eligible for 0-30 days in detention and up to 12 months of community supervision, but do not face the possibility of commitment to a JRA facility.

<sup>2</sup> Committable youth are defined as those youth eligible for 15-36 weeks of confinement in a JRA facility. The youth will receive supervised substance abuse treatment services and 12 months of community supervision as an alternative to JRA confinement.

## Background

On July 1, 1998, CDDA became effective providing juvenile courts with a sentencing option for youth who abuse or are dependent on chemical substances, allowing judges to order youth into substance abuse treatment instead of confinement. The court may revoke the alternative or impose sanctions for youth who fail to meet the program requirements under RCW 13.40.165.

RCW 70.96A.520 requires that:

*“The department shall prioritize expenditures for treatment provided under RCW 13.40.165. The department shall provide funds for inpatient and outpatient treatment providers that are the most successful, using the standards developed by the University of Washington under section 27, Chapter 338, Laws of 1997.” In addition, section 28, Chapter 338, Laws of 1997 requires that “the department shall, not later than January 1 of each year, provide a report to the Governor and the Legislature on the success rates of programs funded under this section.”*

To comply with this legislation, JRA contracted with the University of Washington (UW) in 1999 to conduct an outcome evaluation to support JRA’s annual reports to the Governor and Legislature on CDDA success rates.

The UW’s outcome evaluation compared recidivism, substance abuse, and other measures of success between CDDA-sanctioned treatment and standard probation services. Outcomes for youth in Drug Court were compared to similar youth on standard probation services. The outcome data report on an 18-month follow-up period. Youth were recruited for the evaluation between January 1999 and June 2001. A total of 403 youth from 8 counties were recruited and of those, 165 were placed in CDDA, 53 were placed in a Drug Court, and 185 were in neither CDDA nor Drug Court.

The January 2004 CDDA report submitted by JRA to the Governor and Legislature presented the UW’s final evaluation of the CDDA outcome data. The outcome evaluation showed that the CDDA program had the greatest impact on committable youth. Results revealed that over the 18-month study period, compared to youth receiving standard services, committable youth receiving CDDA:

- incurred fewer convictions;
- were less likely to be detained, and if detained, spent less time in detention;
- were more likely to be enrolled in school;
- were more likely to be working full-time;
- reported better family and social relationships; and
- reported fewer emotional difficulties.

Locally sanctioned youth completing CDDA also incurred significantly fewer convictions, were less likely to be detained, and if detained, spent less time in detention. However, there were not significant differences between locally sanctioned youth completing CDDA and those not in CDDA in other areas of functioning as listed above, unlike the outcomes in those areas for committable youth.

All youth in CDDA received significantly more substance abuse treatment services than youth receiving standard services. However, they did not receive all the treatment services specifically prescribed for youth in the CDDA program. Specifically, youth did not receive the prescribed degree of family services, case management, individual counseling, and urine drug screens. This lack of fidelity to the CDDA service model may, in part, explain why no significant differences in substance use over time were found between committable and locally sanctioned youth completing CDDA and those on standard services.

To enhance the impact and effectiveness of CDDA, the UW recommended that:

1. Substance abuse treatment providers be required to adhere to the protocol for CDDA treatment services.
2. A method to monitor treatment providers' adherence to CDDA guidelines for treatment services be established.
3. Additional fiscal resources be provided to the CDDA program to ensure that youth in CDDA receive needed family therapy services.
4. The CDDA Advisory Committee (Committee) be reconvened to address the above issues. The committee should include at a minimum key stakeholders from JRA, juvenile courts, the DSHS Division of Alcohol and Substance Abuse (DASA), experts on family treatments, and local treatment providers.
5. Additional study of committable youth in CDDA with a longer follow-up period be implemented.

In response to the UW's recommendations, JRA developed an action plan which was included in the January 2004 report to the Legislature (see Attachment 1). JRA reconvened the Committee in April 2004. The JRA Assistant Secretary requested the Committee assess the status of the CDDA program and develop strategies to address:

- Use of evidence-based drug and alcohol treatment interventions proven to attain positive outcomes and consider inclusion of them in CDDA;
- Identification of specific populations most likely to benefit from CDDA services;
- Inclusion of research-based family intervention in CDDA; and
- Development of adherence measures for substance abuse treatment providers delivering CDDA treatment services.

## **CDDA Advisory Committee**

In April 2004, JRA reconvened the Committee which included JRA, DASA, and the county juvenile courts originally involved in the CDDA Outcome Evaluation. The Committee decided that JRA, DASA, and the courts would partner with David Stewart, Ph.D., with the University of Washington to assist with the Committee's efforts to improve provision of the CDDA program. Dr. Stewart is an expert in addressing the intersection of juvenile justice programs, family therapy, and chemical dependency treatment.

With the assistance of Dr. Stewart and his colleagues, the Committee reviewed evidence-based interventions that would enhance CDDA services for youth and address the lack of family intervention in CDDA. The review of possible interventions included examining cost-benefit analyses, assessing the degree to which programs had been successfully disseminated in community settings, meeting with program developers, and matching client characteristics for similarity to CDDA youth.

After reviewing a list of possible interventions, the Committee agreed that Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT) exhibit the greatest potential to support and enhance the current CDDA effectiveness standards. Both programs have the potential to improve family services in CDDA. FFT in particular is favored strongly because it has an existing system of service provision throughout the state. FFT also has a strong quality assurance program to ensure model fidelity. In addition, the average cost per case for FFT is significantly less than MST (\$2,500 per youth for FFT vs. \$5,500 per youth for MST).

In addition, the Washington State Institute for Public Policy (WSIPP) in their January 2004 report, *Outcome Evaluation of Washington State's Research-Based Programs for Juvenile Offenders*, identified FFT as a program that cost effectively reduces recidivism among locally sanctioned youth in Washington.

The Committee has identified the following next steps to improve the effectiveness of the CDDA program.

1. Determine funding sources for CDDA program changes and research;
2. Identify methods for using evidence-based family treatment for chemically dependent and substance abusing adolescents; and
3. Study the effectiveness of CDDA services that include evidence-based family treatment.

The Committee will work with Dr. Stewart to examine potential funding sources and to design a method of service delivery. Three possible service delivery models include evidence-based family treatment provided in a sequential manner with CDDA services, family treatment provided parallel with drug and alcohol treatment services, or an integrated model where evidence-based family treatment and CDDA services work in collaboration. During 2005, the Committee plans to meet regularly and select a method(s) of service delivery and implement one or more of the models. The Committee has decided that any changes to service delivery must be

thoroughly researched to determine the impact of the change on recidivism and other key outcomes.

### **CDDA Outcomes from July 1, 2003 to June 30, 2004 (FY 2004)**

This is a transition report that summarizes the implementation activities for the CDDA program from 1998 to the present. The UW has completed its outcome evaluation as noted earlier in this report and future CDDA reports submitted by JRA will provide information on CDDA success rates.

The following section provides information the CDDA utilization and success rates for FY 2004.

#### **CDDA Utilization**

During FY 2004, a total of 445 youth were placed on CDDA local sanction. On July 1, 2003, there were approximately 424 CDDA local sanction youth remaining on supervision from FY 2003. Of the 869 local sanction youth served in FY 2004, 76 (9 percent) were revoked.

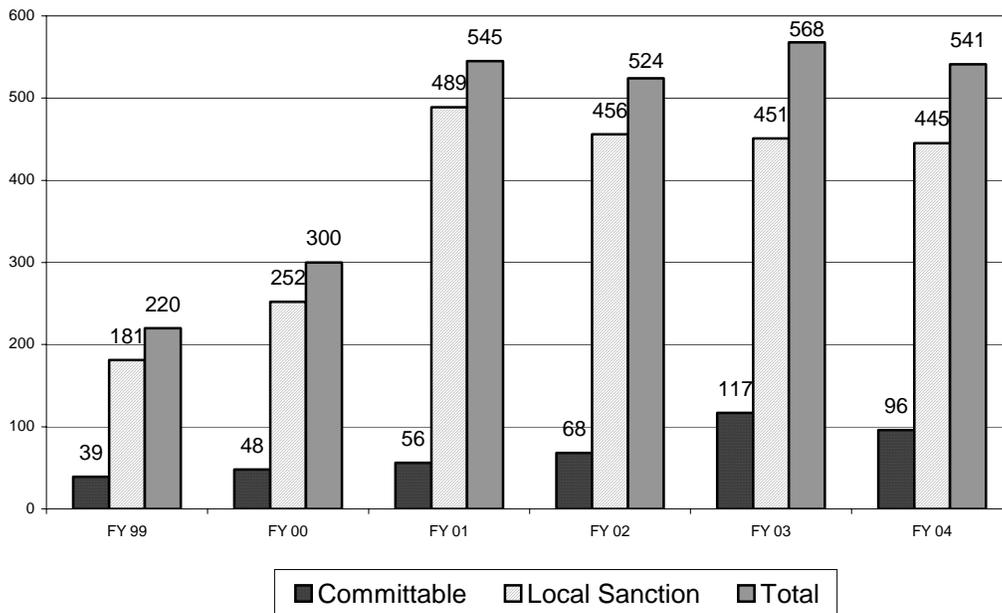
During FY 2004, a total of 96 youth were placed on CDDA committable status. On July 1, 2003, there were approximately 93 committable youth remaining on supervision from FY 2003. Of the 189 youth served in FY 2004, 62 (33 percent) had their disposition alternative revoked and were sent to a JRA institution.

In FY 2004, JRA and DASA prioritized expansion of treatment bed capacity throughout the state. The intent of this effort was to reduce the amount of time CDDA youth waited in detention for inpatient treatment. Therefore, it also reduced the length of waiting lists for CDDA inpatient services.

In FY 2004, JRA and DASA maximized CDDA committable treatment funds by contracting with additional programs. These additional programs used federal funds to match state funds, which increased the total available dollars for treatment. Through use of federal funds, an additional 4.5 treatment beds were added statewide, bringing the total CDDA beds to 12. By accessing additional federal funds, the juvenile courts expanded funding for treatment services for local sanction youth.

Chart 1, on page 9, shows CDDA utilization for both committable and locally sanctioned youth between 1999 and 2004. The chart includes data from JRA and covers all youth reported to be in CDDA programs.

**Chart 1: CDDA Utilization for  
Committable and Locally Sanctioned Youth**



During FY 2004, DASA provided training for all certified providers in the use of Dialectical Behavioral Therapy (DBT). All providers were encouraged to implement the use of this promising intervention in their program. Currently, several key CDDA inpatient treatment providers are using DBT in their treatment programs. No outcome study has been conducted on these programs. However, outpatient providers giving aftercare to these youth report a higher level of skill acquisition and a higher treatment completion rate. The information below is evidence of the impact of the changes.

## Treatment Completion Rates

- **Treatment Completion of CDDA Youth<sup>3</sup> Admitted to Publicly Funded Treatment Programs in Washington State (data as of October 26, 2004)<sup>4</sup>**

Table 1, on page 10, shows the treatment completion results for CDDA youth and is based on 288 youth admitted to, and discharged from, publicly funded substance abuse treatment programs between July 2003 and June 2004<sup>5</sup>.

<sup>3</sup> Youth are defined as below the age of 18.

<sup>4</sup> Data for this section was extracted and compiled October 25, 2004, by Kevin Campbell, Ph.D., and Carole J. Broderick, Ph.D., Division of Alcohol and Substance Abuse, Department of Social and Health Services.

<sup>5</sup>JRA records indicate that 541 youth were enrolled in the CDDA program between July 2003 and June 2004. Publicly funded chemical dependency treatment records were found for 356 (66 percent) of this group. Of these, 68 (19 percent) were still actively engaged in the treatment process. Therefore, these treatment completion data are based upon the remaining 288 youth with both admission and discharge data.

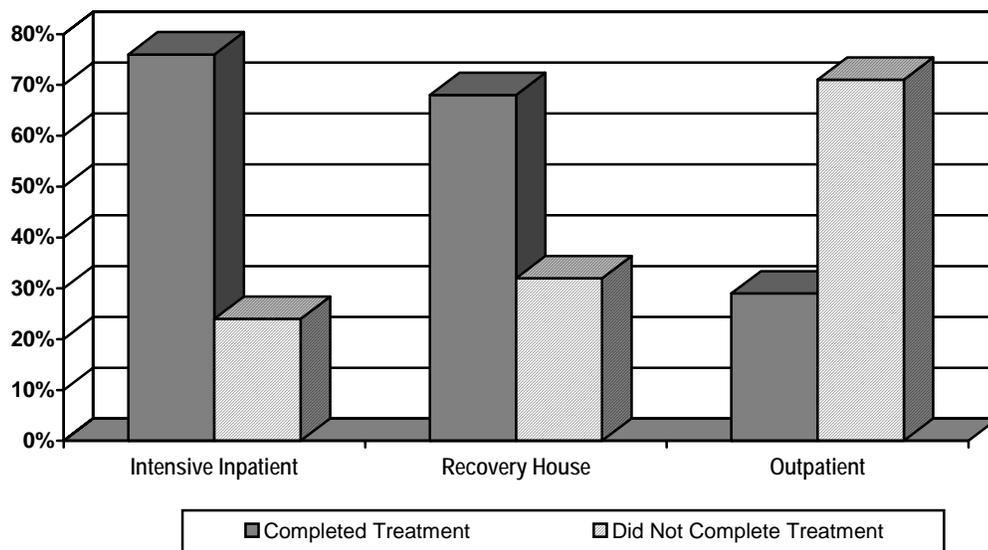
<b>Table 1: Type of Treatment Received by CDDA Clients (n=288)</b>	
<b>Type of Treatment</b>	<b>Percent</b>
Intensive Inpatient Only	18
Recovery House Only	2
Outpatient Only	51
Combination of Types	29

- **Intensive Inpatient Treatment** is the most highly structured program delivered in a residential setting.
- **Recovery Houses** provide social and recreational therapy as well as substance abuse treatment in a residential setting.
- **Outpatient** treatment consists of a variety of services according to a prescribed treatment plan, delivered in a non-residential setting.
- **Combination of Types** refers to the grouping of outpatient treatment with any other treatment modality.

As can be seen from Table 1 above, 80 percent of CDDA youth were involved with outpatient therapy at some point during the selected time-span.

The following chart shows completion rates for CDDA youth by type of treatment.<sup>6</sup>

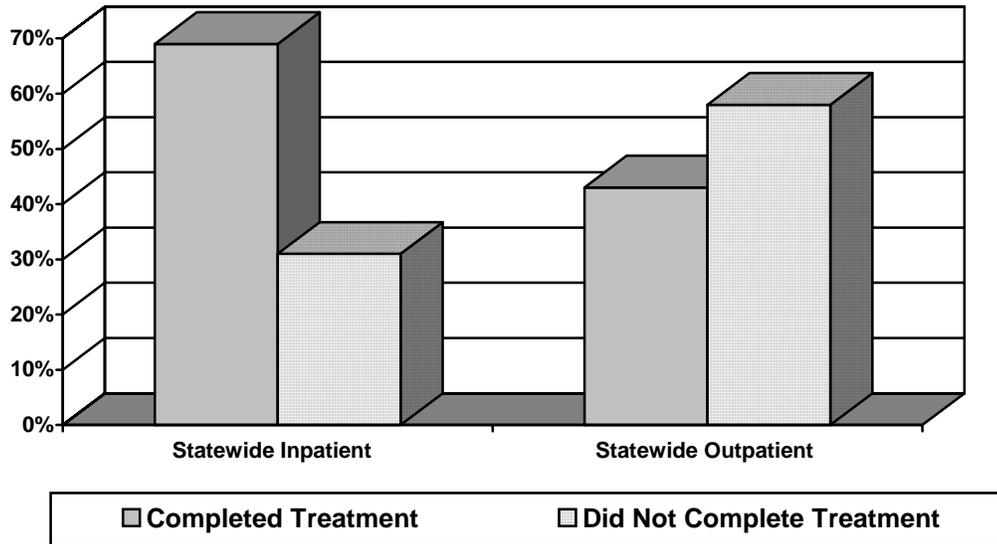
**Chart 2: CDDA Completion Rates**



<sup>6</sup> Clients admitted to a combination of modalities, or to a given modality multiple times, are “double counted.”

For comparison, Chart 3 below shows the completion rates<sup>7</sup> for all Washington State youth receiving publicly funded substance abuse treatment.

**Chart 3: Statewide Completion Rates for Youth in Inpatient and Outpatient Treatment**



CDDA youth who participated in intensive inpatient treatment were somewhat more likely to complete treatment than those in the general treatment population in Washington State. However, CDDA youth who participated in outpatient treatment were somewhat less likely to complete treatment than youth in the general treatment population. To further examine this finding, reasons for discharge were looked at among outpatient non-completers.

<sup>7</sup> The following categories are not included in the calculation of completion rates:

- Transferred to different facility
- Inappropriate Admission
- Withdrew with Program Advice
- Incarcerated
- Funds Exhausted

This information can be found in Table 2 below.

<b>Table 2: Discharge Reasons for CDDA Outpatient Non-Completers (n=75)</b>	
<b>Reason Provided</b>	<b>Percent</b>
Rule Violation	11
Against Program Advice	25
Lack of Engagement <sup>8</sup>	15
No Contact <sup>9</sup>	49

As can be seen from Table 2, the vast majority of CDDA youth who did not complete outpatient treatment did so because they left against program advice or because they did not appear or engage in treatment. These numbers support the need to further explore the low treatment completion rates among CDDA youth leaving outpatient treatment prematurely with a focus on examining methods to increase the likelihood of outpatient treatment completion.

## **Conclusions**

Given the recommendations from the University of Washington's 2004 final evaluation report, the Committee decisions, and the completion data for CDDA youth receiving publicly funded treatment services, JRA and the juvenile courts over the next year will pursue a plan that introduces evidence-based family treatment into the regimen of services provided under the CDDA program. Because family services have a goal to increase the motivation of the entire family to make changes, JRA and the juvenile courts believe that outpatient treatment completion rates will improve as families better understand and support the CDDA program including substance abuse treatment.

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<sup>8</sup> Clients who show a "lack of engagement" are unmotivated to participate in treatment.

<sup>9</sup> Clients with "no contact" have never attended sessions or made contact with their treatment provider as required.

## **Appendix**

### **Juvenile Rehabilitation Administration**

#### **List of Acronyms and Terms**

- **ACA:** American Correctional Association. A national association that develops standards for correctional facilities, jails, and detention facilities.
- **ART:** Aggression Replacement Training. A Cognitive Behavior Therapy program using skill building that has been rigorously evaluated and reduces recidivism with juvenile offenders.
- **ARY:** At-Risk Youth. A petition that may be filed to obtain assistance and support from the juvenile court in maintaining the care, custody, and control of the child and to assist in the resolution of family conflict.
- **BTC:** Basic Training Camp (Camp Outlook). The Juvenile Offender Basic Training Camp administered by the Juvenile Rehabilitation Administration and located near Connell.
- **CA:** Children's Administration. An administration within the Department of Social and Health Services.
- **CBT:** Cognitive Behavior Therapy. A wide ranging treatment approach using behavioral and cognitive change strategies that in evaluations has been effective in reducing recidivism.
- **CCDA:** Community Commitment Disposition Alternative. A sentencing alternative offered through the juvenile courts.
- **CDDA:** Chemical Dependency Disposition Alternative. A program giving youth with chemical and substance abuse issues a disposition alternative in the community offered through the juvenile courts.
- **CF:** Community Facility. JRA's minimum security facilities which are state operated or privately run through a contract with JRA.
- **CHINS:** Child In Need of Services. A petition that may be filed to obtain a court order mandating placement of the child in a residence other than the home of his/her parent because a serious conflict exists between the parent and child that cannot be resolved by delivery of services to the family during continued placement of the child in the parental home.
- **CJAA:** Community Juvenile Accountability Act. State-funded program that supports evidence-based treatment for youth on probation in the juvenile courts.
- **CJCA:** Council of Juvenile Correctional Administrators. A national association of juvenile justice administrators.

- **CJS:** Consolidated Juvenile Services at risk. A program that provides funds to local juvenile courts for the purpose of serving youth on probation.
- **CRA:** Community Risk Assessment. A tool used by JRA to determine eligibility for a youth's placement in the boot camp or a community facility.
- **DASA:** Division of Alcohol and Substance Abuse. A division within the DSHS Health and Rehabilitative Services Administration.
- **DBT:** Dialectical Behavior Therapy. An empirically supported type of CBT that reduces maladaptive behaviors and recidivism with juvenile offenders.
- **Detention Facility:** A secure facility operated by juvenile courts to house youth for fewer than 30 days.
- **Diversion:** An alternative to formal court processing available to some youth who have committed certain offenses for the first or second time.
- **DOSA:** Drug Offender Sentencing Alternative. The adult drug offender sentencing alternative similar to the juvenile CDDA program.
- **DSHS:** Department of Social and Health Services.
- **EBP:** Evidence-Based Program. A program that has been rigorously evaluated and has shown effectiveness at addressing particular outcomes such as reduced crime, child abuse and neglect, or substance abuse. These programs often have a cost benefit to taxpayers.
- **EGCC:** Echo Glen Children's Center. A Juvenile Rehabilitation Administration residential facility located in Snoqualmie most females with mental health and other medical needs and younger males.
- **FFP:** Functional Family Parole. A parole model, delivered by parole counselors that is based on the Functional Family Therapy approach, an evidence-based model for reducing juvenile recidivism.
- **FFT:** Functional Family Therapy. An evidence-based family treatment model that reduces recidivism by juvenile offenders.
- **FIT:** Family Integration Transitions program. A version of Multi-Systemic Therapy that is an evidence-based family intervention model used by JRA to treat youth with co-occurring disorders.
- **GHS:** Green Hill School. A Juvenile Rehabilitation Administration residential facility located in Chehalis serving older males.

- **IAP:** Intensive Aftercare Program. A nationally recognized evidence-based model of transition and reentry for high-risk juvenile offenders.
- **IP:** Intensive Parole. The JRA model of IAP.
- **ISCA:** Initial Security Classification Assessment. The JRA's validated risk tool for determining in which facility to place a youth committed to state care.
- **ITM:** Integrated Treatment Model. JRA's rehabilitation model using CBT/DBT interventions for residential youth followed by FFP for community youth.
- **JRA:** Juvenile Rehabilitation Administration. The Department of Social and Health Services administration responsible for the rehabilitation of court-committed juvenile offenders.
- **JVIP:** Juvenile Vocational Industries Program. A program that provides JRA youth opportunities for vocational training and jobs within a JRA facility.
- **MHDA:** Mental Health Disposition Alternative. A disposition alternative offered through the juvenile courts.
- **MHSD:** Mental Health Systems Design. A JRA committee that reviewed the mental health needs of youth in JRA.
- **MHTP:** Mental Health Target Population. A subset of JRA's population composed of youth that meet at least one of three criteria:
  - (1) A current DSM-IV Axis I diagnosis, excluding those youth who have a sole diagnosis of Conduct Disorder, Oppositional Defiant Disorder, Pedophilia, Paraphilia, or Chemical Dependency;
  - OR
  - (2) Is currently prescribed psychotropic medication;
  - OR
  - (3) Has demonstrated suicidal behavior within the last six months.
- **MI:** Manifest Injustice: A term that refers to a decision to sentence a youth to a term of confinement outside the standard range set by statute.
- **MLS:** Maple Lane School. A JRA residential facility located near Centralia serving older males.
- **MST:** Multi-Systemic Therapy. An evidence-based family treatment model that reduces juvenile offender recidivism.

- **NCCHC:** National Council on Correctional Health Care. The organization that sets the national standards for health care followed by JRA.
- **NYC:** Naselle Youth Camp. A JRA residential facility located near Naselle serving medium security male and female youth.
- **Revocation:** A short term of confinement imposed by JRA on youth under parole supervision for violations of their parole condition(s). Each term of revocation may be no longer than 30 days.
- **RTCP:** Residential Treatment and Care Program. A JRA program for minimum security youth that is based on the “*Blueprint Program*” Multi-Dimensional Treatment Foster Care.
- **SAVY:** Sexually Aggressive/Vulnerable Youth screen. A screening tool used by JRA to identify youth with a history of sexual aggression or sexual vulnerability. The screening tool is used to determine youth suitability for shared sleeping facilities.
- **SAY:** Sexually Aggressive Youth.
- **SDA:** Suspended Disposition Alternative. A disposition alternative offered through the juvenile courts.
- **SSODA:** Special Sex Offender Disposition Alternative. A disposition alternative offered through the juvenile courts for juvenile sex offenders.
- **SSOSA:** Special Sex Offender Sentencing Alternative. A disposition alternative for adult sex offenders.
- **WAJCA:** Washington Association of Juvenile Court Administrators.
- **WSIPP:** Washington State Institute for Public Policy.
- **YOP:** Youthful Offender Program. A program to serve individuals under 18 who were prosecuted as adults. These individuals are may be housed in JRA facilities.