oppaga

Information Brief

December 2003 **Report No. 03-76**

More Youth Are Admitted for Less Serious Offenses, in Part to Meet Treatment Needs

at a glance

Admissions to residential juvenile justice commitment have leveled off during recent years. While most youth are committed for felonies, 40% are committed for misdemeanors and non-law violations of probation.

This occurs in part because treatment resources are concentrated in the department's residential commitment programs. Delinquency judges report that youth sometimes are committed in order to obtain needed treatment. Of youth in residential commitment programs, 76% are being treated for diagnosed mental health needs and 48% are being treated for diagnosed substance abuse needs.

The department proposes to divert appropriate non-law violators to a Re-direction Program for treatment. We endorse the treatment concept but propose an alternative that would allow the comparison of results and provide an additional $1 million in cost savings.

Approximately 29% of the department's special needs residential programs received low quality assurance ratings for mental health and substance abuse. The department should make performance on this standard a critical indicator for programs providing specialized mental health and substance abuse services.

Scope

This report is one of a series that analyzes the commitment offense and criminal history of youth in Department of Juvenile Justice residential commitment beds, as directed by Ch. 2003-397, *Laws of Florida.*[1] This report addresses the following questions relating to residential juvenile admissions and treatment services.

1. Have residential admissions changed over the past four years?
2. What offenses are youth admitted for?
3. What are the criminal histories of youth admitted for misdemeanors and non-law violations of probation?
4. Are other options available for these youth?
5. How many youth in residential programs receive special needs treatment services?
6. How many beds are contracted to provide special needs services and what services are provided?
7. How do treatment services score on Quality Assurance reviews?

[1] The other reports in this series (1) analyze the number of residential beds, the vacancy rate of these beds, and the department's process for tracking capacity and utilization (see OPPAGA Report No. 03-74, *Information Brief: Juvenile Bed Tracking System Improves; Bed Vacancy Rates High for Some Programs,* December 2003); and (2) reviews the department's quality assurance and contract monitoring process (see OPPAGA Report No. 03-73, *Information Brief: Juvenile Justice Can Improve Its Quality Assurance and Program Monitoring Processes,* December 2003).

Methodology

To analyze the commitment offense and criminal history of youth admitted to residential programs, we used data derived from the Juvenile Justice Information System (JJIS). To help ensure the accuracy of this data, we conducted this analysis jointly with Department of Juvenile Justice Bureau of Research and Data staff.[2] To analyze the number and type of special needs beds and the special needs services provided to youth in those beds, the Auditor General and OPPAGA conducted a survey of special needs services provided to all youth in 157 residential commitment programs on September 10, 2003. We also interviewed juvenile court judges in each of the 20 judicial circuits about treatment options and sentencing decisions.

Questions and Answers –

1. Have residential admissions changed over the past four years?

Admissions to residential juvenile justice commitment programs have leveled out over the last four fiscal years, as shown in Exhibit 1.[3] This means that additional beds are not needed unless the Legislature wishes to extend the length of time youth stay in residential commitment.

After admission, some youth are transferred to another program for administrative reasons such as their program closed, or their initial program was unable to meet their treatment needs. The number of transfers has fluctuated over the four-year period, as shown in Exhibit 2.

Exhibit 1
Residential Admissions Have Leveled Out

Type of Admission	Fiscal Year			
	1999-00	2000-01	2001-02	2002-03
First-Time Admission	6,292	6,065	6,418	6,459
Readmission	2,943	2,577	2,534	2,404
Total	9,235	8,642	8,952	8,863

Source: OPPAGA and Department of Juvenile Justice analysis of Juvenile Justice Information System data.

Exhibit 2
The Number of Transfers Fluctuates

	Fiscal Year			
	1999-00	2000-01	2001-02	2002-03
Transfers	760	1,106	732	896

Source: OPPAGA and Department of Juvenile Justice analysis of Juvenile Justice Information System data.

Since youth generally begin a program anew when they are transferred, the department adds transfers to admissions to report total bed needs. However, most transferred youth do not stay in the initial program for the full term. Therefore, we excluded transfers in our admissions analysis because it overstates the number of beds used. For purposes of policy analysis, youth with a short length of stay in either the initial or the transfer bed should only be counted once, instead of for each placement, when evaluating how many beds the department requires to serve youth. The department needs to keep track of the number of days these youth spend in their initial program so that this can be accurately factored into beds analysis.

Transfers are an inefficient use of resources. The department should determine what steps to take to reduce transfers, as this would reduce the number of beds needed.

2. What offenses are youth admitted for?

The majority of youth are admitted to residential programs for felonies, as shown in Exhibit 3. In Fiscal Year 2002-03, 40% of youth were admitted for a misdemeanor or non-law violation of probation. During that year, the

[2] The analysis in this report updates admissions information presented in *The Juvenile Justice Residential Program Should Improve the Contracting Process*, OPPAGA Report No. 02-42, July 2002.

[3] The number of admissions differs from the number of youth admitted because some youth are admitted more than once in the course of a year. However, we found that youth who are admitted for a second or third time in one year account for only 2% of all admissions.

number of youth admitted for felonies declined slightly, while the number admitted for misdemeanors increased slightly. The biggest change was that the number of youth admitted for non-law violations of probation has increased for the last four years.

Exhibit 3
Admissions for Non-Law Violations of Probation Have Increased

Admissions Reason	1999-00		2000-01		2001-02		2002-03	
Felony	5,693	65%	5,192	62%	5,253	60%	5,011	58%
Misdemeanor	2,034	23%	1,994	24%	2,038	23%	2,170	25%
Non-Law Violation of Probation	755	8%	926	11%	1,174	14%	1,276	15%
Other [1]	320	4%	251	3%	234	3%	229	2%
Total Youth Admitted	**8,802**	**100%**	**8,354**	**100%**	**8,699**	**100%**	**8,686**	**100%**

[1] Other includes cases reopened, transferred or pick-up orders where the original offense is unknown, violations of municipal ordinance, non-felony traffic, or federal charges.

Source: OPPAGA and Department of Juvenile Justice analysis of Juvenile Justice Information System data.

Non-law violations of probation include actions such as staying out after curfew or not attending school. Because admissions drive bed needs, the decision to incarcerate youth for infractions unrelated to new crimes is costly.

3. What are the criminal histories of youth admitted for misdemeanors and non-law violations of probation?

As shown in Exhibit 4, the majority of youth admitted for misdemeanors and non-law violations of probation had a felony in their background, and 33.7% were repeat felons. [4] The remaining 23.9%, or 822 youth, did not have felony histories.

Exhibit 4
Most Non-Felony Youth Admitted to Residential Programs Had Prior Felonies

Felony History	2000-01		2001-02		2002-03	
Repeat Felon	1,048	35.9%	1,097	34.1%	1,163	33.7%
One-Time Felon	1,185	40.6%	1,358	42.3%	1,461	42.4%
Non-Felon	687	23.5%	757	23.6%	822	23.9%
Total Admitted for a Misdemeanor or Non-Law Violation of Probation	**2,920**	**100%**	**3,212**	**100%**	**3,446**	**100%**

Source: OPPAGA and Department of Juvenile Justice analysis of Juvenile Justice Information System data.

Since youth committed for a misdemeanor or non-law violation of probation with no felony background could have extensive misdemeanor histories, we also analyzed the number and type of misdemeanors committed by these youth. We divided the non-felony youth into three categories: those with three or more adjudicated misdemeanors, those with two or fewer misdemeanors including an assault and battery adjudication (the only violent misdemeanor), and those with two or fewer misdemeanors and no adjudications for assault and battery. As shown in Exhibit 5, the largest group among these non-felons, and the group that increased the most over the three years, was youth with two or fewer misdemeanors and no assault and battery adjudications.

One possible reason for some of the increase in misdemeanor and non-law violation admissions to residential commitment is that judges commit some youth to residential programs primarily to obtain special needs treatment services.

To investigate this possibility, we interviewed 20 county delinquency court judges from urban, rural and medium-sized counties in all 20 judicial circuits. Fourteen of the 20 judges reported that they sometimes commit youth with less serious delinquency histories because they need intensive special needs treatment services that are not provided in non-residential programs. Three additional judges said they would not commit youth to obtain treatment, but they considered non-residential treatment services in their communities inadequate.

[4] "One-time felon" refers to any youth who had been adjudicated for only one felony, had non-adjudicated felony charges associated with the commitment, had felony charges in the year preceding admission, or had two misdemeanor assault and battery adjudications. Since a second adjudication for misdemeanor assault and battery charges may be counted charged as a felony, it is counted here as a felony. We excluded charges entered as "charges dismissed, not guilty."

Exhibit 5
A Small Number of Non-Felons Admitted for a Misdemeanor or Non-Law Violation of Probation Did Not Have a History of Multiple or Violent Misdemeanors

Misdemeanor History	2000-01		2001-02		2002-03	
No felonies, three or more adjudicated misdemeanors	220	32%	236	31%	241	29%
No felonies, two or fewer adjudicated misdemeanors, one assault and battery adjudication	191	28%	218	29%	229	28%
No felonies, two or fewer adjudicated misdemeanors, no assault and battery adjudications	276	40%	303	40%	352	43%
Total Admitted with No Prior Felonies	**687**	**100%**	**757**	**100%**	**822**	**100%**

Source: OPPAGA and Department of Juvenile Justice analysis of Juvenile Justice Information System data.

4. Are other options available for these youth?

In its 2004-05 budget request, the department seeks funding for nine months of a "Re-direction Program" to divert non-law violation of probation youth from residential programs. The department estimates that implementing this program would result in a net savings of $0.7 million by preventing 61% of the youth served from being admitted to residential programs in Fiscal Year 2004-05. [5]

The proposed Re-direction Program would incarcerate youth in detention for 45 days for an estimated cost of $4,729 per youth. For youth requiring treatment, estimated to be 90%, this would be followed by one of three community-based treatment options at an average cost of $3,500 per youth: four months of Multi-Systemic Therapy (MST), three months of Family Functional Therapy (FFT), or referral to existing community services. [6]

MST and FFT have been proven in national research to reduce recidivism, sex offending, psychiatric symptoms and drug abuse in chronic offenders, sex offenders, other violent offenders, and youth with substance abuse problems. These therapies would reduce costs, both in the long term through reduced recidivism and in the short term because these programs cost less than residential programs. For example, the department estimates the cost of seven months in a residential program at $18,259 per youth, as compared to a $3,500 average cost of MST and FFT. [7]

These community-based treatment programs are a cost-effective alternative that would be appropriate in Florida. They would help address the situation we found in which judges indicate that that some youth are being committed to residential programs because of their treatment needs. The programs are an appropriate match for youth with mental health and substance abuse treatment needs currently being committed for misdemeanors and non-law violations of probation.

However, the 45-day stay in detention that the department proposes to precede therapy is not part of the MST or FFT models and does not appear to be cost-effective. According to department managers, the stay in detention would provide a short sanction while the department conducts assessments of the youth.

We question the value of the proposed incarceration segment for several reasons. First, it would be relatively expensive—at $4,729 per youth, it would cost more than the programs' treatment segment. Second, while incarceration would provide a sanction, it would also significantly disrupt youths' education. The programs themselves include family treatment components that most teenagers would likely consider to be a sanction. Third, the department could assess youth while they live at home as it currently does for residential programs. And finally, research indicates that the recidivism reduction effect of the MST program would likely be reduced due to

[5] For the 216 youth in the program, the department estimates that 132 would successfully complete the program and not recidivate. Once the program is fully operational, research shows that the success rate will likely be higher.

[6] Multi-Systemic Therapy is an intensive family-based treatment that addresses multiple causes of serious antisocial behavior in juvenile offenders. Family Functional therapy is a family-based treatment that focuses on family dynamics and accountability.

[7] This average cost also includes referrals to existing community services.

delinquent group bonding if youth are incarcerated prior to treatment. [8]

We concur with the department's goal of diverting appropriate youth from residential commitment to programs proven in national research. Developing MST and FFT programs in Florida should reduce state delinquency costs. However, by creating an expensive confinement prior to treatment programs proven to reduce recidivism, the department would unnecessarily limit the number of youth who can receive treatment, and may reduce the effectiveness of treatment.

We identified another alternative for legislative consideration. The department could operate the program in two rather than three locations; in this option, the department could use the funds from the unused third location to operate the program at two additional sites that would provide treatment without a period of incarceration. This would allow the department to provide treatment to 91 more youth with its existing funds, and enable the state to evaluate whether there is a benefit to adding a period of incarceration to the treatment model. Treating these additional youth would increase the cost savings from $0.7 million to $1.7 million, as shown in Exhibit 6. The department should compare recidivism outcomes for youth in the combined program compared to youth committed directly to the treatment program and similar youth committed to residential programs. The department and the Legislature could use this information for future policy and funding decisions.

[8] "When Interventions Harm," by Thomas J. Dishion, Joan McCord, and Francois Poulin, *American Psychologist*, September 1999.

5. How many youth in residential programs receive special needs treatment services?

Residential commitment programs report that mental health service treatment based on diagnosed need is provided to 75.8% of youth in residential commitment programs. As shown in Exhibit 7, a significant number of youth also receive substance abuse treatment, psychiatric treatment, and psychotropic medication. Residential commitment programs provide sex offender treatment for 8.5% of juvenile offenders.

Exhibit 7
75.8% of Youth in Residential Commitment Programs Receive Mental Health Treatment

Type of Treatment	Number	Percentage [1] N=6,608
Mental Health Treatment	5,012	75.8%
Substance Abuse Treatment	3,152	47.7%
Psychiatric Treatment	2,570	38.9%
Psychotropic Medication	1,960	29.7%
Sex Offender Treatment	563	8.5%

[1] As youth may receive multiple treatments, percentages add to more than 100%.
Source: OPPAGA/Auditor General survey of DJJ residential programs.

Exhibit 6
By Modifying Its Proposal, the Department Could Implement Programs that Could Save $1.7 Million While Increasing Treatment Services

Alternatives to Commitment for Youth Admitted for a Misdemeanor or a Violation of Probation	Number Served in Residential	Number Served in Treatment Program	Total Number Served	Total Cost	Estimated Cost Avoidance	Estimated Net Savings
DJJ Proposed Redirection Program	216	194	216	$1,713,225	$2,410,214	$ 696,989
OPPAGA Proposal						
Two Pilots with Incarceration	144	130	144	$1,142,150	$1,606,809	$ 464,659
Two Pilots without Incarceration	0	163	163	571,075	1,818,819	1,247,744
Total OPPAGA Proposal	**144**	**293**	**307**	**$1,713,225**	**$3,425,628**	**$1,712,403**

Source: OPPAGA analysis of DJJ legislative budget request documents.

6. How many beds are contracted to provide special needs services and what services are provided?

Fifty-nine percent, or 4,157 of the 7,016 residential commitment beds are designated for youth who have special service needs. As shown in Exhibit 8, these services are provided in two ways: specialized treatment programs or as overlay services provided through supplemental funding to the program.

Exhibit 8
4,157 Beds in Residential Commitment Programs Are Contracted to Provide Special Needs Treatment Services

Type of Program	Number of Programs	Number of Special Needs Beds
Specialized Treatment Program		
Intensive Mental Health	11	462
Specialized Mental Health	1	100
Specialized Substance Abuse	6	310
Specialized Sex Offender	9	468
Specialized Developmental Disabilities	1	29
Total	**28**	**1,369**
Program Receiving Special Needs Overlay Funding		
Substance Abuse Overlay	12	145
Mental Health Overlay Services (High or Maximum Risk)	21	421
Behavioral Health Overlay Services (Low or Moderate Risk)	54	2,222
Total	**81**[1]	**2,788**
General Offender Program	**48**	**0**
Total	**157**	**4,157**

[1] Some programs receive funding for more than one type of overlay service.
Source: OPPAGA/Auditor General survey of DJJ residential programs.

In contrast, general offender programs do not have additional funding for special needs services. Offenders in these programs with diagnosed needs receive treatment funded through community mental health programs or regular per diem funds paid to the provider.

Specialized treatment programs. On September 10, 2003, the department had 1,369 beds in specialized treatment programs. These programs are designed exclusively for juvenile offenders with serious to severe symptoms of mental disorder, substance-related disorder, or developmental disorder; or sexual offenders who are in need of more intensive specialized treatment than provided in general offender programs. Specialized treatment programs provide the most intensive level of clinical staffing and care available within the department's continuum of services.

As shown in Exhibit 9, youth in specialized treatment programs receive a broad array of services tailored to the treatment focus of the program.

Exhibit 9
Youth in Specialized Treatment Programs Received a Broad Array of Services

Type of Specialized Program	Mental Health Treatment	Substance Abuse Treatment	Psychiatric Treatment	Psychotropic Medication	Sex Offender Treatment
Intensive Mental Health (N=445)	100%	65%	93%	76%	2%
Specialized Mental Health (N=100)	100%	75%	100%	89%	0%
Specialized Substance Abuse (N=310)	81%	100%	33%	33%	0%
Specialized Sex Offender (N=431)	55%	23%	42%	30%	100%
Specialized Developmental Disabilities (N=27)	100%	11%	0%	0%	33%

Source: OPPAGA/Auditor General survey of DJJ residential programs.

Special needs overlay programs. As of September 10, 2003, the department had 2,788 beds contracted to provide special needs overlay services, including 2,222 beds contracted to receive behavioral health overlay services (BHOS) reimbursed by federal Medicaid funds. These federal funds can only be used for low and moderate risk programs; offenders in higher risk programs are ineligible because they do not meet the Medicaid requirement for community access. State general revenue funds mental health overlay services for 421 beds in high or maximum risk

programs. In addition, 145 beds were contracted to receive substance abuse overlay funding through federal grants.

Over half of overlay beds were in programs where all of the beds were funded to receive overlay services. In the other programs, the overlay funding was designated for only a portion of the beds. However, the programs are allowed to distribute the money so as to provide services to those youth they consider most appropriate. Thus, a 40-bed program can receive overlay funding for 30 beds, but use the funds to serve all 40 of the youth in the program.

As shown in Exhibit 10, most youth in programs with overlay services receive mental health services and many receive substance abuse treatment.

Exhibit 10
Most Youth in Programs with Overlay Funding Received Mental Health Treatment

Type of Overlay Program	Mental Health Treatment	Substance Abuse Treatment	Psychiatric Treatment	Psychotropic Medication	Sex Offender Treatment
Substance Abuse (N=403)	61%	51%	33%	17%	1%
Mental Health (High or Maximum Risk) (N=892)	68%	44%	38%	31%	2%
Behavioral Health (Low or Moderate Risk) (N=2,334)	90%	52%	43%	30%	1%

Source: OPPAGA/Auditor General survey of DJJ residential programs.

Special needs treatment services are in high demand. Exhibit 11 illustrates the vacancy rates of all residential commitment programs on September 10, 2003. The vacancy rate for beds in specialized programs was 1.5% and the vacancy rate for beds in programs receiving special needs overlay funding was 3.3%. In contrast, the vacancy rate for beds in general offender programs receiving no funding to provide special needs treatment services was considerably higher at 13%.

Exhibit 11
Specialized Treatment Programs Had the Lowest Vacancy Rate

Type of Program	Number of Programs	Number of Beds	Vacancy Rate
Specialized Treatment Program	28	1,369	1.5%
Program Receiving Overlay Funding for Special Needs Services	81	3,576	3.3%
General Offender Program	48	2,071	13.0%
Total	**157**	**7,016**	**5.8%**

Source: OPPAGA/Auditor General survey of DJJ residential programs.

7. How do treatment services score on Quality Assurance reviews?

Although extensive treatment services are delivered in residential programs, the department's quality assurance ratings raise questions about the quality of these services in many programs.

The Bureau of Quality Assurance reviews all Department of Juvenile Justice programs using a comprehensive set of standards. Each standard is scored and used to determine an overall program rating. The standards include delivery of mental health and substance abuse treatment services and address items such as whether all youth receive mental health and substance abuse screening upon admission, whether personnel delivering services meet professional requirements, and whether the program can document that all youth who are receiving mental health treatment have a mental health treatment plan. While these indicators do not directly assess the quality of treatment services, they include elements that are vital to the delivery of professional treatment services.

For programs still under contract in 2003 that were reviewed in 2002, the performance of 29% (5 of 17) of specialized treatment programs was rated as "minimal" or "failed to meet standard"

on the mental health and substance abuse treatment standard. [9, 10]

As shown in Exhibit 12, ratings on the mental health and substance abuse treatment standard for specialized treatment programs were slightly higher than those for programs receiving overlay funding. For programs receiving overlay funding, 40% (28 of 70) received a minimal rating or failed to meet the standard, compared to 29% for specialized programs. Performance for general offender programs also was slightly better than that of programs receiving overlay funding, with 38% (15 of 39) receiving a minimal rating or failed to meet standard and 41% receiving a rating of commendable or exceptional compared to 30% of overlay programs. [11]

Exhibit 12
Many Programs Received Low Ratings on the Mental Health and Substance Abuse Standard

Rating on QA Standard for Mental Health and Substance Abuse Treatment	Specialized Treatment Programs		Programs Receiving Overlay Funding		General Offender Programs	
Minimal or Failed to Meet Standard	5	29%	28	40%	15	38%
Acceptable	5	29%	21	30%	8	21%
Commendable	2	12%	16	23%	11	28%
Exceptional	5	29%	5	7%	5	13%
Total	**17**	**100%**	**70**	**100%**	**39**	**100%**

Source: Data from the DJJ Bureau of Quality Assurance and the Division of Residential and Correctional Programs.

When a program receives a performance score of "failed to meet standards," department staff develops a corrective action plan for the program to implement. [12] Programs with an overall failing score receive a second review in six months. If the program fails the second review, the department must cancel the program unless there are documented extenuating circumstances.

In our December 2003 review of the department's quality assurance process we recommended that the department develop a system for identifying critical areas for performance. [13] Treatment planning and documentation are vital to the professional delivery of special needs services. The department should consider making performance on the mental health and substance abuse standard a critical indicator for programs providing specialized mental health and substance abuse services. Programs could be required to receive a score of "acceptable" on the standard before receiving an overall performance rating of acceptable or above.

Conclusions and Recommendations

Admissions to juvenile justice residential commitment programs and transfers among programs for administrative reasons have leveled off. Transfers, however, remain an inefficient use of resources and drive up the number of beds needed.

- We recommend that the department determine what steps it can take to reduce transfers.

The majority of youth in residential programs are admitted for felonies. However, 40% are being admitted for misdemeanors and non-law violations of probation. With treatment resources concentrated in residential commitment programs, judges report that youth sometimes are committed to obtain needed treatment, contributing to the increase in non-felony admissions.

Providing treatment services earlier in the juvenile justice continuum could reduce the

[9] Not all programs were reviewed because of changes in providers, and because programs with deemed status are reviewed once every two years rather than annually.

[10] Eighty-eight percent of specialized treatment programs had overall scores of acceptable or above; 12% received minimal ratings and none that continued in 2003 had an overall rating of failed to meet standards.

[11] Ratings between program types are not strictly comparable, since requirements for the standard vary depending on the type of mental health and substance abuse services the program is contracted to deliver, but do indicate how well the program met expectations for the type of service delivered.

[12] A rating of 59% or less is considered failed standards.

[13] *Juvenile Justice Can Improve Its Quality Assurance and Program Monitoring Processes*, Report No. 03-73, December 2003.

need for expensive residential commitment beds. The department's proposal to divert non-law violation of probation youth from residential programs by providing short-term incarceration followed by research-based community mental health programs is a step in the right direction. However, cost savings could be increased from $0.7 million to $1.7 million in Fiscal Year 2004-05 and long-term effectiveness could be increased by reducing the number of slots for the incarceration phase of the proposed program and establishing separate pilot projects to implement the community treatment services model alone. The success rate of the two approaches could then be compared.

- We recommend that the department establish two pilot projects for the program combining and incarceration period and a community service period. We further recommend that the department establish two additional projects for 163 youth, using the funds from the third proposed pilot project site to provide treatment only to this group. The department should evaluate the effects of each approach on recidivism.

Although extensive treatment services are delivered in residential programs, many special needs programs received a low Quality Assurance rating for mental health and substance abuse. Twenty-nine percent of specialized treatment programs and 40% of overlay treatment programs received scores of "minimal" or "failed to meet standard" for this standard.

- We recommend that the department make performance on the mental health and substance abuse standard a critical indicator for programs receiving special funding to provide mental health and substance abuse services. These programs should be required to receive a score of "acceptable" on the standard before receiving an overall performance rating of acceptable or above.

Agency Response

In accordance with the provisions of s. 11.45(7)(d), *Florida Statutes,* a draft of our report was submitted to the Secretary of the Department of Juvenile Justice for review and response. The Secretary's written response is included in Appendix A.

Appendix A

STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

December 30, 2003

Mr. Gary R. Vanlandingham, Interim Director
Office of Program Policy and Government Accountability
Claude Pepper Building, Room 312
Tallahassee, Florida 32399-1475

Dear Mr. Vanlandingham:

Pursuant to Section 11.513(5), Florida Statutes, this written explanation is submitted by the Department of Juvenile Justice regarding the recommendations in the OPPAGA information brief entitled "More Youth Admitted for Less Serious Offenses, in Part to Meet Treatment Needs."

Proper classification and placement of youth is a crucial issue in ensuring that services are provided to protect the public and meet the needs of youth. With regard to a youth who is committed to the Department for residential placement, the Department provides the court a recommendation, and the judge makes the decision whether or not to commit the youth. The OPPAGA review found that more than 90 percent of the 8,863 youth admitted into a residential program were currently committed on a felony, or had one or more felony adjudications in their backgrounds. Of the 822 youth who had not been adjudicated on a felony, only 352 had two or fewer misdemeanor adjudications with no assault and battery adjudications. This is less than four percent of the 8,863 admissions into residential commitment programs.

"We recommend that the department determine what steps it can take to reduce transfers."

The Department concurs that transfers be limited to circumstances where they are absolutely necessary. During the past year, a reporting procedure was developed which indicates by program the number of transfers requested, the reason for each transfer request, and whether the transfer request was approved. This information will help to improve the use of transfers.

A key issue in reducing transfers is making an initial appropriate placement. The

Department established a workgroup with provider representatives to improve comprehensive assessments and has developed detailed protocols. The Department believes that better assessments, together with the implementation of the bed management system, will help make appropriate placements and reduce transfers.

It must be noted, however, that most youth complete their program and are not transferred. In FY 2002-03, only 10.3 percent of the youth admitted into a residential program were transferred. Many transfers are appropriate and necessary. For example, it neither protects the public nor helps the youth to allow a youth who escapes repeatedly to remain in a non-secure program. Each transfer request must be evaluated on its individual merits. In some instances, a provider may notice the Department of their decision to terminate a contract. In those circumstances, youth in the program who are not ready to return home must be transferred to another program.

"We recommend that the department establish two pilot projects for the program combining an incarceration period and a community service period. We further recommend that the department establish two additional projects for 163 youth, using the funds from the third proposed project site to provide treatment only to this group. The department should evaluate the effects of each approach on recidivism."

The Department proposed in its Fiscal Year 2004-05 Legislative Budget Request to establish three pilot re-direction programs to serve 216 youth. These programs will provide up to 45 days in residential care, followed by placement into non-residential Multi-Systemic Therapy (MST) or Family Focused Therapy (FFT) programs. OPPAGA's recommendation is to modify this request to provide two programs as the Department has proposed and to provide two programs with only the non-residential MST or FFT component.

The residential component of this model is crucial. Youth will stay in residential care for up to 45 days (it is expected some youth will not need to stay the entire period) to accomplish the following:

- **Stability.** The Department has already observed and/or documented inappropriate behavior if the youth is at a point where he or she is at imminent risk of being returned to a residential commitment program. Before a more dangerous outcome befalls the youth or the community, an intervention that quickly removes the youth from peril and ensures public safety is a valuable resource. The residential resource would be readily available for a timely placement.

- **Assessment.** The time spent in the residential phase of re-direction is not dead time designed solely to meet society's need for retributive justice. During this phase, the youth and family will be assessed for the chances of being a good match for either MST or FFT. The two service types are distinct from each other, and work best with their own unique target populations. Making sure the youth and the family are correctly matched will be a key treatment function of the residential phase of re-direction. If the community treatment decision is a rushed decision, it could have long-term deleterious consequences. Having up to 45 days to make that match improves the chances for a successful outcome.
- **Engagement in the Change Process.** The residential stay will provide an important opportunity to engage the youth and family in treatment and to prepare him or her for participation in the non-residential component. It is critical that the youth and family embrace the programming that is provided and that the youth has an integral role in identifying the goals to be accomplished. The time in residential placement will allow him or her to focus on changing thinking and solving problems in a pro-social manner. This is a key skill that will be carried over into the non-residential phase of re-direction, bridging the two components for the youth, family and treatment team.
- **Transition.** The incarceration phase of re-direction allows a period of time for the treatment team program staff, whether MST or FFT, to prepare the family for the return of the youth, and to prepare the youth for the new ground rules in the family home. It is important for OPPAGA to know that when the Department described this proposed model to the President of MST Services he saw conflict with neither the MST service principles nor the treatment fidelity.

The Department believes that without the residential component, many judges may be reluctant to use the program for the more difficult cases this program is intended to serve. The result may be net widening by placing less serious cases into the program.

The Department is also concerned that the initial attempt to implement this program concept not be so large as to make it difficult to achieve quality services. OPPAGA's recommendation would add one more program and 91 additional youth served. MST and FFT require extensive training and certification. The

capacity to deliver these services among providers is currently limited and this recommendation could tax our ability to deliver a quality service.

OPPAGA's support of the Department's goal of diverting appropriate youth from residential commitment to programs proven in national research is greatly appreciated. The Department believes the approach proposed in its LBR is appropriate for the intended purpose.

"We recommend that the department make performance on the mental health and substance abuse standard a critical indicator for programs receiving special funding to provide mental health and substance services. These programs should be required to receive a score of "acceptable" on the standard before receiving an overall performance rating of acceptable or above."

High quality mental health and substance abuse services are crucial to meeting the needs of youth in specialty programs. The Department will take action to encourage improvement in those programs that fall below acceptable levels in these areas on their Quality Assurance reviews. The Department has already taken steps to accomplish this by the development of a detailed desktop guide that clearly defines expectations for programs and monitors. A data system has been developed to track each program's score on each key indicator. OPPAGA reviewed Quality Assurance scores in 2002. A review of the system-wide scores in 2003 found that programs improved their performance on 11 of 12 key mental health and substance abuse treatment indicators (Enclosure).

For those specialty programs that score below acceptable levels on these standards during 2004, the Department will have monitors provide special attention to this issue and will assist the providers in obtaining the technical assistance required to improve performance. Training workshops on mental health and substance abuse issues will be included in the Department's annual Residential and Correctional Facilities training conference. The Department has actively supported the Youth in Turmoil Conference sponsored by the Florida Juvenile Justice Association and the Florida Association for Alcohol and Drug Abuse Association and will encourage as many programs as possible to participate in this training as well.

The overall quality assurance score is a cumulative measure of the program's performance across all areas reviewed. It allows for a comparison of programs within the residential commitment continuum holding each program to similar standards. If the Department requires specialty programs to score at least acceptable on the mental health and substance abuse indicators to achieve an

overall acceptable score, the ability to make valid comparisons across all programs may be limited. Clearly, mental health and substance abuse are important areas, but other areas, such as health and life safety issues, are also essential to operating quality programs.

The Department supports OPPAGA's goal to improve mental health and substance abuse services and believes this can be accomplished without establishing a separate system for determining the overall QA score in specialty programs.

The Department appreciates the opportunity to comment on this review and will actively pursue improvements in the areas covered in OPPAGA's recommendations. If you need further information, please contact Charles R. Chervanik, Assistant Secretary for Residential and Correctional Facilities at (850) 921-4188, or Richard Kline, Director of Policy and Programming at (850) 921-6295.

Cordially,

/s/ W.G. “Bill” Bankhead
Secretary

WGB/RES/RK/lla

cc: Charles R. Chervanik
Richard Kline

Bureau of Quality Assurance
2002-2003 Residential Mental Health Indicators Average

	Residential Key Indicator	2002	2003	Average Difference	Two Year Average
5.01	All new admissions are screened for substance abuse and mental health problems.	4.93	3.90	-1.03	4.45
5.02 C	Facilities have a mental health/qualified health authority to implement service delivery.*	1.89	1.94	0.05	1.91
5.03	The program has a plan for delivery of mental health services to youth in need of services.	5.01	5.47	0.46	5.23
5.04	The program has a plan for delivery of substance abuse services to youth in need of services.	4.82	5.30	0.48	5.05
5.05	A mental health assessment is done for all youth who indicate impairment during initial screening.	5.45	5.52	0.07	5.48
5.06	A substance abuse assessment is done for all youth who indicate impairment during initial screening.	5.19	5.34	0.15	5.26
5.07	Youth receiving mental health treatment have an individualized mental health treatment plan.	4.94	4.96	0.02	4.95
5.08	Youth receiving substance abuse treatment have an individualized mental health treatment plan.	4.72	4.86	0.14	4.79
5.09	Suicide prevention plan details suicide prevention procedures.	4.49	4.91	0.42	4.69
5.10	The program provides “Suicide Precautions” for potential suicide risk.	3.76	3.86	0.10	3.81
5.11	Placement in secure observation is done only when a youth demonstrates suicide risk behaviors.	3.07	3.69	0.62	3.37
5.12	The mental health and substance abuse plan outlines a crisis intervention and emergency plan.	4.94	5.42	0.48	5.17

Key Indicator Rating: Superior 7, 8, 9; Satisfactory 4, 5, 6; Partial 1, 2, 3; Non-Performance 0

* Key indicator 5.02 is a compliance indicator. The total maximum possible points for this indicator is 2.

Enclosure

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

Visit the *Florida Monitor*, OPPAGA's online service. See http://www.oppaga.state.fl.us. This site monitors the performance and accountability of Florida government by making OPPAGA's four primary products available online.

- OPPAGA publications and contracted reviews, such as policy analyses and performance reviews, assess the efficiency and effectiveness of state policies and programs and recommend improvements for Florida government.
- Performance-based program budgeting (PB^2) reports and information offer a variety of tools. Program evaluation and justification reviews assess state programs operating under performance-based program budgeting. Also offered are performance measures information and our assessments of measures.
- Florida Government Accountability Report (FGAR) is an Internet encyclopedia of Florida state government. FGAR offers concise information about state programs, policy issues, and performance.
- Best Financial Management Practices Reviews of Florida school districts. In accordance with the *Sharpening the Pencil Act*, OPPAGA and the Auditor General jointly conduct reviews to determine if a school district is using best financial management practices to help school districts meet the challenge of educating their students in a cost-efficient manner.

Subscribe to OPPAGA's electronic newsletter, Florida Monitor Weekly, a free source for brief e-mail announcements of research reports, conferences, and other resources of interest for Florida's policy research and program evaluation community.

OPPAGA supports the Florida Legislature by providing evaluative research and objective analyses to promote government accountability and the efficient and effective use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475).

Florida Monitor: http://www.oppaga.state.fl.us/

Project supervised by Kathy McGuire (850/487-9224)
Project conducted by Anna Estes (850/487-0831) and LucyAnn Walker-Fraser (850) 487-9168)
Gary R. VanLandingham, OPPAGA Interim Director