Palm Beach County Criminal Justice Commission

PROGRAM MONITORING AND EVALUATION SUB-COMMITTEE

Palm Beach County Governmental Center
10th Floor, CJC Conference Room
301 N. Olive Avenue
West Palm Beach, Florida 33401
http://www.pbcgov.com/criminaljustice
Tuesday, 12:00pm, March 19, 2013

- D R A F T A G E N D A -

1. **Welcome / Opening Comments,** Lee Waring, Chair

2. **Roll Call & Introduction of Guests**

3. **Approval and/or Additions to the Agenda**

4. **Approval of October 10, 2012 Minutes**

5. **Proposed Chairman's Comments**

   Welcome new members and guests to the Program Monitoring and Evaluation Sub-Committee. Thank all of the program coordinators who provided valuable input on developing individual performance measures and for submitting their most recent results.

6. **New Business**

   A. Scope of Work of the PME Sub-Committee

   B. Highridge Evaluation

7. **Old Business**

   A. Program Performance Indicators – First Report by Programs

   B. Drug Court Outcome Evaluations
      a) Adult Drug Court
      b) Riviera Beach Civil Drug Court
      c) Delinquency Drug Court
      d) Family Drug Court

   C. Reentry Outcome Evaluation

8. **Member and Guest Comments**

9. **Attachments**

   A. Draft Scope of Work (dated November 8, 2011)
   B. Final Report: Proposed Performance Indicators in Conjunction with Service Providers - (dated September 19, 2012). As approved by the Criminal Justice Commission
   C. Baseline Statistics and Program Performance Indicator Reports from: 1) Adult Drug Court, 2) Riviera Beach Civil Drug Court, 3) Delinquency Drug Court, 4) Reentry.

Next PME Meeting: To be determined.

Palm Beach County Criminal Justice Commission

PROGRAM MONITORING AND EVALUATION SUB-COMMITTEE

Palm Beach County Governmental Center
10th Floor, CJC Conference Room
301 N. Olive Avenue
West Palm Beach, Florida 33401
http://www.pbcgov.com/criminaljustice
Wednesday, 12:00pm, October 10, 2012

- D R A F T M I N U T E S -

Members Present:

Lee Waring, Chair
Jim Barr, Criminal Justice Commission
Carey Haughwout, Public Defender
Jennifer Loyless, Public Defender
Chuck Shaw, Palm Beach School District Board

Guests:

Cristy Altaro, Court Administration
Ronald Alvarez, Judge, 15th Judicial Circuit
Patrick Doyle, Riviera Beach Civil Drug Court
Krista Marx, Judge, 15th Judicial Circuit
Felicia Scott, Riviera Beach Civil Drug Court
Dorrie Tyng, Adult Drug Court

Staff:

Michael Rodriguez, Executive Director
Damir Kukec, Research & Planning Manager
Craig Spatara, RESTORE Program Manager
Becky Walker, Criminal Justice Manager

1. **Welcome / Opening Comments,** Lee Waring, Chair

   Mr. Waring welcomed and thanked everyone for coming.

2. **Roll Call & Introduction of Guests**

3. **Approval and/or Additions to the Agenda**

   The agenda was approved with no additions or deletions.

4. **Approval of September 19, 2012 Minutes**

   The minutes from the September 19, 2012 meeting were approved without amendments.

5. Chairman's Comments

Mr. Waring stated that the findings of the two reports discussed in the committee's September 19th meeting was presented at the Criminal Justice Commission meeting. As a result, the Commission recommended that the committee consult with local program providers before asking the Commission to act on the recommendation. As such, the purpose of this meeting was to review and discuss performance measures and levels from programs of the CJC such as Adult Drug Court, Riviera Beach Civil Drug Court, Delinquency Drug Court, and the County's Reentry program. Mr. Waring then asked Damir Kukec to take over the discussion.

6. Old Business

Mr. Kukec first thanked and acknowledged Mr. Waring and Mr. Rodriguez for their vision and leadership on this issue. He noted how historically, they have evolved from reporting on the results from service providers to comparing them with other similar programs by looking at peer-reviewed literature. He referred to Attachment A where they looked at the local programs' recidivism rates and compared them to peer-reviewed literature which showed that local programs faring better than the results shown in the peer-reviewed literature. The results from local programs will then become the standard for which outcomes or the effectiveness of programs will be measured. Mr. Kukec then referred to Attachment B, which outlines the expected level of service and performance from the service providers. He also mentioned about the Children's Services Council news article saying that CSC was only concern as to whether or not their programs are meeting the expectations of the CSC board, which he said the committee can use in delineating whether or not they are going to consider a program for funding. They are now at a point when they are asking the service providers to give a level of service based on the funding they are given.

Mr. Kukec said that most of the local providers are already aware in the sense that they have given their data, although they have not yet seen the proposed short term outcomes they would have to report. He discussed the importance of having a clear definition of recidivism, suggesting that it should refer to re-arrest rates. Mr. Waring added that historically, they looked at activity levels of local programs, and now they would like to make comparisons with other programs around the country. Mr. Waring referred to a grid they have prepared for drug court and reentry for which he requested feedback from the committee.

However, there was first a discussion of what the appropriate definition of recidivism should be and Mr. Kukec stated that they will adopt whatever definition the committee agrees on. Ms. Haughwout suggested that the definition of recidivism does not have to be the same for all programs, but it has to be clear in terms of the goals of the program. Mr. Waring said the committee will continue working on refining the definition of recidivism. There was also a discussion on how the outcomes presented in the reports were decided and a shared concerned that these outcomes did not necessarily reflect the actual experience of the local programs and their future funding implications. Mr. Waring said that was exactly the reason everybody was invited to the meeting – i.e., to validate this information. Mr. Rodriguez then suggested they go through each report and verify the numbers.

A. Defining Expected Performance Measures and Levels to Priorities (Attachment B):

i. Adult Drug Court: minimum of 120 participants; 60% graduation rate; and 10% recidivism rate within the first 90 days. Judge Marx suggested a minimum of 180 participants; 15% recidivism rate, with recidivism defined as arrest and convicted, reported every six months; and graduation rate of 50% based on a 12-month average; tracked for three years.

ii. Civil Drug Court: minimum of 150 court participants; 60% graduation rate; and 10% arrest rate within the first 90 days. Felicia Scott suggested a minimum of 100 participants; under Target Population, adults and adolescents; 50% graduation rate; and 10% arrest rate; reported every six months. Ms. Scott noted that their definition of recidivism will be different from the other programs being that their clients have yet to commit a crime, and therefore, would not have an arrest history, so it was agreed that an arrest and conviction would be more appropriate.

iii. Delinquency Drug Court: 14 court participants; target population as youth on probation with Department of Juvenile Justice; 50% graduation rate; 10% recidivism after first 90 days. Ms. Altaro offered a narrower definition of their target population as youth on probation with a pending violation of probation, with no first degree felonies; filing of delinquency instead of arrest was suggested; 50% graduation rate; 25% recidivism, meaning any misdemeanor or felony arrest regardless of conviction; with six-month reporting period.

Ms. Haughwout wanted to clarify whether these are the acceptable standards being set by the committee; Mr. Waring reiterated that these are just baselines they would like to start working with the caveat that they may need to be modified after six months when they have the ability to review data received from the programs.

Mr. Rodriguez reminded the members that this exercise is a proactive way of addressing an issue that the CJC may bring up in the future in terms of measuring effectiveness of programs it funds. Mr. Waring concurred by saying that this is an opportunity to improve our programs in terms of preventing crime.

B. Interim Report: Outcome Evaluations of Select Programs (Attachment A):

i. RESTORE: 200 adult felons returning to Palm Beach County from Florida Department of Corrections); recidivism defined as re-commitment at the Florida DOC; 15% convicted of a new crime and re-sentenced to DOC within three years after release.

ii. Non-RESTORE: 250 adult ex-offenders (adult misdemeanants and felons) returning to Palm Beach County from Florida Department of Corrections or the county jail; recidivism defined as re-commitment at the Florida DOC; 25% recidivism rate in first three years following release.

C. Update on Evaluations

No updates.

7. New Business

No new business.

8. Member and Guest Comments

No member and guest comments.

9. Adjournment

Mr. Waring thanked everyone for their time and participation and appreciated everyone's input acknowledging it as critical. He said they will be in touch with everyone as they continue to make changes.

Next Meeting: To be determined.

Criminal Justice Commission
Program Monitoring and Evaluation Sub-Committee

Scope of Work

Purpose:

The purpose of the Program Monitoring and Evaluation Sub-Committee is to lead and provide advice on efforts to determine the impact of programs funded by the Criminal Justice Commission.

Background:

Following the direction of the Palm Beach County Board of County Commissioners, the Criminal Justice Commission directed staff to implement a program monitoring and evaluation strategy. As a result, staff implemented various processes to collect information from various programs funded by the Criminal Justice Commission in whole or in part. Some of these efforts started in fiscal year 2010 and included the following components:

1. Staff prepared an annual report summarizing the scope of projects and activities funded by the Criminal Justice Commission.
2. Contracts included new wording to emphasize the collection and maintenance of information for monitoring, reporting, and evaluation purposes. This included the historical contract clause that funding recipients were required to maintain information for up to three after the contract was enforced, and that the County have the right to complete an audit of the recipients programmatic records.
3. Staff developed and implemented training with funding recipients so that each program and activity could develop a programmatic logic model and measurement framework. The County's Department of Social Services, Financially Assisted Agencies (FAA) provided valuable advice and direction for this component.
4. Staff further developed and refined contract policies and procedures, which were reviewed by the Office of Inspector General. The Criminal Justice Commission reviewed and approved the new procedures at an earlier meeting of the full commission.

These components have enabled Criminal Justice Commission staff to better monitor and report on the programs and activities funded by the Commission which include not-for-profits, city governments, state governments and other county departments/agencies that deliver direct services and activities to specific targets. It is also important to note that funding sources include *Ad Valorem*, trust funds, formula state and federal grants, as well as, competitive grants from state and federal governments and other not-for-profit agencies (e.g., Quantum Foundation).

Most of this information is contained in the annual process evaluation reports. During the September 2011 meeting of the Criminal Justice Commission, the Executive Director presented the first draft of the 2010 fiscal year process evaluation, and asked that members review for discussion at the next meeting. He expressed concerns with the preciseness of the reporting of some projects, but remarked that it was Commission's first attempt at obtaining logic models and

performance measures for the projects being funded. As a result of these remarks, private sector member, Mr. Waring suggested that it might prove more useful to assign the evaluation to a sub-committee for review and recommendations to Commission members. At the Vice Chair's request, the following members volunteered to sit on the review committee:

Private Sector Member – Mr. Lee Waring, Chair
Public Defender – Ms. Carey Haughwout (or representative)
Private Sector Member – Mr. Chuck Shaw
Private Sector Member – Mr. Jim Barr
State Attorney – Dave Aronberg (or representative)

Lastly, the work of this sub-committee directly responds to the request of the Palm Beach County Board of Commissioners; and speaks to the authority of the Criminal Justice Commission's ordinance and bylaws. For example:

Sec. 2-218. Authority

The criminal justice commission shall have the following authority and powers:

> a. To review, research and evaluate existing systems and programs within the scope of the criminal justice commission;
>
> b. To establish task forces or subcommittees to study in detail key aspects of programs and systems within the scope of the criminal justice commission;
>
> g. To make recommendations on modifying, creating or abolishing legislation, ordinances or regional or county-wide comprehensive plans dealing with systems and programs within the scope of the criminal justice commission;
>
> i. To request members of all agencies within the auspices of the board of county commissioners to provide the criminal justice commission in a timely manner with all data and information requested by the criminal justice commission, to appear at any meeting or hearing requested by the criminal justice commission, and to otherwise work in cooperation and good faith with the criminal justice commission in pursuing the criminal justice commission's objectives;

Scope of Work:

In general, the Program Monitoring and Evaluation Sub-Committee is to provide leadership on matters dealing with process (did we implement?) and outcome (did we change behavior?) evaluations for the Criminal Justice Commission.

The committee would meet an a bi-annual basis, in preparation for the six month and one year update; which concern monitoring and evaluation activities related to funded programs and activities.

The committee would also meet on an *ad hoc* basis as needed to review and provide comment on extensive outcome evaluations for specific programs and activities.

Members would advocate efforts to obtain access to data (at the individual level) in order to complete quasi experimental models that include both a program group along with a comparison group (often referred to as a "control group"). The comparison group is often very similar to the program group; except for the fact that it is not part of the program group.

The work of the sub-committee is crucial as it will provide a basis for reporting on "return on investment" (ROI); and informs the Criminal Justice Commissions deliberations on whether to fund a program or activity each fiscal year.

The sub-committee will provide suggestions that focus on improvement and enhancement to programming rather than focusing on criticism alone.

Staff would provide secretariat services to the Sub-Committee, sending information in a timely fashion, that may include reports and necessary documents prior to each meeting so that members can provide feedback, suggested comments and advice.

Prepared by: Damir Kukec
Research and Planning Manager
Criminal Justice Commission

Date: November 8, 2011
(Updated: March 10, 2013 - member names only).

(Attachment):

Proposed Evaluation Matrix:

Since the annual report contains a great deal of information, Criminal Justice Commission staff was directed to create a simplified "matrix" or rating scale that could be applied to the various programs and activities funded by the Commission. The matrix would be used to quickly rate a program or activities using a standard rating that would reflect basic requirements and characteristics that promote accountability and transparency.

Implementing agency/organization must demonstrate the following characteristics (yes/no):

1. Provided information that agency is conducting "evidence-based" programming and/or curriculum;
2. Implemented program and/or activities approved by the Commission;
3. Maintained consistent, clear and measureable program goals/objectives;
4. Collected and maintained data on program participants and activities;
5. If applicable, implemented "risk assessment" instrument prior to selecting program participants (does the program model fit the program participant?);
6. Provided timely and full access to program participant data and program activities (ideally, these records should be in electronic format);
7. Provided timely and full access to financial information;
8. Provided timely and full access to program site (on site file review and audit);
9. Completed logic model and measurement framework; and,
10. Completed recent process and outcome evaluation study by an independent body. Ideally, the process and outcome evaluations demonstrated program fidelity and positive outcomes.

If all of these characteristics are met, then the implementing agency/organization would receive a rating of 10 out of 10.

ORDINANCE NO. 88-16
AS AMENDED BY ORDINANCE NOS.
89-3, 90-38, 92-14, 92-25, 93-1, 93-35 AND 95-6.

AN ORDINANCE OF THE BOARD OF COUNTY COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA, ESTABLISHING THE PALM BEACH COUNTY CRIMINAL JUSTICE COMMISSION; PROVIDING FOR CREATION; PROVIDING FOR OBJECTIVE; PROVIDING FOR AUTHORITY; PROVIDING FOR OPERATION; PROVIDING FOR STAFF COOPERATION AND SUPPORT; PROVIDING FOR SEVERABILITY; PROVIDING FOR INCLUSION IN THE CODE OF LAWS AND ORDINANCES; AND PROVIDING FOR EFFECTIVE DATE, AS AMENDED BY ORDINANCE NOS. 89-3, 90-38, 92-14, 92-25, 93-1, 93-35 AND 95-6.

WHEREAS, the coordination of all aspects of the law enforcement and crime prevention efforts in Palm Beach County, Florida is important to Palm Beach County; and

WHEREAS, the board of county commissioners of Palm Beach County, Florida is empowered and has the duty to take such action as is necessary for the coordination of an efficient, cost effective and timely criminal justice system, and to effect the reduction of crime, in Palm Beach County, Florida; and

WHEREAS, for the health, safety and welfare of the citizens of Palm Beach County, the board of county commissioners of Palm Beach County, Florida desires that a commission be established with a broad scope of authority to coordinate all aspects of the state and federal criminal justice system in Palm Beach County, Florida.

NOW THEREFORE, BE IT ORDAINED BY THE BOARD OF COUNTY COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA, that:

Sec. 2-216.Created.

There is hereby established an advisory commission to be known as the "Palm Beach County criminal justice commission," herein referred to as the "criminal justice commission." The criminal justice commission shall be composed of the following membership from the private and public sector:

(a) Public Sector Membership:

1. Chair or Commission member of the Palm Beach County Board of County Commissioners
2. Palm Beach County Sheriff
3. State Attorney,15th Judicial Circuit
4. Public Defender, 15th Judicial Circuit

5. Clerk of the Palm Beach County Circuit Court
6. Chief Judge, 15th Judicial Circuit
7. Administrative Judge, Juvenile Division, 15th Judicial Circuit
8. Supervisory Special Agent, Federal Bureau of Investigation, West Palm Beach
9. Senior Agent, Drug Enforcement Administration, West Palm Beach
10. Member Palm Beach County School Board
11. Member, Palm Beach County Legislative Delegation
12. Member, Municipal League of Palm Beach County
13. District IX Juvenile Justice Manager, Florida Department of Juvenile Justice
14. President, Police Chief's Association
15. Resident Agent in Charge, Bureau of Alcohol, Tobacco & Firearms (ATF), West Palm Beach Field Office, U.S. Treasury Department
16. Chief, West Palm Beach Police Department
17. Circuit Administrator, Florida Department of Corrections, 15th Judicial Circuit
18. Supervisory Special Agent, Florida Department of Law Enforcement
19. President, Crime Prevention Officers' Association
20. United States Attorney, Southern District of Florida or Assistant U.S. Attorney, West Palm Beach
21. Member, Palm Beach County Association of Criminal Defense Lawyers

(b) Private Sector Membership: Twelve (12) persons nominated by the palm beach county economic council, but not necessarily members of the economic council, and confirmed by the board of county commissioners of Palm Beach County, Florida, which persons shall be representative of all segments of Palm Beach County, Florida

The terms for the members representing the board of county commissioners, the school board, the legislative delegation, and the municipal league shall be for a period of two (2) years. The remaining public sector members' term of membership will be for the duration of their position entitling them to sit as a member of the criminal justice commission.

Private sector members shall be appointed for a three-year term, with said term commencing on January 1 for the first year of appointment and expiring on December 31 of the third year.

All members of the criminal justice commission shall be electors of Palm Beach County, Florida. Appointed members of the criminal justice commission shall serve at the pleasure of the appointing body.

(Ord. No. 88-16, § 1, 8-16-88; Ord. No. 89-3, § 1, 3-21-89; Ord. No. 90-38, § 1, 10-16-90; Ord. No. 92-14, § 1, 5-28-92; Ord. No. 92-25, § 1, 9-15-92; Ord. No. 93-1, § 1, 2-1-93; Ord. No. 93-35, § 1, 12-21-93; Ord. No. 95-6, § 1, 3-21-95)

Sec. 2-217. Objectives.

The criminal justice commission is established to study all aspects of the criminal justice and crime prevention systems within the federal, state, county, municipal and private agencies within the county. This purpose shall include the study of the health and human services and educational systems, among others, as they pertain to criminal justice or crime prevention. The criminal justice commission shall make recommendations to the board of county commissioners on policies and programs designed to accomplish the following objectives:

a. To provide overall coordination to law enforcement and crime prevention efforts in the county;
b. To provide an efficient, cost effective and timely criminal justice system in the county; and
c. To effect the reduction of crime in the county on a permanent basis.

(Ord. No. 88-16, § 2, 8-16-88)

Sec. 2-218. Authority.

The criminal justice commission shall have the following authority and powers:

a. To review, research and evaluate existing systems and programs within the scope of the criminal justice commission;
b. To establish task forces or subcommittees to study in detail key aspects of programs and systems within the scope of the criminal justice commission;
c. To adopt from time to time rules and bylaws providing for the governance of the criminal justice commission, which rules and bylaws will be adopted by a majority vote of the members of the criminal justice commission;
d. To establish an executive committee by the majority vote of the members of the criminal justice commission, which Executive Committee will have such powers and authority as delegated by the criminal justice commission;
e. To review and comment on all grant requests for programs and systems within the scope of the criminal justice commission;
f. To make recommendations on modifying, creating or abolishing public and private systems and programs within the scope of the criminal justice commission;
g. To make recommendations on modifying, creating or abolishing legislation, ordinances or regional or county-wide comprehensive plans dealing with systems and programs within the scope of the criminal justice commission;
h. To assist the consolidation of systems and programs within the scope of the criminal justice commission when approved by the board of county commissioners;

i. To request members of all agencies within the auspices of the board of county commissioners to provide the criminal justice commission in a timely manner with all data and information requested by the criminal justice commission, to appear at any meeting or hearing requested by the criminal justice commission, and to otherwise work in cooperation and good faith with the criminal justice commission in pursuing the criminal justice commission's objectives;
j. To enter contracts and hire personnel as required to pursue the objectives of the criminal justice commission, subject to approval by the board of county commissioners; and
k. To take all acts reasonably required by the criminal justice commission in the exercise of the authority set forth above and the pursuit of the criminal justice commission's objectives.

(Ord. No. 88-16, § 3, 8-16-88)

Sec. 2-219. Operation.

Members of the criminal justice commission shall serve without compensation but may apply for reimbursement for authorized expenses incurred in connection with their official duties. The criminal justice commission shall operate with such funding and staffing as the board of county commissioners shall approve from time to time. Without prior approval, the criminal justice commission shall have no authority to incur expenses for Palm Beach County, Florida, would become liable.

(Ord. No. 88-16, § 4, 8-16-88)

Sec. 2-220. Staff cooperation and support.

The staff of the board of county commissioners, including but not limited to the county administrator, the county attorney and the public safety department of the county, are hereby charged with the responsibility to furnish to the criminal justice commission such records, documents, reports and other data on criminal justice matters which, in the opinion of the criminal justice commission, are reasonably necessary in order that the criminal justice commission may fulfill the duties required of it hereunder. Support services for the criminal justice commission shall be made available by the public safety department.

(Ord. No. 88-16, § 5, 8-16-88)

Sec. 2-221. Administration.

The criminal justice commission shall employ an executive director who shall hire such other administrative, professional and clerical assistance as necessary to carry out its duties authorized by this article, and as provided for in the criminal justice commission's budget, reviewed and approved by the board of county commissioners.

The executive director will be selected by the criminal justice commission and approved by the board of county commissioners. The goals and performance evaluations of the executive director shall be accomplished jointly by the county administrator and the criminal justice commission. The executive director shall also have contemporaneous access to ongoing operations and planning within the public safety department, division of criminal Justice of the county.

(Ord. No. 88-16, § 6, 8-16-88)

Sec. 2-222. Severability.

If any section, paragraph, sentence, clause, phrase, or work of this ordinance is for any reason held by the Court to be unconstitutional, inoperative or void, such holding shall not affect the remainder of this ordinance.

Sec. 2-223. Inclusion in the code of laws and ordinance.

The provisions of this ordinance shall become and be made a part of the code of laws and ordinances of Palm Beach County, Florida. The Sections of the ordinance may be renumbered or relettered to accomplish such, and the word "ordinance" may be changed to "section," "article," or any other appropriate word.

Sec. 2-224. Effective date.

The provisions of this ordinance shall become effective upon approval and filing with the Secretary of State.

APPROVED AND ADOPTED by the board of county commissioners of Palm Beach County, Florida, on the 16th day of August, 1988.

Acknowledgment by the Department of State of the State of Florida, on this, the 25th day of August, 1988.

EFFECTIVE DATE: Acknowledgment from the Department of State received on 29th day of August, 1988 and filed in the Office of the Clerk of the board of county commissioners of Palm Beach County, Florida.

Palm Beach County
Highridge Family Center Report

Title: Outcomes Study: Palm Beach County Highridge Family Center for at risk adolescents (11 to 16 years old).

History and Background:
The current fiscal crisis has caused all levels of government to re-think their approach to combating crime and reducing delinquency. Falling home prices, and rising unemployment rates means that local governments now have less money to provide services and programs that their constituents have come to expect (e.g., public safety). Initially, the Department of Public Safety, Division of Youth Affairs requested an evaluation of the Highridge Family Center by the Criminal Justice Commission. Subsequently, the Criminal Justice Mental Health and Substance Abuse Committee on Juvenile Populations (CJMHSA) requested the Criminal Justice Commission to undertake reviews of existing programs with a focus on outcomes rather than simply process. Specifically they requested a review of the Highridge Family Center. They are asking for information concerning efficacy in order to prioritize program funding for new and existing programs.

In response to this request from Youth Affairs and the directive of the CJMHSA, the Department of Public Safety, Youth Affairs and the Criminal Justice Commission, are completing the review in partnership. The Youth Affairs Division is part of the Department of Public Safety, a county government department. The mission of the Youth Affairs is to provide families of Palm Beach County with the highest quality in home counseling therapy, residential care, and psychological services in order to divert "at risk" children from the Juvenile Justice System.[1] The Criminal Justice Commission was created by County Ordinance in 1988 to facilitate collaboration among law enforcement and crime prevention efforts, to promote an effective criminal justice system, and reduce crime on a permanent basis. The County Ordinance gives authority to the Commission to undertake research and evaluation projects that fall under its purview.

Scope of the Research:
This research project is being conducted in partnership with two Palm Beach County Government Departments 1) Public Safety, Youth Affairs and 2) Criminal Justice Commission. The staff members involved are Dr. Twila Taylor, Dr. Tony Spaniol, Michael Rodriguez, Damir Kukec, Becky Walker, Katherine Hatos, and student interns Katie Aguila and Hannah Norcini.

We are following a cohort of approximately 1467 youth who participated in the County's Highridge Family Center Program for youth exhibiting behavioral issues, and may be at risk of engaging in delinquent or criminal behavior from 2003-2009. The purpose of the research is to examine the outcomes for the youth after they were discharged from Highridge Family Center; and to see if they became involved with the juvenile/criminal justice system. We further examined, within limitations, educational information for the youth.

[1] For more information on the Youth Affairs Division and the services they offer, please see http://www.pbcgov.com/publicsafety/youthaffairs/.

Introduction

The purpose of this report is to examine Highridge Family Center in terms of the demographic profile of the youth served, treatment model, completion rates, and outcomes based on the impact on home, school and community/peers. The outcomes that were analyzed were the survey of parents conducted from 2005-2008, school graduation, FCAT scores, dropout rate, absences, disciplinary referrals and proportion of year's growth and involvement in the juvenile /criminal justice system. The Criminal Justice Commission staff prepared this report utilizing information from a variety of sources. The first concept to be examined was how to compare Highridge to other similar programs in terms of model and treatment modalities. In addition to examining the model, the established outcome measures were to be analyzed and compared with similar populations. Data from the Florida Department of Law Enforcement was used to measure involvement with the juvenile/criminal justice system and data from the Palm Beach School District was examined for the school measures. The data from the school district is still in the process of being analyzed and is not currently available for review.

The first section of this report was based on a review through interview, written documents, program policies, direct observation, and answers to direct questions. A literature review was conducted to identify similar programs for comparison and to identify programs recognized as evidence based. It is attached as Appendix A.

Highridge is described as an at-risk youth prevention center. In searching three national evidence-based practice programs there were none found that fit the partial residential model serving as a prevention programs for at-risk youths. Therefore, the Criminal Justice Commission wanted to look at both residential treatment centers and evidence-based practice models for prevention, in order to better analyze the Highridge program model.

Based on the review of current literature it was determined that Highridge is anomalous in that it does not follow any kind of evidence based practice model; however, they do incorporate some therapies that are evidence based such as cognitive behavioral therapy. It was difficult to identify similar programs since Highridge is a partial residential center but not considered as a residential treatment center. As such, comparing populations and recidivism rates was more difficult.

The outcome measures identified through interviews and a review of performance measures presented through Office of Finance, Management and Budget are completion rates, bed utilization rates and preventing youth from becoming involved in the juvenile justice system. The completion rates varied from a high of 55% to a low of 39%.

In addition information from Highridge on a survey of parents and youth is included. This analysis revealed a significant difference from pre to post treatment on the parents' stress as related to the adolescent domain, $t(138) = 17.52$; $p < .000$. These results are indicative of the positive effect of intervention strategies. Specifically, the therapeutic strategies employed at Highridge Family Center targeted and successfully addressed adolescents' rule-breaking behaviors, mood interferences and social environments, reducing the associated experiences of parental stress.

The Florida Department of Law Enforcement provided the data on the arrests for youth who were involved in the program. Those arrests are broken down into before, during and after the

program and whether the youth completed the program, were withdrawn or released. Also examined are the number and types of offenses. The complete analysis is attached as Appendix E. The results showed that of the 1467 youth 745 had an arrest history. Of those who completed the program 62% were not arrested after completing the program.

Background/Model

Highridge Family Center is the only residential program offered by the Youth Affairs Division within the Department of Public Safety. Highridge is a 3 month Monday through Friday, 48 bed residential facility for Palm Beach County "at risk" youth between the ages of 11 and 16. The program focuses on 3 main areas for intervention: home, school, and peers. The youth attend the on-site Palm Beach County alternative school where they learn how to be successful in the classroom setting. The youth return to the residence after school and attend psycho educational, therapy, and community groups based in a therapeutic milieu that operates using a behavioral point/level system. Licensed therapists have evening hours to accommodate mandatory family therapy sessions and individual therapy sessions as needed. In order to facilitate generalization of skills to the home and community environment, parents and youth practice their newly learned skills each weekend while they are home and are rated using the same behavioral point system used at the facility. This unique model allows for less restriction than a traditional residential facility and more intensity and structure than traditional one hour per week outpatient therapy. The associated costs are a onetime fee of $75 for the application and a $75 activity fee. Referrals for treatment are primarily provided by the school system (guidance counselors, teachers, principals, assistant principals), the court system (various diversion programs, state attorney, public defender), various community service agencies, and word of mouth recommendations.

For admission to Highridge Family Center the following criteria must be met:

- Palm Beach County Resident
- Ages 11-16
- Home, School, Peer issues (documented on Family Information Form Appendix C)
- Willing to participate in treatment (both child and family)
- Medically/Psychiatrically Stable
- Able to provide transportation to and from the facility

The following preclude acceptance into the program:

- Recent psychiatric hospitalizations
- Psychiatrically unstable (danger to self/others, psychosis)
- Substance abuse as the primary issue
- Over 17
- Adjudicated delinquent/on probation
- Noncompliance on part of child or family to participate in treatment

Highridge has a wide spectrum of staff members including: associate, bachelor and master's level counselors, licensed master's therapists, pre-doctoral psychology interns, post-doctoral

psychology residents and registered nurses. Clinical staff is professionally supervised by a doctor of psychology who has extensive experience working with families and adolescents.

Highridge offers a range of services for both adolescents, and their families. Included in the residential services are: family therapy, educational services, group therapy, individual therapy, anger management groups, behavior management, substance abuse prevention and education groups, adolescent sexuality education and prevention groups, recreational activities, nutritional services, and parent education.

Parental participation is mandatory for admission and success at Highridge. Parents attend weekly family therapy sessions lasting 50 minutes to an hour. If parents miss two sessions, the adolescent may be asked to leave the program. During family therapy, parents and the adolescent work through identified treatment goals based on each family's presenting problems and developed in collaboration with the family and therapist. Having the parental support throughout this program is critical to successful completion.

Highridge School is an alternative school within the Palm Beach County School District. The Palm Beach County School District via Highridge School employs 7 full and part time certified teachers to ensure that adolescents are able to continue their academic requirements in conjunction with learning the skills needed to be successful in a classroom setting. Highridge's school offers a maximum class size of 20 students and every child has the benefit of additional one-on-one work time with their teachers. Every classroom is also staffed by a behavioral specialist employed by Highridge Family Center. Behavioral specialists remain in the classrooms to help children stay focused, on task, and attentive to the teaching staff through the use of observation, immediate feedback, redirection, one to one intervention, problem solving, conflict resolution, verbal de-escalation, and use of the behavioral point system. The behavioral and teaching staff is trained to manage children who have academic difficulties, Individualized Education Plans, and 504 Accommodation Plans. These daily observations and interventions are relayed to the academic and clinical team members working in the best interest of the child in order to ensure the behavioral and academic interventions are working as intended. Treatment plans are guided by daily feedback from all staff members and adapted as necessary throughout the three months the child attends Highridge Family Center.

History

There is no formal documented record of the history of Highridge Family Center. This information was obtained by Dr. Tony Spaniol through interviews with Max Beverly who was the former director of Youth Affairs. The history of the Highridge Family Center begins over five decades ago. It encompasses significant social change and legislative action which had direct impact upon how juveniles were treated once deemed dependent or delinquent. The original residential program was called the Sabal Palm Detention Center. This 48-bed facility stood directly in front of where the current Highridge Center now stands. It was built in the mid-fifties to house dependent and delinquent youth. It housed males and females as well as serving as a nursery facility for abandoned infants.

In the early 60's, state law required that dependent and delinquent youth be housed separately. Sabal Palm remained a commitment facility to be used by the Juvenile Courts for delinquent youth. In 1967, Mr. Max Beverly became Director of Detention Services including the Sabal

Palm facility. Mr. Beverly was responsible for the integration of the Riviera Beach Children's Home with the Sabal Palm facility. By 1968, Mr. Beverly saw the need to shift programming at Sabal Palm from "warehousing" delinquent youths to treating them. He began his effort to hire Master's level clinicians to offer counseling to these adolescents and thus began the treatment culture of the Sabal Palm facility.

In the early 70's, state laws changed and delinquent youths could no longer be committed to a residential facility unless it was run by the State of Florida. Mr. Beverly, working closely with Juvenile Court Judge Emory Newell, saw an opportunity to utilize the Sabal Palm facility as a "stop-gap" measure to prevent less severe delinquent youths from being sent to the state industrial schools. They approached the Board of County Commissioners with the idea and it was well received. This marked the beginning of the Sabal Palm Center as a "prevention" program for at-risk youths.

As years passed, Mr. Beverly worked toward enhancing the therapeutic nature of the facility, hiring more therapists and seeking consult from Chief Psychologist Lisa Mays. Ultimately, this lead to the hiring of a Psychologist to help direct the path of the Sabal Palm program and to address the increasingly complex nature of the youths served. Mr. Beverly, in consultation with this clinical team, recognized the importance of family (parental) involvement and made the decision to shape Sabal Palm as a five-day program. This served the twofold purpose of keeping parents actively involved in their child's care as well as cut staffing costs. This allowed him to hire better educated and even more competent clinical staff.

The 48-bed Sabal Palm facility soon began to show signs of aging and the Board of County Commissioners decided to construct a new facility, adding 24 beds and dedicating the Highridge Family Center to the same goal of preventing youths from criminal activity. The current program continues the long tradition of keeping parents involved in the care of their child. It is staffed by well trained and dedicated doctoral and master's level clinical staff as well as bachelor's level behavioral staff. The program allows for intervention in the three major areas of a youths life: home, school, and community (peers). In 2008 the facility funding was reduced to accommodate 48 beds. The program began accepting youth referred from the juvenile court system and on certain medications.

Model

Staff Requirements

Highridge has 4 dorms, 12 residents per dorm, 2 per room. Each dorm is assigned and equipped with a treatment team consisting of the following: a family therapist, 2 day counselors, and 1 night counselor. The credentials of the staff: all day shift staff, with the exception of one, include a 4 year degree in the social services field (or if the degree is in a non-related field then they have experience with at risk youth and/or residential programs). The minimum qualification for the night shift position is an associate's degree. The requirements for a Family Therapist are that they have a Florida License at the Master's Level (Psychology, Marriage and Family Therapy, Mental Health Counseling, or a related field). Highridge also has a pre-doctoral level internship and post-doctoral residency both in Clinical Psychology. These positions are filled as a result of a nationwide search of eligible candidates and are part of their training program for Clinical Psychologists.

Staffing
Staffing for the behavioral milieu consists of: 2 counselors for each dorm of 12 residents (ratio of 1:6) for day shift. Night shift staffing is 1 staff per dorm. Additionally, Highridge has a nurse/supervisor throughout the night. Other staffing consists of 4 school behavioral staff that are in the classrooms with the youth during the school hours. They are responsible for supervision of the children and using various interventions to help the youth learn how to be successful in a classroom setting.

Therapist Duties: Direct service activities include: conducting weekly family therapy sessions (up to 12), conducting 5 therapy groups per week, individual sessions as needed, crisis intervention as needed, behavioral interventions as needed such as commitment checks, privilege freezes, and overnight parental interventions. Other duties include: documentation, individual and group supervision, development, implementation and management of individualized treatment plans, didactic trainings and attendance at various meetings.

Dorm Counselor Duties include: ensuring safety of all residents and monitoring them at all times, being responsible for implementing the behavioral point/level system consisting of rating the residents' behavior after each block of time on the schedule and providing rewards and consequences, conducting community groups and conflict resolution on a daily basis multiple times per day, conducting goals-group in mornings and reading-group at night, ensuring residents are using appropriate coping skills to manage emotions—being there in the moment to help them respond in a healthier way, ensuring residents get from one activity to another on time, monitoring mealtimes, outside structured activities, shower time, homework time, and bedtime.

Night staff conducts 30 minute and hourly rounds throughout the night and Night staff is responsible to awaken residents in mornings, supervise morning routine, ensure residents are ready for breakfast and then escort them to school. Night staff is also responsible for data entry and the forms dealing with the residents' points, level, and supplies necessary regarding the residents' points, level, and tracking of the various behavioral interventions used on a daily basis.

Therapies

Milieu Therapy
Therapeutic community and token economy residential programs have been studied and compared at length. Research has shown that in general, there is little difference between the two treatment modalities for the majority of presenting problems and that an even higher success rate might be achieved by combining the two programs and the beneficial aspects of each (Mann-Feder, 1996). Highridge Family Center combines a therapeutic community with a token economy where adolescents earn points for levels and privileges or consequences. Therapeutic communities often stress self-regulation, peer confrontation and the development of insight necessary for behavioral change. Token economy programs typically focus on behavior modification principles and use point systems for behavior change, typically seen as a result of consequences and reinforcements (Mann-Feder, 1996). Highridge uses milieu therapy which is a planned treatment environment in which every day events and interactions are therapeutically designed for the purpose of enhancing social skills, improving decision making, coping skills, and building confidence. A therapeutic milieu provides the residents with a consistent, nurturing environment with predictable and consistent expectations. It features

normalizing and developmental perspectives that use common structures familiar to all children, such as daily routines, consistent rules and activities.
Highridge follows a behavioral point-level system that has a daily schedule broken down into 18 parts (called service units). For each of these service units, the adolescent will be assessed on his/her behavior, attitude, and cooperation resulting in a score of below average, average or above average. Points are totaled on a daily basis with the resident receiving a new card each day. Points for each week are tracked, and at the end of each week, if the adolescent earns enough points, they are eligible to apply for the next Level. Highridge's program consists of five different levels. Each level is achieved based on a combination of points earned and values and characteristics displayed. If an adolescent does not treat the program seriously, this will result in being dropped to a lower level or not attaining the next higher level. Values are associated with each of the levels. This system makes a distinct connection between the rewards and privileges associated with the levels to the development of positive values and characteristics in the adolescent throughout their work in the program. The levels go in the following order: **Adjustment** —Entry level, **Commitment** —Level 1, **Responsible** —Level 2, **Trustworthy** — Level 3, **Integrity/Maturity** —Level 4. Despite the fact that the adolescents go home on the weekends they are still in the program and therefore are accountable for their behaviors. Parents are responsible for completing weekend point cards using the same behavioral point system that the program uses. The parents rate their child's behavior at the end of each day that they have them on the weekends and return the point cards when they return their child to the facility. Therefore, the child's level is directly tied to their behavior at home with their family on the weekends, as well as their behavior in school and with their peers.

Family Therapy
Jones (1985) produced some of the first research into the area of family therapy with adolescents and suggested that a child can make no more progress than their family is also able to make. The assumption from Jones' research is that children cannot be put back into dysfunctional environments and expected to maintain change without mutual change occurring with caregivers. "Family therapy is pragmatically defined as any psychotherapy that directly involves family members in addition to an index patient and/or explicitly attends to the interaction among family members." (Pinsof, W. & Wynne, L., 1995). Family therapy allows the adolescent and parent/guardian to come together with a therapist present to discuss their identified treatment issues with a focus on interactional patterns. Family therapy and parental involvement is mandatory. There is a formal treatment plan that is reviewed and signed by the family members, therapist, and treatment team members. This plan is presented in treatment team meetings. Progress is discussed weekly in both individual and large group treatment teams as well as with the family. The goals are related to the presenting problem. Whatever the adolescent's situation may be, there is a goal mapped out specifically for that case. Highridge identifies 3-4 overall goals, with numerous objectives associated with each goal to assist the child and family in achieving the goals. The overall goals focus on family reorganization (hierarchy, boundaries, communication, limit setting, consistency in parenting, etc.), school issues (completing homework, behaving in class, respecting authority, etc), and individual issues (increasing self esteem, increasing coping skills/anger management skills, increasing leadership skills, increasing social sills/problem solving skills, etc.) The discharge summary documents the progress made on the goals. Highridge also has monthly 2 hour Parent Training meetings during the last week of each month. This is a support group as well as an educational group where the parents learn

specific skills to help them in parenting their adolescent. The 3 topics which correspond to the 3 months of treatment are: behavior modification, communication, and problem solving.

Group Therapy
Group therapy has been shown to be effective and beneficial with adolescents due to their extreme focus on peer group acceptance. The following groups are provided:

Weekend Wrap Up Group is a group in which adolescents report how they implemented their newly learned coping skills and addressed their treatment goals over the weekend. The parents of the adolescents are able to participate through the therapist's review of the weekend point cards. This allows for adolescents to receive feedback on how to modify their behavior and encourages accountability for weekend interactions with their parents and peers in their community. The group focuses on how the adolescent has displayed the values and characteristics associated with their level while they were at home over the weekend.

Therapy Group is a process oriented group that focuses on the issues that brought the adolescents to treatment. There are no more than 6-8 residents in this group. This allows group members to develop cohesiveness and trust among the members. As members feel safe in the group setting, they are able to address significant issues they are struggling with. As group cohesion increases, adolescents gain valuable interpersonal learning, a sense of responsibility for their actions, a sense of belonging, and the invaluable experience of learning how to appropriately identify and express their emotions.

Anger Management Group – Highridge utilizes a curriculum that was adapted from The King County Step Up Model. Step-Up is a nationally recognized domestic violence counseling program for teens that have been violent with family members. Violent behavior includes threats, intimidation, property destruction, degrading language and physical violence. The goal of Step-Up is for youth to stop using violent behavior and to replace abusive behavior with respectful behavior so that all family members feel safe at home. The overall goal of Step-Up is to stop the cycle of family violence. Domestic violence can begin in the teen years with abuse of family members, as well as intimate partners, and continues on into adult relationships. Changing violent and abusive behavior during adolescence helps prevent continuing the cycle of violence. (website: http://www.kingcounty.gov/courts/stepup.aspx)

Level Process Group is a group focusing on helping the adolescents focus on working through the emotions associated with either receiving or not receiving their level. This group also focuses on the values that are associated with each level and how the adolescents demonstrate the values and characteristics, either in the milieu, at school, and at home on the weekends.

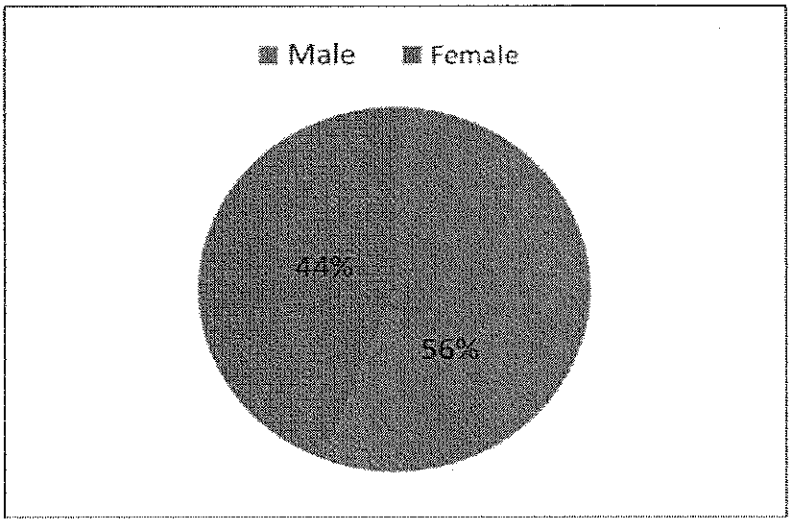
Individual Therapy
Individual therapy is provided to the adolescents on an "as needed" basis for gathering psychosocial information, dealing with a specific behavioral or family issue or an issue relating to participation in the program. Each therapist uses an approach based on a systemic framework that incorporates Cognitive Behavioral Therapy and Solution Focused techniques, depending on the presenting problems and approach that meets the need of the adolescent.

Follow Up Treatment
Outpatient family therapy is highly recommended after the adolescent completes his/her three month residential treatment. Youths Services Bureau, under the Division of Youth Affairs, offers four locations where outpatient treatment can be provided at no cost to families: Belle Glade, Delray Beach, Central County, and North County.

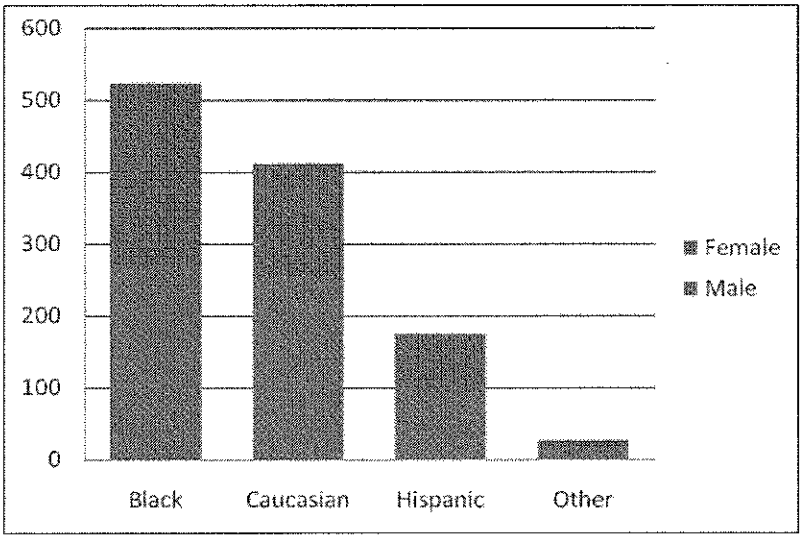
Demographics

Demographic information was gathered from both the Highridge database and school system to describe the cohort of 1467 youth participating in the program from 2003-2009. The demographic is also combined within a breakdown of completion, withdrawal and release. The program describes three reasons for completing (ending) program participation: 1) complete; 2) withdraw; and 3) release. The first reason denotes that the program participant ended the program by successfully completing the program. Withdraw suggests that the program "fit" was not necessarily the best for the individual and that other programming may be necessary. However, this category also includes reasons related to changing family circumstances (e.g., family moving, participant is not ready to participate, or the participant is "home sick" and does not return). Lastly, the reason "release" identifies program participants who are asked to leave the program for non-compliance and repeated rule violations and therefore can be seen to represent unsuccessfully completing the program.

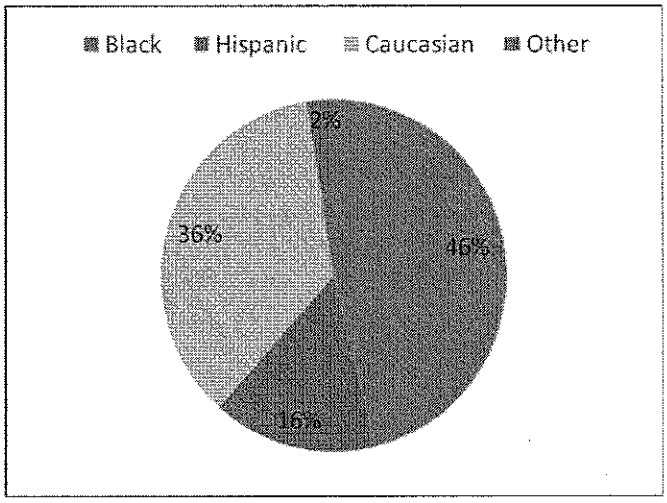
Gender Distribution



Male: Female Ratio



Race

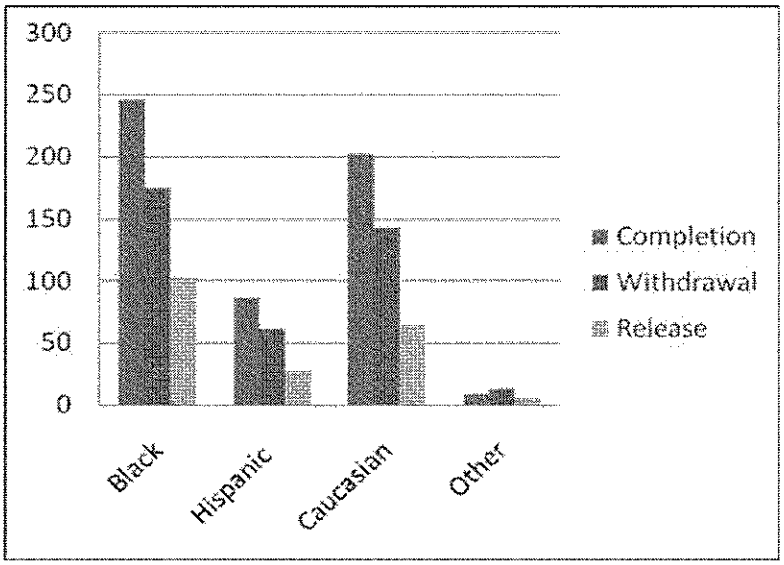


This table represents the unique youth program participants by most recent program start date (and start year)

Source: Highridge Programmatic Data

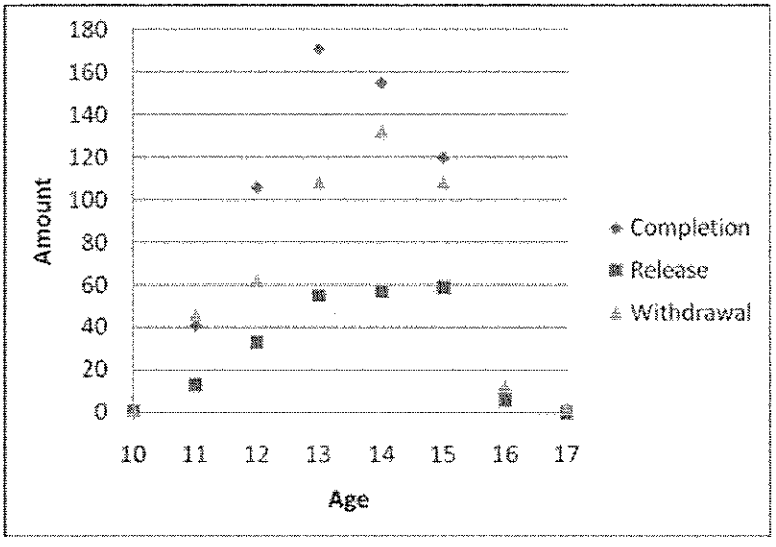
Program Start Year			Frequency	Percent	Valid Percent	Cumulative Percent
2003	Valid	Completed	52	47.7	47.7	47.7
		Released for Violation	22	20.2	20.2	67.9
		Withdrawn	35	32.1	32.1	100.0
		Total	109	100.0	100.0	
2004	Valid	Completed	120	51.9	51.9	51.9
		Released for Violation	42	18.2	18.2	70.1
		Withdrawn	69	29.9	29.9	100.0
		Total	231	100.0	100.0	
2005	Valid	Completed	99	44.4	44.4	44.4
		Released for Violation	37	16.6	16.6	61.0
		Withdrawn	87	39.0	39.0	100.0
		Total	223	100.0	100.0	
2006	Valid	Completed	103	46.6	46.6	46.6
		Released for Violation	35	15.8	15.8	62.4
		Withdrawn	83	37.6	37.6	100.0
		Total	221	100.0	100.0	
2007	Valid	Completed	84	39.1	39.1	39.1
		Released for Violation	43	20.0	20.0	59.1
		Withdrawn	88	40.9	40.9	100.0
		Total	215	100.0	100.0	
2008	Valid	Completed	131	54.8	54.8	54.8
		Released for Violation	40	16.7	16.7	71.5
		Withdrawn	68	28.5	28.5	100.0
		Total	239	100.0	100.0	
2009	Valid	Completed	82	43.6	43.6	43.6
		Released for Violation	34	18.1	18.1	61.7
		Withdrawn	72	38.3	38.3	100.0
		Total	188	100.0	100.0	

Race versus Program Outcome



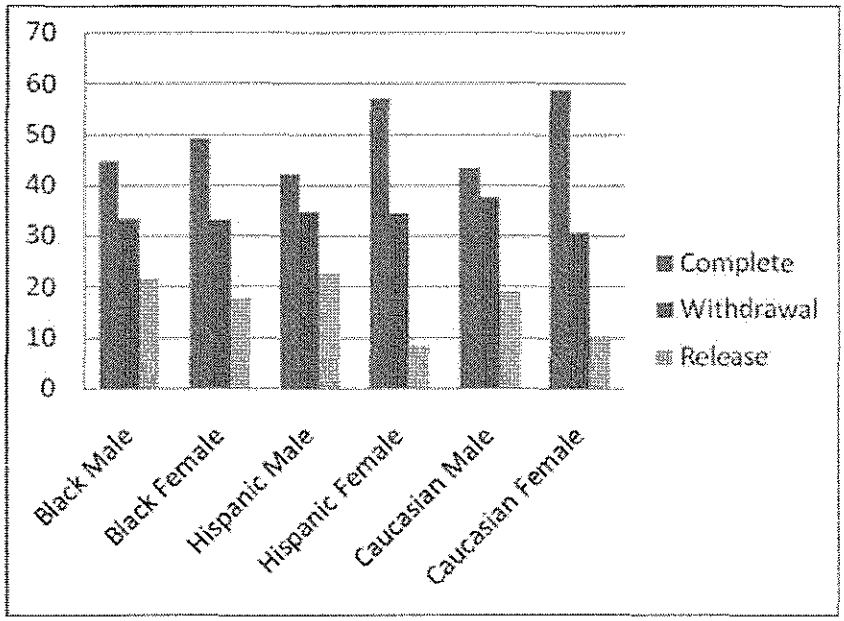
- All races exhibit similar completion rates
- The average completion rate is 48.5%
- All races have a higher percentage of completions than withdrawals or releases

Age versus Program Outcome



- Ages 13 and 14 have the highest percentage of completions
- Ages 11-15 have a greater percentage of completions than withdrawals or releases

Program Outcome, Proportion



- Females are more likely then males to complete the program
- Males are more likely than females to be released from the program
- Caucasian females are the most likely to complete the program

Methodology and Limitations

The formally established goals and outcome measures for Highridge Family Center submitted on an annual basis are completion rate and bed utilization. In reviewing the history from Dr. Spaniol it was indicated that preventing youth from becoming involved in the juvenile justice system was a goal. Also the literature (website and brochure) on Highridge indicate that this is accomplished by having a positive impact on home, school and peers. Therefore we looked at those three areas.

The limitations of viewing the data on these three areas are: Outcome measures are ideally established and tracked from the beginning of a program. Since Highridge has not only a long history in the community but has also made changes in its structure and focus during this time rendering it more difficult to track outcomes.

1- Home: Highridge Family Center received funding for three years to conduct surveys with parents on their perception of changes made after completing the program. The data available are surveys done from 2005-2008. The full summary report is attached as Appendix B.
Limitations: These surveys were not continued and there were no follow up surveys completed after a designated time frame due to budget constraints.

2- School: The Criminal Justice Commission requested from the school district, data on graduation, FCAT scores, disciplinary referrals and absences, participation in adult education.
Limitations: The data received is in need of further analysis and refinement and is therefore not presented at this time.

3- Peers/Community: Initially both jail booking data, and Department of Juvenile Justice data were reviewed and for overall consistency and completeness of data it was decided to examine names submitted to Florida Department of Law Enforcement (FDLE) to obtain arrest history. Limitations: any referrals done by law enforcement not reported to FDLE are not part of this data.

Outcomes

Home

Study Dates: October 2005 – April 2008

Instruments Used: Stress Index for Parents of Adolescents (SIPA)
Behavior Assessment System for Children, Second Edition (BASC-2)

- Parent Rating Scale
- Child Self-Report, Adolescent Self-Report

Study Participants:

Pre Test	Range of 461-532
Post Test	Range of 139-175 (lower due to following factors: treatment dropout, invalid test results, language barriers, study dropout, etc.)

Stress Index for Parents of Adolescents (SIPA)
Results from the SIPA indicated that upon admission to Highridge Family Center parents were experiencing high levels of stress associated with adolescent delinquency/antisocial attitudes, moodiness/emotional lability, and social isolation/withdrawal. Delinquency/Antisocial measures the stress the parent experiences as a result of the adolescent's violation of social normal and acts of juvenile delinquency. Moodiness/Emotional Lability measures the parent's perception of the adolescent's affective characteristics such as sudden mood changes, irritability, and temper problems. Social Isolation/Withdrawal measures the parent's perception of the level of the adolescent's social isolation and passivity. These are all subscales that feed into the adolescent domain indicating that the majority of stress experienced by the parents upon admission was directly related to difficulties with adolescent mood and behavior. Upon completion of the program, the parents reported significant improvements in their levels of stress regarding these particular subscales. Results were analyzed using a paired-sample t test. This analysis revealed a significant difference from pre to post treatment on the parents' stress as related to the adolescent domain, $t(138) = 17.52$; $p < .000$. These results are indicative of the positive effect of intervention strategies. Specifically, the therapeutic strategies employed at Highridge Family Center targeted and successfully addressed adolescents' rule-breaking behaviors, mood interferences and social environments, reducing the associated experiences of parental stress.

The full results are attached as Appendix B.

School
The data received from the Palm Beach County School District on Highridge youth and a comparison group is in need of further analysis and refinement.

Peers/Community

The list of 1467 youth who participated in Highridge from 2003-2009 was submitted to the Florida Department of Law Enforcement to ascertain the arrest history, the date and type of offenses. The data was broken down by the completion status, before, during and after treatment, types of offenses, and the following chart which depicts the breakdown by arrests by time frame after participation in the program. A more complete breakdown of arrests and charges is attached as Appendix D.

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
When Did Arrest Take Place? (With Most Recent Admission) * REASON	722	96.9%	23	3.1%	745	100.0%

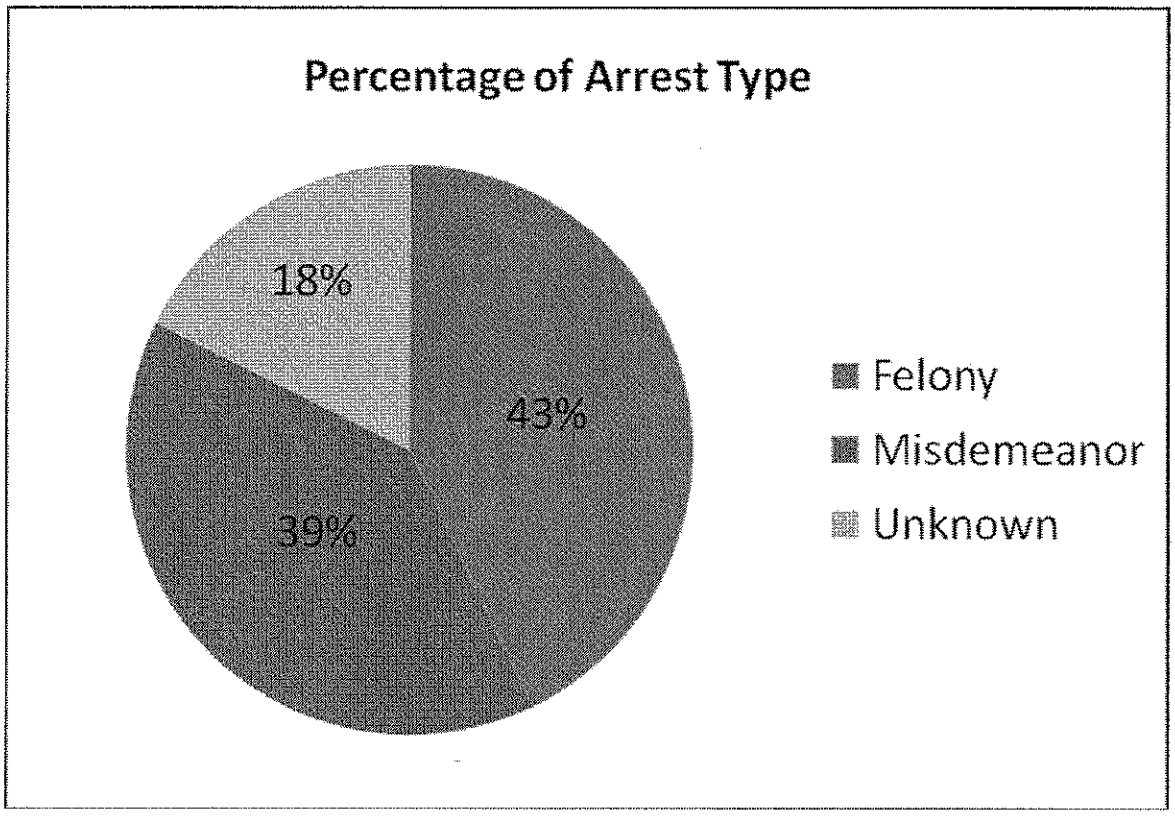
When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

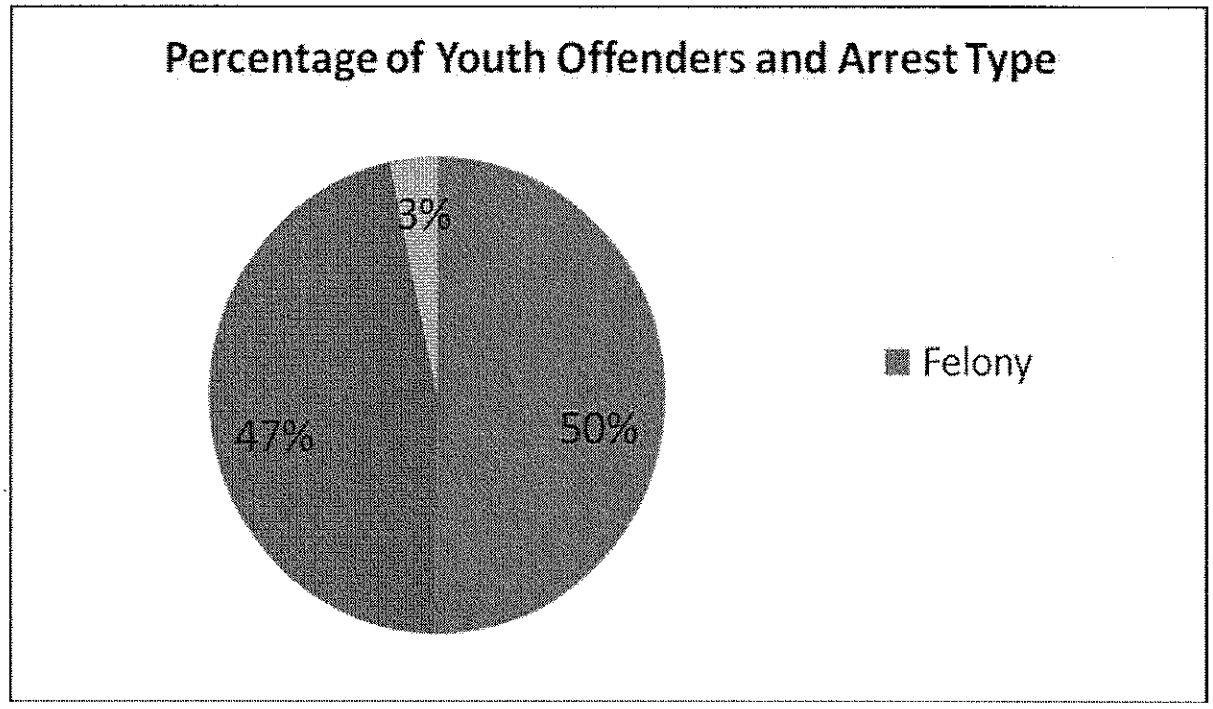
			REASON			
			COMPLETE	RELEASE	WITHDRAW	Total
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	78	52	88	182
		% within When Did Arrest Take Place? (With Most Recent Admission)	33.5%	28.8%	33.0%	100.0%
		% within REASON	24.2%	32.7%	21.8%	25.2%
	During Programming	Count	8	5	11	24
		% within When Did Arrest Take Place? (With Most Recent Admission)	33.3%	20.8%	45.8%	100.0%
		% within REASON	2.6%	3.1%	4.0%	3.3%
	After Exit from Programming	Count	211	102	203	516
		% within When Did Arrest Take Place? (With Most Recent Admission)	40.9%	19.8%	39.3%	100.0%
		% within REASON	73.0%	64.2%	74.1%	71.5%
Total		Count	289	159	274	722
		% within When Did Arrest Take Place? (With Most Recent Admission)	40.0%	22.0%	38.0%	100.0%
		% within REASON	100.0%	100.0%	100.0%	100.0%

Page 3

Years to First Offense After Program Exit * REASON Crosstabulation

			REASON			
			COMPLETE	RELEASE	WITHDRAW	Total
Years to First Offense After Program Exit	Less Than 1 Year	Count	56	45	86	187
		% within Years to First Offense After Program Exit	29.9%	24.1%	46.0%	100.0%
		% within REASON	26.5%	44.1%	42.4%	36.2%
	Between 1 and 3 Years	Count	124	50	98	272
		% within Years to First Offense After Program Exit	45.6%	18.4%	36.0%	100.0%
		% within REASON	58.8%	49.0%	48.3%	52.7%
	Between 4 and 5 Years	Count	30	7	16	53
		% within Years to First Offense After Program Exit	56.6%	13.2%	30.2%	100.0%
		% within REASON	14.2%	6.9%	7.9%	10.3%
	Greater Than 5 Years	Count	1	0	3	4
		% within Years to First Offense After Program Exit	25.0%	.0%	75.0%	100.0%
		% within REASON	.5%	.0%	1.5%	.8%
Total		Count	211	102	203	516
		% within Years to First Offense After Program Exit	40.9%	19.8%	39.3%	100.0%
		% within REASON	100.0%	100.0%	100.0%	100.0%


Percentage of Arrest Type
18%
43%
39%
Felony
Misdemeanor
Unknown


Percentage of Youth Offenders and Arrest Type
3%
47%
50%
Felony

Breakdown of Offenses by Charge (5293 Charges)

Offense	Charges	Percent
Assault and Battery	995	18.8
Failure to Appear	574	10.8
Shoplifting & Larceny	527	10.0
Burglary	492	9.3
Drug Offenses	481	9.1
Robbery	160	3.0
Weapons Offenses	154	2.9

Breakdown of Offenses by Youth (745 youth) (Most serious offense)

Offense	# of Youth	Percent
Assault & Battery	337	45.2
Shoplifting & Larceny	91	12.2
Burglary	88	11.8
Robbery	83	11.1
Drug Offenses	44	5.9
Failure to Appear	26	3.5

Cost

The budget for the Highridge Family Center for 2011 was $2,315,847, based on 48 beds at 5 days a week for 50 weeks that equates to $193.00/ day/ bed.

Literature Review

In searching three nationally recognized sites for evidence-based practice programs there were none regarding residential prevention programs serving at-risk youths. There are a number of programs that are residential and serve at risk youth such as Wilderness Camps, Boot Camps, Therapeutic Boarding Schools, Residential Treatment Centers, and Faith Based Programs. Therefore, the Criminal Justice Commission wanted to look at both residential treatment centers and evidence-based practice models for prevention, in order to reach a better understanding of Highridge's program.

According to the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide, few evidence-based practices have been tested in residential treatment centers

(RTCs). Critics of residential placement often express concerns about decisions to remove youths from their homes and communities to treat them in settings such as RTCs. Some argue that placing youths with psychiatric or behavioral problems together in a residential environment may cause more harm to an individual's treatment process. In addition, the costs of placing youths in residential programs such as RTCs can be substantial to the juvenile justice system (Bettman and Jasperson 2009). A report from the Justice Policy Institute (2009) estimates that reporting States spend an average of $7.1 million a day keeping youths in residential facilities. Thus, many jurisdictions across the country have implemented alternative options to secure residential placements and confinement for youths who could be served better in community-based treatment programs, instead of receiving treatment in residential settings such as RTCs (though these alternatives may not be appropriate for all youths). Further examination of this is attached in Appendix A.

Summary and Discussion

This evaluation of the Highridge Family Center presents a unique opportunity to examine the results of a program that has had a long history of serving the youth of Palm Beach County. The primary purpose of the study was to look at the program model, how this model was implemented, and the outcomes resulting from the program model. Furthermore, the report has been prepared as a retrospective assessment, rather than establish goals, outcomes and performance measures, given the history and the multiple programmatic changes over time.

Highridge incorporates proven therapeutic strategies which offer a range of techniques to fit the unique needs of the adolescent and their families. The results indicate that the average completion rate is 48.5%, and of these youth, only 8.4% were arrested within the first year after leaving the program. This is a significantly lower percentage of arrests compared to those who were released or withdrew from the program. Moreover, survey responses demonstrate that parents saw positive changes in their child after completion of the program.
The results from this evaluation prompt certain recommendations for the Highridge Family Center. From a programmatic perspective, Highridge ought to continue utilizing cognitive behavioral and family therapy, because it has been shown to be effective with this population[2]. Nevertheless, to ensure that the effectiveness and outcomes of the treatment can be determined, Highridge needs to formulate a clear mission and goals, as well as employ a risk assessment measure before admitting an individual.

In examining the results of this effort there are some findings and there are some questions that prompt further research.

[2] Please see Appendix A: Delinquency, Criminality, and Violence Prevention

Appendix A

Model Programs

Alternatives to secure corrections or confinement, including residential placements, are special programming approaches designed to prevent youths from being placed out of the home environment for any significant length of time. The concept follows from the premise that time spent in out-of-home placement may do more harm than good for these youths. Further, these alternatives give such youths the benefit of remaining in their communities with greater access to needed resources (i.e., necessary treatment and medical services) without endangering the community and at much less expense then secure residential placement (OJJDP 2001). In addition, the many problems associated with reentry are avoided because the youth is never entirely estranged from the community for a lengthy period of time. Finally, this approach keeps less serious or nonviolent offenders at home or in their home communities, thus increasing the availability of secure beds for the most serious and violent offenders (OJJDP 2001).

There are several different types of secure confinement and placement alternatives, including home confinement or house arrest, day or evening reporting centers, shelter care, specialized foster care, and intensive supervision programs. Wraparound/case management is another program type designed to keep youth at home and out of institutions or residential placements whenever possible. The strategy involves "wrapping" a comprehensive array of individualized services and support networks "around" young people, rather than forcing them to enroll in inflexible treatment programs. Many of the wraparound initiatives and programs that have been evaluated, including Wraparound Milwaukee and Connections, have concentrated on youths with mental health needs. The research on these programs finds that youths who receive wraparound/case management services show improvements in behavior and everyday functioning, as well as reduced risks of delinquency, compared with youths who do not receive those services.

Evidence-Based Practices

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide also suggests the benefits of using Cognitive Behavioral Therapy (CBT) as well as incorporating Family Therapy. Cognitive–Behavioral Therapy/Treatment is a problem-focused approach to helping people identify and change the dysfunctional beliefs, thoughts, and patterns of behavior that contribute to their problems. Its underlying principle is that thoughts affect emotions, which then influence behaviors. CBT combines two very effective kinds of psychotherapy: cognitive therapy and behavioral therapy.

Cognitive therapy concentrates on thoughts, assumptions, and beliefs. With cognitive therapy, people are encouraged to recognize and to change faulty or maladaptive thinking patterns. Cognitive therapy is a way to gain control over inappropriate repetitive thoughts that often feed or trigger various presenting problems (Beck 1995). For instance, in a young person who is having trouble completing a math problem, a repetitive thought may be "I'm stupid, I am not a

good student, I can't do math." Replacing such negative thoughts with more realistic thoughts, such as "This problem is difficult, I'll ask for help," is a well-tested strategy that has been found to help many young people face their academic problems. Replacing negative behaviors with positive behaviors is also a well-known strategy to help change behaviors, particularly when the new behavior is reinforced. The combination of cognitive therapy and behavioral therapy has proven highly beneficial. For example, in the midst of a panic attack, it may feel impossible to gain control over thoughts and apply cognitive therapy techniques. In this case, a behavioral technique such as deep breathing may be easier to implement, which may help to calm and focus thinking.
The distinctive features of CBT are as follows:

- It is the most evidence-based form of psychotherapy.
- It is active, problem focused, and goal directed. In contrast to many "talk therapies," CBT emphasizes the present, concentrating on what the problem is and what steps are needed to alleviate it.
- It is easy to measure. Since the effects of the therapy are concrete (i.e., changing behaviors), the outcomes tend to be quite measurable.
- It provides quick results. If the person is motivated to change, relief can occur rapidly.

The studies reviewed provide consistent empirical evidence that CBT is associated with significant and clinically meaningful positive changes, particularly when therapy is provided by experienced practitioners (Waldron and Kaminer 2004). CBT has been successfully applied across settings (e.g., schools, support groups, prisons, treatment agencies, community-based organizations, churches) and across ages and roles (e.g., students, parents, teachers). It has been shown to be relevant for people with differing abilities and from a diverse range of backgrounds. Studies have found that parents perceive CBT favorably and prefer CBT to pharmacotherapy for treating both externalizing and internalizing disorders (Brown et al. 2007). The strategies of CBT have been used successfully to forestall the onset, ameliorate the severity, and divert the long-term consequences of problem behaviors among young people. Problem behaviors that have been particularly amenable to change using CBT have been 1) violence and criminality, 2) substance use and abuse, 3) teen pregnancy and risky sexual behaviors, and 4) school failure. Across the range of continuum-of-care, many model programs have successfully incorporated the strategies of CBT to effect positive change. The future of CBT may involve its integration with other types of approaches. For instance, integration of CBT with motivational interviewing may increase treatment effectiveness among less compliant individuals and populations (Zinbarg et al. 2010). Integrating CBT with strengths-based approaches may similarly yield improved outcomes (Zinbarg et al. 2010). This type of integration may be particularly important for achieving improved outcomes with delinquent youth.

Delinquency, Criminality, and Violence Prevention
The most widely used approaches to treatment in criminal justice today are variations of CBT (Little 2005). Distorted cognition is one of the most notable characteristics of chronic offenders (Beck 1999). Faulty thought processes include self-justificatory thinking, misinterpretation of social cues, deficient moral reasoning, and schemas of dominance and entitlement (Lipsey, Chapman, and Landenberger 2001). Cognitive–behavioral treatments for juvenile offenders are

designed to correct dysfunctional thinking and behaviors associated with delinquency, crime, and violence. Moral Reconation Therapy is one CBT approach that has been implemented successfully in a host of correctional systems, such as residential juvenile facilities and boot camps, and in numerous other venues, such as schools and job training programs (Little 2001).

Meta-analyses of programs designed for criminal offenders have shown cognitive–behavioral programs to be highly effective in reducing recidivism rates (Little 2005; Lipsey, Chapman, and Landenberger 2001; Pearson et al. 2002; Wilson, Bouffard, and MacKenzie 2005; Walker et al. 2004). A meta-analysis by Landenberger and Lipsey (2005) looked at whether certain components of CBT programs used with adult and juvenile offenders were associated with greater recidivism effect sizes. They concluded that programs with better implementation quality and fidelity, along with higher-risk offender populations, were associated with greater effect sizes. Programs incorporating anger control and interpersonal problem-solving components enhanced effectiveness, while those incorporating victim impact and behavior modification components diminished effectiveness. Programs were equally effective for adult and juvenile populations. Programs with the most effective CBT implementation and components corresponded to a decrease in recidivism of 50 percent, compared with a control condition. Examples of successful programs that draw on CBT are Operation New Hope and SAFE–T.

Many of the model programs that target young people who are at risk for delinquency often involve the family in applying the strategies of CBT. Some model programs that have proven successful in this area include Functional Family Therapy, Multisystemic Therapy, and the Michigan State Diversion Project. Multiple context approaches such as these that encourage CBT implementation in the home and in the school have demonstrated their effectiveness at positively changing the life course of some of these young people (Brosnan and Carr 2000). A good example of a multicontext program is FAST Track. Techniques used to promote change include modeling, reframing and reattribution, and behavioral training.

Family Therapy

The family is often a key factor in the prosocial development of youth. Several literature reviews (Henggeler, 1989; Loeber and Dishion, 1983; Loeber and Stouthamer–Loeber, 1986; and Snyder and Patterson, 1987) support the contention that family functioning provides an early and sustained impact on family bonding, conduct disorders, school bonding, choice of peers, and subsequent delinquency.

The family is of critical importance because it is the primary social unit during the formative years of early childhood. It is the primary and sometimes sole source of emotional support, learning opportunities, moral guidance, self esteem, and physical necessities. But when the family fails to fulfill these responsibilities, the children often suffer the consequences (Kumpfer and Alvarado, 1997). Family dysfunction (family history of violence, favorable attitudes toward problem behaviors, poor socialization, poor supervision, poor discipline, family disorganization, family isolation, or family disruptions) is an important influence on future delinquent and antisocial behavior. Family dysfunction provides children with models and opportunities to

engage in problem behavior. For example, family drug use is consistently linked to adolescent drug use (Newcomb and Bentler, 1988); children living in homes in which the marital relationship has been disrupted by divorce or separation are likely to display problem behaviors (Wells and Rankin, 1991), particularly depending on how much satisfaction they derive from their relationship with the parents (Videon, 2002); and family management practices such as failure to set clear expectations for children's behavior, poor monitoring and supervision, and severe and inconsistent discipline consistently predict later delinquency and substance abuse (Capaldi and Patterson, 1996; Hawkins, Arthur, and Catalano, 1995).

This research suggests that improving family functioning should reduce problem behaviors. Today, there are several major categories of interventions designed to strengthen family functioning and thus prevent future problem behaviors. These family strengthening interventions include family skills training, family education, family therapy, family services, and family preservation programs. This section generically refers to family intervention programs as family therapy.

THEORETICAL CONTEXT

The family can wield tremendous influence on an adolescent's risk for delinquency because it is the primary socialization context for children (Simons et al., 1998; Patterson, Reid, and Dishion, 1992). The theoretical foundation for this relationship is generally grounded in theories of social control believing that delinquent acts are more likely to occur when an individual's bond to society is weak or broken (Hirschi, 1969). Under this perspective, the family acts as a socializing agent by introducing and endearing children to conventional norms and values. It argues that a strong affectionate tie between child and parent is one of the fundamental means for establishing this societal bond and thus for insulating adolescents from delinquency and other problem behaviors (Brook, Whiteman, Finch, and Cohen, 1998). Unfortunately, poor family functioning or nontraditional family structures can decrease or inhibit the development of parental attachment and thus break the bond with society, leaving individuals without the internal controls that discourage criminal behavior. Gottfredson and Hirschi (1990) argue that as a result of inept parenting some adolescents tend to be impulsive, defiant, physical, and risk-taking (Stewart et al., 2002; Conger, Patterson, and Ge, 1995). Such youths are more strongly attracted to delinquent acts than are those who have been socialized to possess strong internal controls. However, ineffective parenting is seen as a result of two factors (Thornberry, 1987; Simons, Chao, and Conger, 2001). First, parents and children tend to be similar in their temperament, personality, and cognitive abilities (Plomin, Chipuer, Loehlin, 1990). Thus, there is a tendency for impulsive, aggressive children to have parents who also possess these characteristics, and these characteristics tend to interfere with effective parenting. Second, recent research indicates that parent–child interaction is a reciprocal process. In other words, not only does ineffective parenting increase the probability of child conduct disorders, but also hostile, obstinate child behavior often elicits negative parenting behavior—resulting in a reduction in effective parenting (Patterson, Reid, and Dishion, 1992). Thus the personal characteristics of the parents combine with the difficult behavior of the child to create a volatile mixture of antagonistic relationships.

Consequently, it is imperative that delinquency prevention programs reinforce the parent– child bond as a means of preventing delinquent behavior. One way of reinforcing the parent–child

relationship is to decrease risk factors and increase protective factors for delinquent behavior through parent training and family strengthening programs. These programs address important family protective factors such as parental supervision, attachment to parents, and consistency of discipline (Huizinga, Loeber, and Thornberry, 1995). They also address some of the most important family risk factors such as poor supervision, excessive family conflict, family isolation, sibling drug use, and poor socialization (Kumpfer and Alvarado, 1995).

EVIDENCE OF IMPACT

This section examines the scientific research regarding family strengthening programs. These programs concentrate on changing the maladaptive patterns of interaction and communication in families in which youths already exhibit behavioral problems. In addition, some family strengthening programs use multicomponent interventions, including behavioral parent training, child social skills training, and family therapy. These multicomponent programs are known as family skills training. Family strengthening programs typically are implemented with youths diagnosed with mild emotional and behavioral problems such as conduct disorder, depression, and school or social problems. The program is usually conducted by trained therapists in clinical settings with the parents and child. Kumpfer (1999) identifies several types of family strengthening techniques. They include the following:

- Structural family therapy (Minuchin, 1974; Szapocznik et al., 1983; Powell and Dosser, 1992) stresses families' coping skills and strategies as well as learning new ways to respond.

- Strategic family therapy (Haley, 1963; Szapocznik and Kurtines, 1989) is pragmatic and goal oriented.

- Structural–strategic family therapy (Stanton and Todd, 1982), as the name implies, combines a concentration on patterns of family interactions with goal-specific approaches.

- Behavioral family therapy programs (those with a therapist working with one family) or behavior family training (those with a therapist working with several families in a group) contain separate skill-building training for parents and children during part of the session (Rosenthal and Bandura, 1978). The family is then brought together for activities during the last part of the therapy session.

- Functional family therapy (Alexander and Parsons, 1973; Alexander and Parsons, 1982) is a short-term approach designed to engage and motivate youths and families to change negative affect (Alexander et al., 2000).

- Multisystemic family therapy addresses delinquent youth behavior within the context of the family, school, and community. Interventions are goal oriented and emphasize development of family strengths (Henggeler and Borduin, 1990).

According to Howell (1995), who looked at several meta-analyses and evaluations of various therapy models, early research indicates that family therapy is effective in reducing family conflict and children's antisocial behavior. For example, Functional Family Therapy (FFT) is

geared to help youths ages 11–18 who are at risk for, or are engaging in, delinquent behavior such as violence and substance abuse or who have been diagnosed with conduct disorder, appositional defiant disorder, or disruptive behavior disorder. The intervention consists of 8–12 hours of direct service for mild cases (26–30 hours for serious cases) and is delivered in several phases. Eleven matched or randomly assigned control/comparison group studies were conducted between 1973 and 1997, with follow-ups at 1, 2, 3, and 5 years. The model has been applied to populations in urban and rural settings and among many racial and ethnic groups. The results suggest that FFT has produced reductions in recidivism, out-of-home placements, or subsequent sibling referrals of at least 25 percent and as much as 55 percent (Alexander et al., 1998).

Another effective family-focused intervention is Multisystemic Therapy (MST), which targets chronic, violent, or substance-abusing juvenile offenders (ages 12–17) who are at risk for out-of-home placement (as are their families). MST services are delivered in the home, school, and community rather than in a clinic or residential treatment setting. Emphasis is placed on promoting behavior change in the youth's own environment. Services are more intensive than traditional family therapies and include several hours of treatment per week rather than the traditional 50 minutes. The emphasis is on developing an indigenous support network for the family in which the family is empowered to handle difficulties with the offending youth, and the youth is empowered to cope with family, peer, school, and neighborhood problems. Four randomized clinical trials compared the effectiveness of MST with usual community treatment for juvenile offenders and their families. Offenders in the MST group showed reductions in re-arrest rates between 25 and 70 percent. There were reductions in out-of-home placements between 47 and 64 percent in the three studies where data were obtained. Drug-related arrests decreased in three sites where researchers gather data for this outcome. One site showed decreased aggression; in the other two sites there was no difference (Henggeler et al., 1998).

In summary, the research regarding family strengthening initiatives is impressive. Overall, analyses of family-based programs find that family strengthening initiatives (compared with programs that concentrate solely on parents or children) have more immediate and direct impact on improving family relationships, support, and communication and on reducing family conflict (Kumpfer and Alvarado, 1997; Szapocznik and Kurtines, 1989; Szapocznik, 1997).

Group Therapy

Chunn's (2007) study found the following:

Group Therapy with Children
Shulman (2006, p. 327) describes that group work with children can be difficult because the children feel as though they are "bad kids" for needing group therapy. If contracting with the children in the initial stages of the group is not done openly and truthfully, it can impede the therapeutic work of the group because the children can feel anxious. Schiffer (1984) states that group therapy, however, can be an effective therapeutic method for children because it is usually implemented when children are experiencing socialization as an important element of daily life. Children are usually moving beyond the close bond to their families, so therefore, they are more

influenced by extra-familial groups (Schiffer, 1984, p. 1). McArdle et al. (2002) performed a 12 week study that tested the use of group therapy for children at risk for emotional and behavioral problems. The improvement of the children was determined using the Teacher Report Form, the Youth Self-Report, and the parent-completed Child Behavior Checklist. Group therapy in this study was found to be better than no intervention, and it was shown to enhance subjective well-being and school adjustment, which they explain corroborates earlier studies of group therapy for at-risk children.

Children often find group work more bearable than individual therapy because it matches where the child is developmentally (Schiffer, 1984, p. 2). Abrams (2000) agrees that children are often quiet with adults, but talkative and noisy with peers. She found that establishing a group of peers allowed the children to be more comfortable. Levinsky and McAleer describe that a group of peers also allows children to "combat feelings of differentness and isolation" (as cited in Abrams, 2000, p. 57). Children are often resistant to discuss their thoughts and feelings in individual therapy due to embarrassment, but groups allow the factor of universalization, which shows the children that they share many similar thoughts and feelings (Schiffer, 1984, p. 228).

In group therapy, children will quickly learn the new role of the adult, which they have never experienced. A group therapist for children should change the norms from children's regular settings to allow them more freedom, although the therapist should always be available to them if they need help (Schiffer, 1984, p. 3). Abrams (2000, p. 67) expresses that having fewer rules for children in groups can empower children by reversing the power dynamics. Abrams did not have structured punishments in her study, but instead allowed the group of children to collectively decide how to handle situations in which a member is having difficulty behaving. She felt that this also allowed the children to explore their feelings about times when they had perceived adults acting unfairly to them. When they challenged her authority, she searched for the underlying issues, which strengthened the group relationships. Schiffer (1984, p. 16) explains that a group can develop as a "social gestalt" in which the group creates an environment of norms that deter individual children from acting out in the group. Due to the importance of peer acceptance for children, a group can help to raise a child's self-esteem and strengthen his or her sense of identity. These positive outcomes can be supported by "creative accomplishments with arts and crafts media, proficiency in active games and sports, and other activities that have special meanings for latency children" (Schiffer, 1984, p. 17).

The structure and composition of a group for children is an important consideration. Schiffer (1984, p. 8) contends that older children must be in a group with other children and a therapist of the same gender because of their developmental stage. Yet, children who are younger would still benefit from group members of the same gender, but it is not as crucial. Schiffer (1984, p. 19) states that groups should meet for about one hour every week and preferably one and a half hours for older children. Schiffer (1984, p. 227) describes that in the early experimental years of group treatment, activity-group therapy was found to significantly help children with emotional difficulties, but it did not eliminate their problems as expected. Activity-group therapy is

structured so that children are able to participate in the group without instructions from the group leader, but the therapist is available for help when needed. Activity-interview group psychotherapy was then developed, which consisted of activity as well as discussions of problems led by the group therapist. This type of group was found to be more effective. These discussions are easier for children in groups than in individual therapy due to the factor of universalization. Therapists should have an active role in discussing themes with the group, but only at "psychologically opportune times," so that the children are not threatened (Schiffer, 1984, p. 229).

Social Skills Group Therapy with Children

An essential advantage to all group therapy, according to Yalom (1995) and Zastrow and Kirst-Ashman (2004), is that it allows group members to develop socializing techniques. Yalom (1995) explains that this can range from developing basic social skills to highly sophisticated social skills for long-term group members, such as processing and conflict resolution. The group leader, usually a therapist, can model behavior to the group members, such as methods of communication (Yalom, 1995, p. 16). As mentioned previously, specifically learning appropriate social skills can significantly help children with mental health disorders. Successful social skills also allow children to experience "teacher acceptance, academic achievement, peer acceptance, positive peer relationships, and friendships" (Lane, Menzies, Barton-Arwood, Doukas, & Munton, 2005, p. 18). Grizenko et al. (2000, p. 502) explain that numerous studies show social skills training is successful. Lane et al. (2005, p. 21) describe a social skills intervention developed in 1991 by Gresham and Elliot that focuses on the five following major social skills: cooperation, assertion, responsibility, empathy, and self-control. In a study of social skills group therapy by Grizenko et al. (2000, p. 504), the following skills were taught: introducing yourself, joining in, knowing your feelings, self-control, dealing with your anger, responding to teasing, and staying out of fights. Fraser et al. (2001) explain that social skills can be improved by enhancing a child's ability to process social cues, which are social actions of other people that can be seen, heard, or felt. Examples of social cues are facial expressions, tone, word choice, and body language. Fraser et al. (2001, p. 3) argue that children should be taught to interpret social cues differently depending on the context of a social situation. They contend that social problem solving should be taught to children in the following six steps: encoding cues, interpreting cues, formulating and refining social goals, searching for and formulating responses to social situations, deciding on particular responses, and enacting or implementing response decisions.

Lane et al. (2005) explain that Gresham and Elliot's social skills intervention included five stages for each of the five previously mentioned social skills. In the first stage called the "tell phase," a social skill is discussed by the group. The next phase involves the children role playing the skill, which is called the "show phase." In the "do phase," the children are asked to define the skill and role play and discuss it again. The next stage involves detailed follow-through and practice activities. Finally, the children are asked to use the skill in contexts beyond the group and discuss their experiences with the group in the "generalization phase." The social skills intervention used by Grizenko et al. (2000, p. 504) consisted of 12 sessions in which one skill was focused on in a session, which is similar to the intervention described by Lane et al. (2005).

The participating children were given snacks during the last ten minutes of each session as a reward for attendance. In the Grizenko et al. (2000, p. 506) study, social skills group were found to be more effective if the children were taught to understand the perspective of the other person involved in the interaction.

A group developed by the Arapahoe/Douglas Mental Health Network entitled "I Can Make New Friends" uses role-play, art and educational activities in order for children to learn and practice the social skills involved in forming and maintaining friendships. A group intervention focused on social skills must first evaluate and then improve social skills (Lane et al., 2005, p. 18). One study had teachers complete a version of Walker and Severson's Systematic Screening for Behavior Disorders to identify the behavior problems of the children. Another study used the *Student Risk Screening Scale* to identify elementary students at risk for antisocial behavior (Lane et al., 2005, p. 19-20). A method of monitoring the progress of the social skills intervention is necessary to determine the success of the intervention. Lane et al. (2005, p. 24) recommend monitoring progress by using teacher ratings, self-report, and through direct observation. In the study by Grizenko et al. (2000, p. 503-505), parents and teachers evaluated behavior and social skills using two questionnaires, the Child Behavior Checklist-Revised and the Matson Evaluation of Social Skills with Youngsters, which were completed prior to treatment, directly after the treatment, and nine months after the treatment. The participating children also were interviewed and completed a self evaluating questionnaire, the Self Perception Profile for Children.

The clients of Children's Intensive Services (CIS) in Pawtucket, Rhode Island may benefit greatly from the therapeutic advantages that group therapy can provide. CIS, however, does not offer many groups, which could be due to a variety of reasons, such as fear of groups and the difficulty of transporting clients to a group. As a social worker, it is essential to incorporate the theories of social group work when developing a therapy group, such as the theories that state that every person is interrelated with others and everyone's most fundamental desire is to be loved. Some of the most useful aspects of group therapy are the "all-in-the-same-boat phenomenon," acceptance of group members, learning social skills, and group members challenging one another. The structure of the group and roles of the group members are important considerations when conducting a therapy group. Children should be engaged in activities during group therapy. Social skills group therapy is theorized to be helpful for children with mental health disorders, especially children who are physically aggressive. In this type of group therapy, it is effective to teach children the phases of using social skills and using discussion and role-play to understand each social skill.

The University of Massachusetts's Center for School Counseling Research, (Carey, Dimmit, & McGannon, 2005) suggest that Prout and Prout (1998) found that school based psychotherapy has demonstrable beneficial effects on student well being but not academic achievement. Wilson (1986) found that directive counseling and behavioral counseling had positive effects on academic achievement with underachieving students. Additionally, including skills training improved effectiveness. Group counseling can improve elementary student's school behavior (Gerler, 1985). The review of outcome research completed by Whiston & Sexton (1998) also revealed that group-format social skills training develops adolescents' skills and reduces

aggressive and hostile behavior. Additionally, that peer mediation programs help the trained mediators who showed transfer of knowledge outside school setting.

The outcome studies reviewed by St. Claire (1989) indicated that group cognitive-behavioral and relaxation training interventions with middle school students can reduce teacher reports and referrals for disciplinary problems and that group counseling can improve middle school students' self concept. Bundy & Poppen (1986) reported that Behavioral and Adlerian consultation with teachers can improve elementary students' academic performance, work habits, and classroom behavior and Adlerian parent consultation and parent effectiveness training can increase student academic performance, student motivation and parent-child relationship quality.

Highridge Family Center
Pre/Post Test Data Results

Study Dates: October 2005 – April 2008

Instruments Used: Stress Index for Parents of Adolescents (SIPA)
Behavior Assessment System for Children, Second Edition (BASC-2)
- Parent Rating Scale
- Child Self-Report, Adolescent Self-Report

Study Participants: Pre Test Range of 461-532
Post Test Range of 139-175 (lower due to following factors: treatment dropout, invalid test results, language barriers, study dropout, etc.)

Demographic Information	**Pre**	**%**	**Post**	**%**
Gender				
Male	321	59.2%	100	51.5%
Female	221	40.8%	94	48.5%
Race				
African American	203	38.0%	70	36.3%
Caucasian	199	37.2%	77	39.9%
Hispanic	112	21.0%	38	19.7%
Caribbean Island	3	0.6%	1	0.5%
Native American	1	0.2%	1	0.5%
Other	16	3.0%	6	3.1%
Average Age	14.06		14.05	
Average # children in household	2.5			
Household Income				
$24,999 or below	209	41.4%	69	37.7%
$25k-49,999	142	28.1%	55	30.0%
$50k-99,999	42	8.3%	19	10.4%
$100,000 & above	8	1.6%	4	2.2%
Prefer not to answer	104	20.6%	36	19.7%

Most common **presenting problems**

1. Disrespect	83.6%	84.6%
2. Lying	70.7%	74.9%
3. Academic Problems	78.5%	77.9%
4. Disruptive	65.8%	67.7%
5. Detention	65.1%	63.6%
6. Suspension	56.2%	47.2%
7. Fighting	46.4%	43.1%
8. Verbal aggression	46.2%	45.1%
9. Profanity	44.4%	39.0%
10. Poor Peer Relations	41.3%	40.0%

11. Running Away	23.3%	25.1%

The list of most common presenting problems for the pre and post test samples indicates no significant difference in the reasons for seeking treatment at the time of intake interview between the two groups. Therefore, the profile of those who completed the post test measures displayed the same presenting problems as those who dropped out of treatment, dropped out of the study, or who provided invalid test results. These results cannot be used to determine a profile of who is more likely to complete treatment and take the post test measures based on presenting problems and reason for seeking treatment.

Description of Instruments Used:

The Stress Index for Parents of Adolescents (SIPA) is a 112-item self-report measure for parents used to assess the degree to which specific stressors are affecting the parents of adolescents. Results from the SIPA provide information on the parent and adolescent domains, as well as a measure of Life Stress, which assesses current situational stressors such as divorce, job loss, marriage, death of family member, or recent move. The adolescent domain assesses the amount of stress experienced by a parent as a function of specific characteristics of his/her child. The parent domain assesses the level of stress experienced by a parent as a function of the effect of parenting on other life roles, the relationship with a spouse or partner, social isolation, and parenting competence.

The SIPA was developed from a normative sample consisting of 778 parents of adolescents from the general population and a clinical sample of 159 parents of adolescents who had received a DSM-IV diagnosis of one of the following: Mood Disorders, Attention-Deficit/Hyperactivity disorder, Oppositional Defiant Disorder, Conduct Disorder, and Anxiety Disorder. The SIPA is highly reliable with internal consistency for all SIPA subscales exceeding .80, with the majority ranging from the high .80s to .90. The alpha coefficients for the SIPA domains all exceed .90, indicating a high level of internal consistency. Furthermore, test-retest reliability has demonstrated that parents' responses to the SIPA remain stable over a meaningful period of time. The SIPA developers examined content, convergent, and discriminant validity to ensure that the SIPA measured what it had set out to measure. They assessed validity using both normative and clinical samples and found that the SIPA can be utilized as an effective screening measure to identify parents and adolescents with relationship stressors.

The Behavior Assessment System for Children, Second Edition (BASC-2) is a widely used, comprehensive set of rating scales that can be used to facilitate the differential diagnosis and classification of a variety of emotional and behavioral disorders of children as well as to aid in the development of treatment plans. The BASC-2 is a norm-referenced, standardized behavioral assessment and is a multidimensional assessment in that it measures numerous aspects of behavior and personality, including adaptive as well as negative, or clinical, dimensions.

The Parent Rating Scales (PRS) measures adolescents' adaptive and problem behaviors in community and home settings and is completed by the parent. The PRS provides information on behaviors relating to Externalizing Problems, Internalizing Problems, Adaptive Skills, and also

provides a Behavioral Symptoms Index. Externalizing Problems measures the more disruptive nature of behavior, and, at the adolescent level, examines hyperactivity, aggression, and conduct problems. Internalizing Problems measures behaviors that are not marked by acting-out behaviors, and at the adolescent level, examines anxiety, depression, and somatization. Adaptive Skills investigates appropriate emotional expression and control, daily living skills, and communications skills and includes prosocial, organizational, and study skills. The Behavioral Symptoms Index provides a measure of overall behavior and estimates the general level of functioning or presence of an impairment. The BASC-2 has demonstrated excellent reliability. Reliability has been calculated separately for both the parent and the child forms of the inventory. For the General norm samples, composite score reliabilities are very high ranging from the low to middle .90s for Adaptive Skills and the Behavioral Symptoms Index, and in the middle .80s to the middle .90s for Externalizing Problems and Internalizing Problems. Reliabilities of the individual scales are also high with the median values ranging from .83 to .86 at the adolescent level. To assess the validity of the BASC-2, the developers attempted to measure the correlations between the BASC-2 composites and scales to ensure that they reflected the current scientific understanding of behavioral dimensions. As expected on the PRS, correlations within clinical scales and adaptive scales are positive, whereas correlations between clinical scales and adaptive scales are negative.

The Self-Report of Personality (SRP) is completed by the adolescent and has also demonstrated strong reliability and validity. The SRP also measures Internalizing Problems and Externalizing Problems, but also assess School Problems, Inattention/Hyperactivity, Personal Adjustment, and provides an Emotional Symptoms Index. School Problems provides a broad measure of adaptation to various aspects of school. Inattention/Hyperactivity provides the information for the consideration of an Attention Deficit/Hyperactivity Disorder diagnosis consideration. Personal Adjustment examines level of adjustment difficulties with respect to relationships with parents, self-esteem, and self-reliance. The Emotional Symptoms Index is the SRP's most global indicator of serious emotional disturbances. For the General norm samples, composite score reliabilities are very high with scores in the middle .90s for the Internalizing Problems composite and the Emotional Symptoms Index and in the middle to upper .80s for the School Problems, Inattention/Hyperactivity, and Personal Adjustment composites. Reliabilities of the individual scales are also high with median values near .80. As with the PRS, the SRP demonstrated strong validity with positive correlations within the clinical scales and adaptive scales and negative correlations between clinical scales and adaptive skills.

Results

Stress Index for Parents of Adolescents (SIPA)

Results from the SIPA indicated that upon admission to Highridge Family Center parents were experiencing high levels of stress associated with adolescent delinquency/antisocial attitudes, moodiness/emotional lability, and social isolation/withdrawal. Delinquency/Antisocial measures the stress the parent experiences as a result of the adolescent's violation of social normal and acts of juvenile delinquency. Moodiness/Emotional Lability measures the parent's perception of the adolescent's affective characteristics such as sudden mood changes, irritability, and temper

problems. Social Isolation/Withdrawal measures the parent's perception of the level of the adolescent's social isolation and passivity. These are all subscales that feed into the adolescent domain indicating that the majority of stress experienced by the parents upon admission was directly related to difficulties with adolescent mood and behavior. Upon completion of the program, the parents reported significant improvements in their levels of stress regarding these particular subscales. Results were analyzed using a paired-sample t test. This analysis revealed a significant difference from pre to post treatment on the parents' stress as related to the adolescent domain, $t(138) = 17.52$; $p < .000$. These results are indicative of the positive effect of intervention strategies. Specifically, the therapeutic strategies employed at Highridge Family Center targeted and successfully addressed adolescents' rule-breaking behaviors, mood interferences and social environments, reducing the associated experiences of parental stress.

Upon admission, parents' reported levels of stress as a function of life roles, the relationship with a spouse or partner, social isolation, and parenting competence were within the normal range. At the time services were completed, parents reported significantly lower levels of parent stress related to these concepts than at time of admission. These results are based on a paired-sample t test, $t(138) = 4.94$; $p < .000$.

A paired-samples t test revealed no significant differences on Life Stress from pre to post treatment, $t(136) = 1.22$; $p < .224$. This provides support that the treatment interventions, rather than a decrease in stressful life events, may have assisted in decreasing parental stress levels.

Behavior Assessment System for Children, Second Edition (BASC-2)
Parent Rating Scale (PRS), Child Self-Report (SRP), Adolescent Self-Report (SRP)

Paired-samples t tests were used to analyze the results. A significant difference between parent report of their children's externalizing behavior problems was found from pre to post treatment, $t(154) = 14.09$; $p < .000$. Parents reported their child's aggression, conduct problems, and hyperactivity significantly decreased from the clinical range upon admission to the normal range at completion of treatment. A significant difference was found for parent report of their children's internalizing behaviors between the time of admission to completion, $t(156) = 8.19$; $p < .000$. Anxiety, depression, somatic complaints, withdrawal, and attention problems were not viewed as clinically significant problems upon admission; however, the parents noted significant decreases by the end of treatment. Further analysis found a significant increase in adaptive skills from pre to post treatment, $t(156) = -14.05$; $p < .000$. Parents reported that their children showed a significant increase in social skills, leadership, ability to communicate effectively, and an increase in flexibility/adaptability.

Paired-sample t tests were used to analyze the children's self-report. The children did not report any clinically significant problems at the time of admission. Results show significant differences from pre to post treatment with decreased school problems [$t(174) = 3.87$, $p < .000$], decreased internalizing and externalizing problems [$t(169) = 5.23$, $p < .000$] [$t(171) = 7.46$, $p < .000$], decreased attention problems [$t(176) = 4.91$, $p < .000$], and improved relations with parents and peers [$t(174) = -7.86$, $p < .000$] by the end of their stay at Highridge Family Center.

Highridge Family Center
Pre/Post Test Data Results

Study Dates: October 2005 – April 2008

Instruments Used: Stress Index for Parents of Adolescents (SIPA)
Behavior Assessment System for Children, Second Edition (BASC-2)
- Parent Rating Scale
- Child Self-Report, Adolescent Self-Report

Study Participants: Pre Test Range of 461-532
Post Test Range of 139-175 (lower due to following factors: treatment dropout, invalid test results, language barriers, study dropout, etc.)

Demographic Information	**Pre**	**%**	**Post**	**%**
Gender				
Male	321	59.2%	100	51.5%
Female	221	40.8%	94	48.5%
Race				
African American	203	38.0%	70	36.3%
Caucasian	199	37.2%	77	39.9%
Hispanic	112	21.0%	38	19.7%
Caribbean Island	3	0.6%	1	0.5%
Native American	1	0.2%	1	0.5%
Other	16	3.0%	6	3.1%
Average Age	14.06		14.05	
Average # children in household	2.5			
Household Income				
$24,999 or below	209	41.4%	69	37.7%
$25k-49,999	142	28.1%	55	30.0%
$50k-99,999	42	8.3%	19	10.4%
$100,000 & above	8	1.6%	4	2.2%
Prefer not to answer	104	20.6%	36	19.7%

Most common **presenting problems**		
1. Disrespect	83.6%	84.6%
2. Lying	70.7%	74.9%
3. Academic Problems	78.5%	77.9%
4. Disruptive	65.8%	67.7%
5. Detention	65.1%	63.6%
6. Suspension	56.2%	47.2%
7. Fighting	46.4%	43.1%
8. Verbal aggression	46.2%	45.1%
9. Profanity	44.4%	39.0%
10. Poor Peer Relations	41.3%	40.0%

11. Running Away	23.3%	25.1%

The list of most common presenting problems for the pre and post test samples indicates no significant difference in the reasons for seeking treatment at the time of intake interview between the two groups. Therefore, the profile of those who completed the post test measures displayed the same presenting problems as those who dropped out of treatment, dropped out of the study, or who provided invalid test results. These results cannot be used to determine a profile of who is more likely to complete treatment and take the post test measures based on presenting problems and reason for seeking treatment.

Description of Instruments Used:

The Stress Index for Parents of Adolescents (SIPA) is a 112-item self-report measure for parents used to assess the degree to which specific stressors are affecting the parents of adolescents. Results from the SIPA provide information on the parent and adolescent domains, as well as a measure of Life Stress, which assesses current situational stressors such as divorce, job loss, marriage, death of family member, or recent move. The adolescent domain assesses the amount of stress experienced by a parent as a function of specific characteristics of his/her child. The parent domain assesses the level of stress experienced by a parent as a function of the effect of parenting on other life roles, the relationship with a spouse or partner, social isolation, and parenting competence.

The SIPA was developed from a normative sample consisting of 778 parents of adolescents from the general population and a clinical sample of 159 parents of adolescents who had received a DSM-IV diagnosis of one of the following: Mood Disorders, Attention-Deficit/Hyperactivity disorder, Oppositional Defiant Disorder, Conduct Disorder, and Anxiety Disorder. The SIPA is highly reliable with internal consistency for all SIPA subscales exceeding .80, with the majority ranging from the high .80s to .90. The alpha coefficients for the SIPA domains all exceed .90, indicating a high level of internal consistency. Furthermore, test-retest reliability has demonstrated that parents' responses to the SIPA remain stable over a meaningful period of time. The SIPA developers examined content, convergent, and discriminant validity to ensure that the SIPA measured what it had set out to measure. They assessed validity using both normative and clinical samples and found that the SIPA can be utilized as an effective screening measure to identify parents and adolescents with relationship stressors.

The Behavior Assessment System for Children, Second Edition (BASC-2) is a widely used, comprehensive set of rating scales that can be used to facilitate the differential diagnosis and classification of a variety of emotional and behavioral disorders of children as well as to aid in the development of treatment plans. The BASC-2 is a norm-referenced, standardized behavioral assessment and is a multidimensional assessment in that it measures numerous aspects of behavior and personality, including adaptive as well as negative, or clinical, dimensions.

The Parent Rating Scales (PRS) measures adolescents' adaptive and problem behaviors in community and home settings and is completed by the parent. The PRS provides information on behaviors relating to Externalizing Problems, Internalizing Problems, Adaptive Skills, and also

provides a Behavioral Symptoms Index. Externalizing Problems measures the more disruptive nature of behavior, and, at the adolescent level, examines hyperactivity, aggression, and conduct problems. Internalizing Problems measures behaviors that are not marked by acting-out behaviors, and at the adolescent level, examines anxiety, depression, and somatization. Adaptive Skills investigates appropriate emotional expression and control, daily living skills, and communications skills and includes prosocial, organizational, and study skills. The Behavioral Symptoms Index provides a measure of overall behavior and estimates the general level of functioning or presence of an impairment. The BASC-2 has demonstrated excellent reliability. Reliability has been calculated separately for both the parent and the child forms of the inventory. For the General norm samples, composite score reliabilities are very high ranging from the low to middle .90s for Adaptive Skills and the Behavioral Symptoms Index, and in the middle .80s to the middle .90s for Externalizing Problems and Internalizing Problems. Reliabilities of the individual scales are also high with the median values ranging from .83 to .86 at the adolescent level. To assess the validity of the BASC-2, the developers attempted to measure the correlations between the BASC-2 composites and scales to ensure that they reflected the current scientific understanding of behavioral dimensions. As expected on the PRS, correlations within clinical scales and adaptive scales are positive, whereas correlations between clinical scales and adaptive scales are negative.

The Self-Report of Personality (SRP) is completed by the adolescent and has also demonstrated strong reliability and validity. The SRP also measures Internalizing Problems and Externalizing Problems, but also assess School Problems, Inattention/Hyperactivity, Personal Adjustment, and provides an Emotional Symptoms Index. School Problems provides a broad measure of adaptation to various aspects of school. Inattention/Hyperactivity provides the information for the consideration of an Attention Deficit/Hyperactivity Disorder diagnosis consideration. Personal Adjustment examines level of adjustment difficulties with respect to relationships with parents, self-esteem, and self-reliance. The Emotional Symptoms Index is the SRP's most global indicator of serious emotional disturbances. For the General norm samples, composite score reliabilities are very high with scores in the middle .90s for the Internalizing Problems composite and the Emotional Symptoms Index and in the middle to upper .80s for the School Problems, Inattention/Hyperactivity, and Personal Adjustment composites. Reliabilities of the individual scales are also high with median values near .80. As with the PRS, the SRP demonstrated strong validity with positive correlations within the clinical scales and adaptive scales and negative correlations between clinical scales and adaptive skills.

Results

Stress Index for Parents of Adolescents (SIPA)

Results from the SIPA indicated that upon admission to Highridge Family Center parents were experiencing high levels of stress associated with adolescent delinquency/antisocial attitudes, moodiness/emotional lability, and social isolation/withdrawal. Delinquency/Antisocial measures the stress the parent experiences as a result of the adolescent's violation of social normal and acts of juvenile delinquency. Moodiness/Emotional Lability measures the parent's perception of the adolescent's affective characteristics such as sudden mood changes, irritability, and temper

problems. Social Isolation/Withdrawal measures the parent's perception of the level of the adolescent's social isolation and passivity. These are all subscales that feed into the adolescent domain indicating that the majority of stress experienced by the parents upon admission was directly related to difficulties with adolescent mood and behavior. Upon completion of the program, the parents reported significant improvements in their levels of stress regarding these particular subscales. Results were analyzed using a paired-sample t test. This analysis revealed a significant difference from pre to post treatment on the parents' stress as related to the adolescent domain, $t(138) = 17.52$; $p < .000$. These results are indicative of the positive effect of intervention strategies. Specifically, the therapeutic strategies employed at Highridge Family Center targeted and successfully addressed adolescents' rule-breaking behaviors, mood interferences and social environments, reducing the associated experiences of parental stress.

Upon admission, parents' reported levels of stress as a function of life roles, the relationship with a spouse or partner, social isolation, and parenting competence were within the normal range. At the time services were completed, parents reported significantly lower levels of parent stress related to these concepts than at time of admission. These results are based on a paired-sample t test, $t(138) = 4.94$; $p < .000$.

A paired-samples t test revealed no significant differences on Life Stress from pre to post treatment, $t(136) = 1.22$; $p < .224$. This provides support that the treatment interventions, rather than a decrease in stressful life events, may have assisted in decreasing parental stress levels.

Behavior Assessment System for Children, Second Edition (BASC-2)
Parent Rating Scale (PRS), Child Self-Report (SRP), Adolescent Self-Report (SRP)

Paired-samples t tests were used to analyze the results. A significant difference between parent report of their children's externalizing behavior problems was found from pre to post treatment, $t(154) = 14.09$; $p < .000$. Parents reported their child's aggression, conduct problems, and hyperactivity significantly decreased from the clinical range upon admission to the normal range at completion of treatment. A significant difference was found for parent report of their children's internalizing behaviors between the time of admission to completion, $t(156) = 8.19$; $p < .000$. Anxiety, depression, somatic complaints, withdrawal, and attention problems were not viewed as clinically significant problems upon admission; however, the parents noted significant decreases by the end of treatment. Further analysis found a significant increase in adaptive skills from pre to post treatment, $t(156) = -14.05$; $p < .000$. Parents reported that their children showed a significant increase in social skills, leadership, ability to communicate effectively, and an increase in flexibility/adaptability.

Paired-sample t tests were used to analyze the children's self-report. The children did not report any clinically significant problems at the time of admission. Results show significant differences from pre to post treatment with decreased school problems [$t(174) = 3.87$, $p < .000$], decreased internalizing and externalizing problems [$t(169) = 5.23$, $p < .000$] [$t(171) = 7.46$, $p < .000$], decreased attention problems [$t(176) = 4.91$, $p < .000$], and improved relations with parents and peers [$t(174) = -7.86$, $p < .000$] by the end of their stay at Highridge Family Center.

Youth Affairs Family Information Form

Appendix C

TODAY'S DATE: _____ **REFERRED BY:** _____

AGENCY: _____

CHILD FOR WHOM YOU ARE SEEKING SERVICES:

CHILD'S Full Name (include middle initial):
(First)_____ **(MI)** _____ **(Last)** _____

SEX: _____ **DOB:** _____ **Race:** _____

SCHOOL: _____ **GRADE:** _____

DOES THE CHILD LIVE OUTSIDE YOUR HOME? NO ( ) YES ( )

IF YES, WITH WHOM DOES THE CHILD LIVE? _____

RELATIONSHIP TO CHILD (check one): ☐ PARENT ☐ LEGAL GUARDIAN ☐ OTHER
Explain Other_____

ADDRESS WHERE CHILD LIVES: Address _____
City _____ **Zip**_____

PARENT INFORMATION:

1. Parental Status (check one): ☐ **Natural** ☐ **Adoptive** ☐ **Foster** ☐ **Stepparent** ☐ **Other**
Explain Other:_____

NAME: _____ **SEX**_____ **DOB** _____ **Race**_____
MARITAL STATUS (circle one): Married Single Divorced
Separated Widowed Living Together
ADDRESS/_____ **City** _____
Zip Code _____ **HOME PHONE** _____ **Work** _____ **Cell** _____
EMPLOYER _____

2. Parental Status (check one): ☐ **Natural** ☐ **Adoptive** ☐ **Foster** ☐ **Stepparent** ☐ **Other**
Explain Other_____

NAME: _____ **SEX**_____ **DOB** _____ **Race**_____
MARITAL STATUS (circle one): Married Single Divorced
Separated Widowed Living Together
ADDRESS/_____ **City** _____
Zip Code _____ **HOME PHONE** _____ **Work** _____ **Cell** _____
EMPLOYER _____

3. Parental Status (check one): ☐ **Natural** ☐ **Adoptive** ☐ **Foster** ☐ **Stepparent** ☐ **Other**
Explain Other_____

NAME: _____ **SEX**_____ **DOB** _____ **Race**_____
MARITAL STATUS (circle one): Married Single Divorced
Separated Widowed Living Together
ADDRESS/_____ **City** _____
Zip Code _____ **HOME PHONE** _____ **Work** _____ **Cell** _____
EMPLOYER _____

4. **Parental Status** (check one): ☐ **Natural** ☐ **Adoptive** ☐ **Foster** ☐ **Stepparent** ☐ **Other**
Explain Other______________________

NAME: ________________________________ **SEX**_____ **DOB** ______ **Race**________
MARITAL STATUS (circle one): Married Single Divorced
Separated Widowed Living Together
ADDRESS/________________________________**City** ______________________
Zip Code _______**HOME PHONE** ___________ **Work** ____________ **Cell** _____________
EMPLOYER ____

HOUSEHOLD INCOME:
___$0 - $24,999 ___$25,000 - $49,999 ___$50,000 - $99,999

___Over $100,000 ___Prefer not to answer

CUSTODY (circle one): SOLE JOINT MARRIED **PROOF OF CUSTODY:** YES ( ) NO ( )

DO YOU HAVE TRANSPORTATION? YES ( ) NO ( )
WHO? List name(s) ____

OTHER CHILDREN OR ADULTS IN THE HOME:

NAME____________________________________ **SEX**______ **DOB** _______**Race** _______
SCHOOL____ **GRADE**___________
RELATIONSHIP TO CHILD _______________

NAME____________________________________ **SEX**______ **DOB** _______**Race** _______
SCHOOL____ **GRADE**___________
RELATIONSHIP TO CHILD _______________

NAME____________________________________ **SEX**______ **DOB** _______**Race** _______
SCHOOL____ **GRADE**___________
RELATIONSHIP TO CHILD _______________

NAME____________________________________ **SEX**______ **DOB** _______**Race** _______
SCHOOL____ **GRADE**___________
RELATIONSHIP TO CHILD _______________

NAME____________________________________ **SEX**______ **DOB** _______**Race** _______
SCHOOL____ **GRADE**___________
RELATIONSHIP TO CHILD _______________

HAS/IS YOUR CHILD:

1. **Currently receiving services from another agency/professional?** Yes ( ) No ( )
   Name of agency/professional: ____
2. **Received prior services from another agency/professional?** Yes ( ) No ( )
   Name of agency/professional: ____

3. **A History of psychiatric hospitalization?** Yes ( ) No ( ) **If yes, please list when and where?**

____

4. **A History of medical concerns?** Yes ( ) No ( ) **If yes please explain?**

____

5. **Please list current or previous medications:**

____

6. **A History of specialized school services?** Yes ( ) No ( ) **If yes explain?**

---

7. A History of arrest or charges? Yes ( ) No ( ) If yes explain?

_____

PLEASE CHECK THE REASON(S) YOU ARE SEEKING SERVICES

- ☐ Academic Problems
- ☐ Alcohol Use-Parent
- ☐ Alcohol Use-Child
- ☐ Anxious/Nervous
- ☐ Bedwetting
- ☐ Depressed
- ☐ School Detentions
- ☐ Disrespectful
- ☐ Disruptive
- ☐ Domestic Violence
- ☐ Drug Use-Parent
- ☐ Drug Use-Child
- ☐ Emotional Abuse
- ☐ Fighting
- ☐ Fire Setting
- ☐ Grief/Loss
- ☐ Harms Animals
- ☐ Homicidal Ideas
- ☐ Lying
- ☐ Neglect
- ☐ Parenting Issues
- ☐ Parent Divorce/Separation
- ☐ Physical Abuse
- ☐ Physically Aggressive
- ☐ Poor Peer Group
- ☐ Profanity
- ☐ Running Away
- ☐ Self Injury
- ☐ Sexual Abuse
- ☐ Inappropriate Sexual Behavior
- ☐ Stealing
- ☐ Suspension
- ☐ Suicidal/Ideas of hurting self
- ☐ Truant
- ☐ Verbally Aggressive
- ☐ Court Ordered
- ☐ Court Referred
- ☐ DCF Referred

Other_____

Completed by Youth Affairs Staff (Circle location Client Assigned)

HRFC:	Buttonwood	Mangrove	Oak	Palmetto	Sawgrass	Seagrape
YSB:	Central	North	South	Glades		
Ed Center:	Central	North	South	Belle Glade		

CASE TYPE (Please select all that apply): Family CBT Group School Group Parenting Group Parenting JDVP FIRE YOUTH COURT

☐ ☐

PARENTS ☐ Agree ☐ Disagree to participate in Research Project.

CASE NUMBER: _____ THERAPIST: _____

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
When Did Arrest Take Place? (With Most Recent Admission) * REASON	722	96.9%	23	3.1%	745	100.0%

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			REASON			Total
			COMPLETE	RELEASE	WITHDRAW	
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	70	52	60	182
		% within When Did Arrest Take Place? (With Most Recent Admission)	38.5%	28.6%	33.0%	100.0%
		% within REASON	24.2%	32.7%	21.9%	25.2%
	During Programming	Count	8	5	11	24
		% within When Did Arrest Take Place? (With Most Recent Admission)	33.3%	20.8%	45.8%	100.0%
		% within REASON	2.8%	3.1%	4.0%	3.3%
	After Exit from Programming	Count	211	102	203	516
		% within When Did Arrest Take Place? (With Most Recent Admission)	40.9%	19.8%	39.3%	100.0%
		% within REASON	73.0%	64.2%	74.1%	71.5%
Total		Count	289	159	274	722
		% within When Did Arrest Take Place? (With Most Recent Admission)	40.0%	22.0%	38.0%	100.0%
		% within REASON	100.0%	100.0%	100.0%	100.0%

Most Recent Exit Reason from Programming by Most Recent Arrest
745 **Youth Participants** with arrest record with Florida Department of Law Enforcement

When did the arrest take place?	Reason for Exit			
	Complete	Release	Withdraw	Total
Prior to Admission	26	8	11	45
During Admission	5	0	3	8
After Exit from Programming	258	151	260	669
Total with Matched Arrests	**289**	**159**	**274**	**722**
Total Analyzed	**671**	**253**	**502**	**1426**

Missing: for 23 cases programming start and end dates are missing.

% of Arrested - Most Recent Exit Reason from Programming by Most Recent Arrest
745 Youth Participants with arrest record with Florida Department of Law Enforcement

When did the arrest take place?	Column Percentage Reason for Exit			
	Complete	Release	Withdraw	Total
Prior to Admission	9%	5%	4%	6%
During Admission	2%	0%	1%	1%
After Exit from Programming	89%	95%	95%	93%
% Total with Matched Arrests	**100%**	**100%**	**100%**	**100%**

% of Total Program Participation - Most Recent Exit Reason from Programming by Most Recent Arrest
1458 Youth Participants with valid reason for exit from programming

When did the arrest take place?	Column Percentage Reason for Exit			
	Complete	Release	Withdraw	Total
Prior to Admission	4%	3%	2%	3%
During Admission	1%	0%	1%	1%
After Exit from Programming	38%	60%	52%	47%
% Total of Program Population	**43%**	**63%**	**55%**	**51%**

Missing: for 32 cases, the reason was missing.

Most Recent Exit Reason from Programming by Most Recent Arrest
3054 Arrest records with Florida Department of Law Enforcement

When did the arrest take place?	Reason for Exit			
	Complete	Release	Withdraw	Total
Prior to Admission	89	68	75	232
During Admission	11	7	14	32
After Exit from Programming	849	733	1140	2722
Total with Matched Arrests	**949**	**808**	**1229**	**2986**

Missing: for 68 cases programming start and end dates are missing.

% of Arrest Records

When did the arrest take place?	Column Percentage Reason for Exit			
	Complete	Release	Withdraw	Total
Prior to Admission	9%	8%	6%	8%
During Admission	1%	1%	1%	1%
After Exit from Programming	89%	91%	93%	91%
% Total with Matched Arrests	**100%**	**100%**	**100%**	**100%**

Most Recent Exit Reason from Programming by Most Recent Arrest
5293 **Charge records** with Florida Department of Law Enforcement

When did the arrest take place?	Reason for Exit			
	Complete	Release	Withdraw	Total
Prior to Admission	122	82	100	304
During Admission	23	9	18	50
After Exit from Programming	1515	1288	2030	4833
Total with Matched Charges	**1660**	**1379**	**2148**	**5187**

Missing: for 106 cases programming start and end dates are missing.

% of Charge Records

When did the arrest take place?	Column Percentage Reason for Exit			
	Complete	Release	Withdraw	Total
Prior to Admission	7%	6%	5%	6%
During Admission	1%	1%	1%	1%
After Exit from Programming	91%	93%	95%	93%
% Total with Matched Charges	**100%**	**100%**	**100%**	**100%**

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			REASON
			COMPLETE
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	122
		% within When Did Arrest Take Place? (With Most Recent Admission)	40.1%
		% within REASON	7.3%
	During Programming	Count	23
		% within When Did Arrest Take Place? (With Most Recent Admission)	46.0%
		% within REASON	1.4%
	After Exit from Programming	Count	1515
		% within When Did Arrest Take Place? (With Most Recent Admission)	31.3%
		% within REASON	91.3%
Total		Count	1660
		% within When Did Arrest Take Place? (With Most Recent Admission)	32.0%
		% within REASON	100.0%

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			REASON
			RELEASE
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	82
		% within When Did Arrest Take Place? (With Most Recent Admission)	27.0%
		% within REASON	5.9%
	During Programming	Count	9
		% within When Did Arrest Take Place? (With Most Recent Admission)	18.0%
		% within REASON	.7%
	After Exit from Programming	Count	1288
		% within When Did Arrest Take Place? (With Most Recent Admission)	26.7%
		% within REASON	93.4%
Total		Count	1379
		% within When Did Arrest Take Place? (With Most Recent Admission)	26.6%
		% within REASON	100.0%

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			REASON
			WITHDRAW
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	100
		% within When Did Arrest Take Place? (With Most Recent Admission)	32.9%
		% within REASON	4.7%
	During Programming	Count	18
		% within When Did Arrest Take Place? (With Most Recent Admission)	36.0%
		% within REASON	.8%
	After Exit from Programming	Count	2030
		% within When Did Arrest Take Place? (With Most Recent Admission)	42.0%
		% within REASON	94.5%
Total		Count	2148
		% within When Did Arrest Take Place? (With Most Recent Admission)	41.4%
		% within REASON	100.0%

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			Total
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	304
		% within When Did Arrest Take Place? (With Most Recent Admission)	100.0%
		% within REASON	5.9%
	During Programming	Count	50
		% within When Did Arrest Take Place? (With Most Recent Admission)	100.0%
		% within REASON	1.0%
	After Exit from Programming	Count	4833
		% within When Did Arrest Take Place? (With Most Recent Admission)	100.0%
		% within REASON	93.2%
Total		Count	5187
		% within When Did Arrest Take Place? (With Most Recent Admission)	100.0%
		% within REASON	100.0%

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			REASON
			COMPLETE
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	89
		% within When Did Arrest Take Place? (With Most Recent Admission)	38.4%
		% within REASON	9.4%
	During Programming	Count	11
		% within When Did Arrest Take Place? (With Most Recent Admission)	34.4%
		% within REASON	1.2%
	After Exit from Programming	Count	849
		% within When Did Arrest Take Place? (With Most Recent Admission)	31.2%
		% within REASON	89.5%
Total		Count	949
		% within When Did Arrest Take Place? (With Most Recent Admission)	31.8%
		% within REASON	100.0%

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			REASON
			RELEASE
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	68
		% within When Did Arrest Take Place? (With Most Recent Admission)	29.3%
		% within REASON	8.4%
	During Programming	Count	7
		% within When Did Arrest Take Place? (With Most Recent Admission)	21.9%
		% within REASON	.9%
	After Exit from Programming	Count	733
		% within When Did Arrest Take Place? (With Most Recent Admission)	26.9%
		% within REASON	90.7%
Total		Count	808
		% within When Did Arrest Take Place? (With Most Recent Admission)	27.1%
		% within REASON	100.0%

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			REASON
			WITHDRAW
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	75
		% within When Did Arrest Take Place? (With Most Recent Admission)	32.3%
		% within REASON	6.1%
	During Programming	Count	14
		% within When Did Arrest Take Place? (With Most Recent Admission)	43.8%
		% within REASON	1.1%
	After Exit from Programming	Count	1140
		% within When Did Arrest Take Place? (With Most Recent Admission)	41.9%
		% within REASON	92.8%
Total		Count	1229
		% within When Did Arrest Take Place? (With Most Recent Admission)	41.2%
		% within REASON	100.0%

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			Total
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	232
		% within When Did Arrest Take Place? (With Most Recent Admission)	100.0%
		% within REASON	7.8%
	During Programming	Count	32
		% within When Did Arrest Take Place? (With Most Recent Admission)	100.0%
		% within REASON	1.1%
	After Exit from Programming	Count	2722
		% within When Did Arrest Take Place? (With Most Recent Admission)	100.0%
		% within REASON	91.2%
Total		Count	2986
		% within When Did Arrest Take Place? (With Most Recent Admission)	100.0%
		% within REASON	100.0%

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			REASON
			COMPLETE
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	26
		% within When Did Arrest Take Place? (With Most Recent Admission)	57.8%
		% within REASON	9.0%
	During Programming	Count	5
		% within When Did Arrest Take Place? (With Most Recent Admission)	62.5%
		% within REASON	1.7%
	After Exit from Programming	Count	258
		% within When Did Arrest Take Place? (With Most Recent Admission)	38.6%
		% within REASON	89.3%
Total		Count	289
		% within When Did Arrest Take Place? (With Most Recent Admission)	40.0%
		% within REASON	100.0%

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			REASON
			RELEASE
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	8
		% within When Did Arrest Take Place? (With Most Recent Admission)	17.8%
		% within REASON	5.0%
	During Programming	Count	0
		% within When Did Arrest Take Place? (With Most Recent Admission)	.0%
		% within REASON	.0%
	After Exit from Programming	Count	151
		% within When Did Arrest Take Place? (With Most Recent Admission)	22.6%
		% within REASON	95.0%
Total		Count	159
		% within When Did Arrest Take Place? (With Most Recent Admission)	22.0%
		% within REASON	100.0%

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			REASON
			WITHDRAW
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	11
		% within When Did Arrest Take Place? (With Most Recent Admission)	24.4%
		% within REASON	4.0%
	During Programming	Count	3
		% within When Did Arrest Take Place? (With Most Recent Admission)	37.5%
		% within REASON	1.1%
	After Exit from Programming	Count	260
		% within When Did Arrest Take Place? (With Most Recent Admission)	38.9%
		% within REASON	94.9%
Total		Count	274
		% within When Did Arrest Take Place? (With Most Recent Admission)	38.0%
		% within REASON	100.0%

When Did Arrest Take Place? (With Most Recent Admission) * REASON Crosstabulation

			Total
When Did Arrest Take Place? (With Most Recent Admission)	Prior to Admission	Count	45
		% within When Did Arrest Take Place? (With Most Recent Admission)	100.0%
		% within REASON	6.2%
	During Programming	Count	8
		% within When Did Arrest Take Place? (With Most Recent Admission)	100.0%
		% within REASON	1.1%
	After Exit from Programming	Count	669
		% within When Did Arrest Take Place? (With Most Recent Admission)	100.0%
		% within REASON	92.7%
Total		Count	722
		% within When Did Arrest Take Place? (With Most Recent Admission)	100.0%
		% within REASON	100.0%

When Did Arrest Take Place? (With Most Recent Admission)

Start Year (Most Recent Start Year)			Frequency	Percent	Valid Percent	Cumulative Percent
2003	Valid	Prior to Admission	3	4.1	4.1	4.1
		After Exit from Programming	71	95.9	95.9	100.0
		Total	74	100.0	100.0	
2004	Valid	Prior to Admission	3	2.4	2.4	2.4
		After Exit from Programming	121	97.6	97.6	100.0
		Total	124	100.0	100.0	
2005	Valid	Prior to Admission	2	1.7	1.7	1.7
		During Programming	2	1.7	1.7	3.3
		After Exit from Programming	117	96.7	96.7	100.0
		Total	121	100.0	100.0	
2006	Valid	Prior to Admission	7	7.0	7.0	7.0
		During Programming	1	1.0	1.0	8.0
		After Exit from Programming	92	92.0	92.0	100.0
		Total	100	100.0	100.0	
2007	Valid	Prior to Admission	6	5.4	5.4	5.4
		During Programming	3	2.7	2.7	8.0
		After Exit from Programming	103	92.0	92.0	100.0
		Total	112	100.0	100.0	
2008	Valid	Prior to Admission	8	7.5	7.5	7.5
		After Exit from Programming	99	92.5	92.5	100.0
		Total	107	100.0	100.0	
2009	Valid	Prior to Admission	16	19.0	19.0	19.0
		During Programming	2	2.4	2.4	21.4
		After Exit from Programming	66	78.6	78.6	100.0
		Total	84	100.0	100.0	

Reason for Most Recent Exit from Program * When Did Arrest Take Place? (With Most Recent Admission) Crosstabulation

Count

		When Did Arrest Take Place? (With Most Recent Admission)			
		Prior to Admission	During Programming	After Exit from Programming	Total
Reason for Most Recent Exit from Program		4	0	114	118
	COMPLETE	22	5	202	229
	RELEASE	8	0	124	132
	WITHDRAW	11	3	229	243
Total		45	8	669	722

Offense Group 2 (SPSS)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Assualt & Battery	995	18.8	18.8	18.8
	Parole & Probation Violation	919	17.4	17.4	36.2
	Failure to Appear	574	10.8	10.8	47.0
	Shoplifting & Larceny	527	10.0	10.0	57.0
	Burglary	492	9.3	9.3	66.3
	Drug Offenses	481	9.1	9.1	75.3
	Robbery	160	3.0	3.0	78.4
	Weapons Offenses	154	2.9	2.9	81.3
	Damage Property - Criminal Mischief	141	2.7	2.7	83.9
	Vehicle Theft	120	2.3	2.3	86.2
	Fraud	115	2.2	2.2	88.4
	Disorderly Conduct	106	2.0	2.0	90.4
	Tresspassing	103	1.9	1.9	92.3
	Traffic Offenses	100	1.9	1.9	94.2
	Obstruction of Justice	78	1.5	1.5	95.7
	Stolen Property - Dealing	48	.9	.9	96.6
	Out of County Warrant	29	.5	.5	97.1
	Sex Offenses	23	.4	.4	97.6
	Public Order Crimes	20	.4	.4	98.0
	Possession of Liquor	19	.4	.4	98.3
	Kidnapping	16	.3	.3	98.6
	Crimes Against Person	14	.3	.3	98.9
	Family Offense - Child Neglect	13	.2	.2	99.1
	Homicide	9	.2	.2	99.3
	Arson	6	.1	.1	99.4
	Drugs - Health & Safety	6	.1	.1	99.5
	Sexual Assault	5	.1	.1	99.6
	Forgery	5	.1	.1	99.7
	Conservation	4	.1	.1	99.8
	Smuggle Contraband	3	.1	.1	99.8
	Property Crimes	3	.1	.1	99.9
	County Ordinance	2	.0	.0	99.9
	Gambling	1	.0	.0	100.0
	Procuring for Prostitution	1	.0	.0	100.0

Offense Group 2 (SPSS)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Municipal Ordinance	1	.0	.0	100.0
	Total	5293	100.0	100.0	

Offense Group 2 (SPSS)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Assualt & Battery	337	45.2	45.2	45.2
	Shoplifting & Larceny	91	12.2	12.2	57.4
	Burglary	88	11.8	11.8	69.3
	Robbery	83	11.1	11.1	80.4
	Drug Offenses	44	5.9	5.9	86.3
	Failure to Appear	26	3.5	3.5	89.8
	Vehicle Theft	12	1.6	1.6	91.4
	Parole & Probation Violation	8	1.1	1.1	92.5
	Homicide	7	.9	.9	93.4
	Kidnapping	7	.9	.9	94.4
	Fraud	7	.9	.9	95.3
	Damage Property - Criminal Mischelf	7	.9	.9	96.2
	Sexual Assault	5	.7	.7	96.9
	Disorderly Conduct	4	.5	.5	97.4
	Arson	3	.4	.4	97.9
	Forgery	3	.4	.4	98.3
	Traffic Offenses	3	.4	.4	98.7
	Sex Offenses	2	.3	.3	98.9
	Weapons Offenses	2	.3	.3	99.2
	Tresspassing	2	.3	.3	99.5
	Stolen Property - Dealing	1	.1	.1	99.6
	Possession of Liquor	1	.1	.1	99.7
	Conservation	1	.1	.1	99.9

MSO
youth offenders

Offense Group 2 (SPSS)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Out of County Warrant	1	.1	.1	100.0
	Total	745	100.0	100.0	

MSO = youth offenders.

Offense Group 3 (SPSS) * REASON Crosstabulation

		REASON				Total
			COMPLETE	RELEASE	WITHDRAW	
Offense Group 3 (SPSS)	Out of County Warrant	0	1	0	0	1
		.0%	100.0%	.0%	.0%	100.0%
		.0%	.3%	.0%	.0%	.1%
		.0%	.1%	.0%	.0%	.1%
	Court Related Offense & Violations	4	9	6	15	34
		11.8%	26.5%	17.6%	44.1%	100.0%
		17.4%	3.1%	3.8%	5.5%	4.6%
		.5%	1.2%	.8%	2.0%	4.6%
	Public Order Crimes	0	4	2	2	8
		.0%	50.0%	25.0%	25.0%	100.0%
		.0%	1.4%	1.3%	.7%	1.1%
		.0%	.5%	.3%	.3%	1.1%
	Property Crimes	5	113	44	94	256
		2.0%	44.1%	17.2%	36.7%	100.0%
		21.7%	39.1%	27.7%	34.3%	34.4%
		.7%	15.2%	5.9%	12.6%	34.4%
	Crimes Against Person	14	160	107	160	441
		3.2%	36.3%	24.3%	36.3%	100.0%
		60.9%	55.4%	67.3%	58.4%	59.2%
		1.9%	21.5%	14.4%	21.5%	59.2%
	Traffic Offenses	0	2	0	1	3

Offense Group 3 (SPSS) * REASON Crosstabulation

		REASON				
			COMPLETE	RELEASE	WITHDRAW	Total
Offense Group 3 (SPSS)	Traffic Offenses	.0%	66.7%	.0%	33.3%	100.0%
		.0%	.7%	.0%	.4%	.4%
		.0%	.3%	.0%	.1%	.4%
	Weapons Offenses	0	0	0	2	2
		.0%	.0%	.0%	100.0%	100.0%
		.0%	.0%	.0%	.7%	.3%
		.0%	.0%	.0%	.3%	.3%
Total		23	289	159	274	745
		3.1%	38.8%	21.3%	36.8%	100.0%
		100.0%	100.0%	100.0%	100.0%	100.0%
		3.1%	38.8%	21.3%	36.8%	100.0%

Years to First Offense After Program Exit * REASON Crosstabulation

			REASON			Total
			COMPLETE	RELEASE	WITHDRAW	
Years to First Offense After Program Exit	Less Than 1 Year	Count	56	45	86	187
		% within Years to First Offense After Program Exit	29.9%	24.1%	46.0%	100.0%
		% within REASON	26.5%	44.1%	42.4%	36.2%
	Between 1 and 3 Years	Count	124	50	98	272
		% within Years to First Offense After Program Exit	45.6%	18.4%	36.0%	100.0%
		% within REASON	58.8%	49.0%	48.3%	52.7%
	Between 4 and 5 Years	Count	30	7	16	53
		% within Years to First Offense After Program Exit	56.6%	13.2%	30.2%	100.0%
		% within REASON	14.2%	6.9%	7.9%	10.3%
	Greater Than 5 Years	Count	1	0	3	4
		% within Years to First Offense After Program Exit	25.0%	.0%	75.0%	100.0%
		% within REASON	.5%	.0%	1.5%	.8%
Total		Count	211	102	203	516
		% within Years to First Offense After Program Exit	40.9%	19.8%	39.3%	100.0%
		% within REASON	100.0%	100.0%	100.0%	100.0%

References

Battin, S., Hill, H., Abbott, R., Catalano, R., & Hawkins, J. (1998). The contribution of gang membership to delinquency beyond delinquent friends. *Criminology, 36,* 93-115.

Bureau of Economic Analysis, Bureau of Labor Statistics, Natural Agricultural Statistics Service, national Venter for Health Statistics. US Census Bureau. Revised 10-Jul-2009.

Burns, B., Hoagwood, K., & Mrazek, P. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Review, 2,* 199-254.

Byrnes, E., Hansen, K., Malloy, T., Carter, C., & Curry, D. (1999). Reductions in criminality subsequent to group, individual, and family therapy in adolescent residential and day treatment settings. *International Journal of Group Psychotherapy, 49,* 307-322.

Casey, R. & Berman, J. (1985). The outcome of psychotherapy with children. *Psychological Bulletin, 98,* 388-400.

Chamberlain, P. & Rosicky, J. (1995). The effectiveness of family therapy in the treatment of adolescents with conduct disorders and delinquency. *Journal of Marital and Family Therapy, 21,* 441-459.

Estrada, A. & Pinsof, W. (1995). The effectiveness of family therapies for selected behavioral disorders of childhood. *Journal of Marital and Family Therapy, 21,* 403-440.

Farrington, D. (1989). Early predictors of adolescent aggression and adult violence. *Violence and Victims, 4,* 79-100.

Farrington, D. (1991). Childhood aggression and adult violence: Early precursors and later-life outcomes. In *Development and Treatment of Childhood Aggression,* edited by D. Pepler and K. Rubin. Hillsdale, NJ: Erlbaum.

Institute of Medicine. (1989). Research on children and adolescents with mental, behavioral, and developmental disorders. Washington, DC: National Academy Press.

Jones, J. (1985). Stages of family involvement in the residential treatment of adolescence. *Journal of Marital and Family Therapy, 11,* 381-389.

Kaplan, H. & Sadock, B. (1991). *Synopsis of psychiatry* (6th ed). Baltimore, MD: Williams & Wilkins.

Kazdin, A. (1993). Psychotherapy for children and adolescents: Current progress and future research directions. *American Psychologist, 48*, 644-657.

Kazdin, A. (2000). Predictors of youth violence. *Juvenile Justice Bulletin*, April 2000.

Kirby, L. & Fraser, M. (1997). Risk and resilience in childhood. In M. Fraser (Ed.), *Risk and resilience in childhood: An ecological perspective*. Washington, DC: NASW Press, 10-33.

Klinteberg, B., Andersson, T., Magnusson, D. and Stattin, H. (1993). Hyperactive behavior in childhood as related to subsequent alcohol problems and violent offending: A longitudinal study of male subjects. *Personality and Individual Difference, 15*, 381-388.

Lewis, M. (1985). Residential treatment. In M. Kaplan & B. Sadock (Eds), *Comprehensive textbook on psychiatry* (4th ed). Baltimore, MD: Williams & Wilkins.

Lipsey, M., Wilson, D., & Cothern, L. (2000). Effective intervention for serious juvenile offenders. *Juvenile Justice Bulletin*, April 2000.

Loeber, R. (1990). Development and risk factors of juvenile antisocial behavior and delinquency. *Clinical Psychology Review, 10*, 1-41.

Maguin, E. & Loeber, R. (1996). Academic performance and delinquency. In *Crime and Justice: A Review of Research, 20*, edited by M. Tonry. Chicago, IL: University of Chicago Press, 145-264.

Mann-Feder, V. (1996). Adolescents in therapeutic communities. *Adolescence, 31*, 17-28.

OJJDP Statistical Briefing Book. Online. Available: http://www.ojjdp.gov/ojstatbb/offenders/qa03202.asp?qaDate=19990930. Released on September 30, 1999.

OJJDP Statistical Briefing Book. Online. Available: http://www.ojjdp.gov/ojstatbb/offenders/qa03106.asp?qaDate=2008. Released on December 21, 2010.

Pepler, D. & Rubin, K. (Eds.) (1991). The development and treatment of childhood aggression. Hillsdale, NJ: Erlbaum.

Pfeiffer, S. & Strezeleck, B. (1990). Inpatient psychiatric treatment of children and adolescents: A review of outcome studies. *Journal of the American Academy of Child and Adolescent Psychiatry, 29*, 847-853.

Pinsof, W. & Wynne, L. (1995). The efficacy of marital and family therapy: An empirical overview, conclusions, and recommendations. *Journal of Marital and Family Therapy, 21,* 585-607.

Puzzanchera, C., Sladky, A., and Kang, W. 2010. Easy access to juvenile populations: 1990-2009. Online. Available: http://www.ojjdp.gov/ojstabb/ezapop/

Riche, M. (1983). Integrating families into a healing community: The use of structural and strategic family therapy in a psychodynamically oriented hospital. *Residential Group Care and Treatment, 1,* 67-84.

Robins, L. & Rutter, M. (Eds.) (1990). Straight and devious pathways from childhood to adulthood. Cambridge, England: Cambridge University Press.

Rosen, M. (1998). *Treating children in out-of-home placements.* New York: Haworth Press.

Sampson, R. & Lauritsen, J. (1994). Violent victimization and offending: Individual-, situational-, and community-level risk factors. In *Understanding and Preventing Violence, 3, Social Influences*, edited by A. Reiss and J. Roth. Washington, DC: National Academy Press, 1-114.

Shadish, W., Ragsdale, K., Glaser, R. & Montgomery, L. (1995). The efficacy and effectiveness of marital and family therapy: A perspective from meta-analysis. *Journal of Marital and Family Therapy, 21,* 345-360.

Spaniol, T. (2011). Brief history of Highridge Family Center. Document produced electronically, September 13, 2011.

Sunseri, P. (2001). The prediction of unplanned discharge from residential treatment. *Child and Youth Care Forum, 30,* 283-303.

Wildom, C. (1989). The cycle of violence. *Science, 244,* 160-166.

Williams, J. (1994). Understanding substance abuse, delinquency involvement, and juvenile justice system involvement among African-American and European-American adolescents. Unpublished dissertation, University of Washington, Seattle, WA.

Zingraff, M., Leiter, J., Myers, K., & Johnson, M. (1993). Child maltreatment and youthful problem behavior. *Criminology, 31,* 173-202.

Highridge Family Center Report Addendum

Date: November 29, 2012

To: CJMHSA Committee

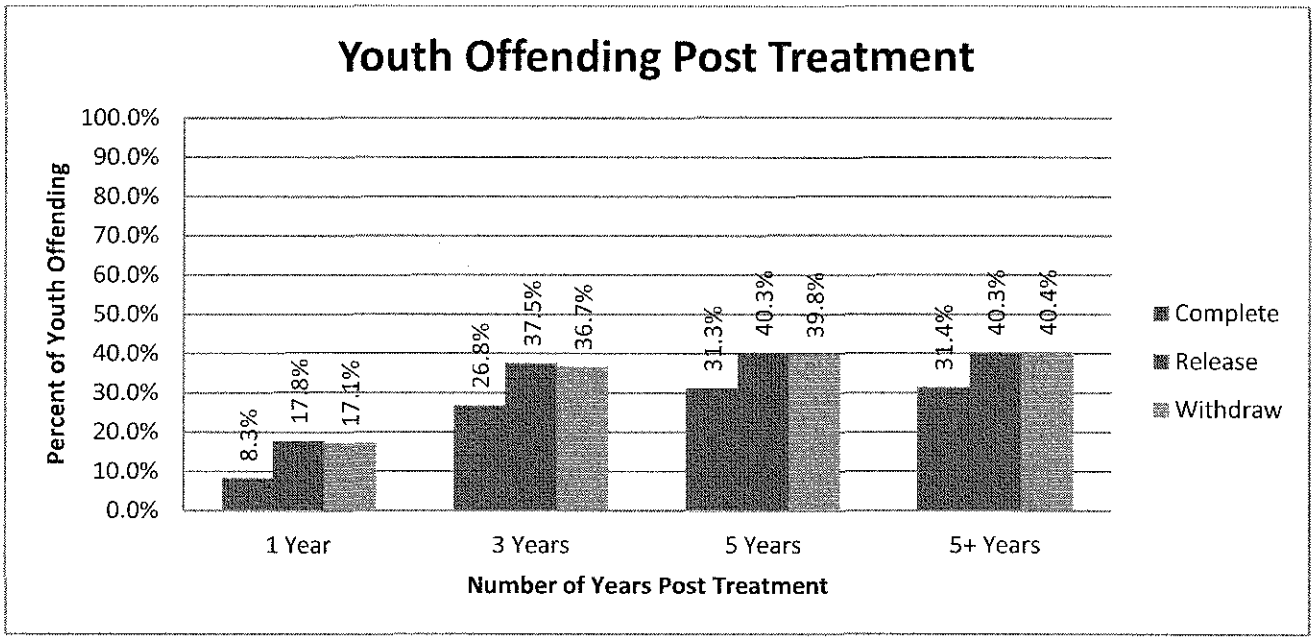
From: Twila D. Taylor, Psy.D., Chief of Clinical Services, Highridge Family Center
Tony Spaniol, Psy.D., Youth Affairs Division Director

Typical Profile of Highridge Resident

- Court Involved (Youth Court, IDDS, FVIP, Plea & Pass). Some youth are on their 2nd or 3rd "diversionary" program.
- On 2 or more psychotropic medications to treat diagnoses of Bipolar Disorder, Depression, ADHD, Psychosis NOS, PTSD, Anxiety disorders, etc.
- Multiple school suspensions
- Gang affiliated (males)
- Need for outpatient substance abuse treatment

Arrest Record Table Interpretation

Data is from the charts on page 11 (completion number) and 15 (post treatment offenses) of the report.



91.7% of Completers had not been arrested at 1 year follow up (615 out of 671)
73.2% of Completers had not been arrested at 3 year follow up (491 out of 671)
68.7% of Completers had not been arrested at 5 year follow up (461 out of 671)
68.6% of Completers had not been arrested at 5+ year follow up (460 out of 671)

Definitions of Complete, Release, and Withdraw

- **Complete** - Child and family successfully completed 12 weeks of treatment
- **Release** - Highridge discharged child or family due to repeated rule violations or safety issues
- **Withdraw** - Family or child chose to leave treatment

Highridge Family Center Report Addendum

Typical Reasons for Withdrawal from Highridge

- Child in need of a different level or type of service (i.e. psychiatric hospitalization)
  - Actively psychotic (i.e. hearing voices, command hallucinations, seeing things that are not really there)
  - Acutely suicidal (i.e. positive suicidal ideation with plan and intent and unwilling to contract for safety)
- Child refuses to enter the program
- Parent unable or unwilling to comply with parent participation component of treatment
- Child and/or family moves
- Transportation difficulties

Typical Reasons for Release from Highridge

- Physically assaulted staff /youth
- Repeated physical threats and posturing towards youth/staff
- Inappropriate sexual acting out in facility
- Used or brought drugs into the facility/sent to residential drug treatment
- Parent lack of participation in treatment

Update on "Action Plan/Future Directions" presented on 11/15/2011

1. The Division of Youth Affairs has been developing a computer application that will render more accurate, dependable data to be implemented early in 2012. Data provided by this application will be used to develop an on-going yearly analysis of our performance.
   Completed - Development of Case Manager Pro, a customized computer application and database designed and developed specifically for Youth Affairs.

2. In January 2012, Youth Affairs will begin a pre, post, and 1 year follow up psychological assessment to measure treatment outcome using the following:
   a. The Behavioral Assessment Scale for Children (BASC)
   b. The Family Adaptability and Cohesion Scales (FACES IV)
   Ongoing. Now scheduled to be implemented January 2013. We were awaiting the completion of the Case Manager Pro database and the purchase of an evidence based assessment tool. Both the BASC-2 and the FACES IV are widely used assessment measures in research studies of treatment efficacy.

3. Youth Affairs is researching assessment measures which will help in the determination of choosing an appropriate level of care for those seeking our help. We are interested in identifying a profile of a youth most likely to succeed at any given level of care.
   Completed – We have purchased an evidence based assessment tool called Youth Assessment & Screening Instrument (YASI) which focuses on risk and protective factors to determine appropriate levels of care and ensure we are treating the "at risk" population.

4. Youth Affairs will research the difference in the arrest rate from 1 to 3 years follow up in order to determine whether a timely intervention at 2 or 3 years post-discharge may have impact upon arrest rates.

Ongoing – Through our Youth Service Bureau, Youth Affairs offers 3 months of ongoing "aftercare" treatment to all youth upon leaving Highridge to include school visits, individual, group or family therapy. We will continue to try to make contact with the youth between the 1 and 3 year post treatment time frame in order to decrease any police contact.

5. HRFC and The School District of Palm Beach County will partner to develop or adopt a curriculum to measure the success of teaching our residents about the *process* of learning. We hope to gain greater access to School Board data in order to measure our impact upon school performance.
   In process – Highridge staff have met with Alternative Education staff regarding pre and post test measures of academic performance as well as how we might measure "the process of learning."

6. We are considering expansion and development of curriculum for residents of HRFC on the implications of involvement in the Juvenile Justice System.
   Completed – Lorna Wallach, M.Ed., Court Liaison, has implemented a weekly Court Group to educate our youth about involvement in the Juvenile Justice System and how they can remain "crime free."

7. Youth Affairs is in the process of more clearly defining "completion".
   Completed – With the development of the Case Manager Pro computer application and database, we have more clearly defined completion into 3 different levels of completion to account for progress made with treatment goals in addition to tracking the completion of 12 weeks of treatment.

Baseline Statistics

The following baseline statistics reflect historical data provided to the Criminal Justice Commission at the March 2012 Annual Planning Meeting and the agreed upon minimal performance indicators approved by the Criminal Justice Commission on October 22, 2012.

Programmatic and Literature

Palm Beach County Programs		**Evaluation Results of Similar Programs**		
Local Programs	**Outcome**	**Comparison**	**Outcome**	**Impact Assessment**[1]
Adult Drug Court	12% recidivism rate - since program inception	Adult Drug Court Meta Analysis[2]	38% recidivism rate	Effective
Delinquency Drug Court	17% recidivism rate - since inspection	Juvenile Drug Courts[3]	24% recidivism rate	Promising
Civil Drug Court	28% recidivism rate - October 2009 to September 2011	No comparative studies were found for this report	On-going local evaluation with FDLE arrest data	Unknown
Reentry (RESTORE)	.08 % recidivism rate (7% are re-arrested following release) – since program inception	Florida Department of Corrections (DOC)	33% recidivism rate (return to DOC facility)	Promising

[1] The rating contained in this table refers to the literature rather than the local programs. The promising rating is noted as the literature is more mixed in terms of findings when compared to the findings related to studies of adult drug courts. In the case of civil drug court, we were still unable to find a similar program in the literature.

[2] Mitchell Ojmarrh, et al. Drug Courts' Effects on Criminal Offending for Juveniles and Adults., The Campbell Collaboration., 2012:4. February 2, 2012. This study included 92 different adult drug courts across the United States.

[3] Hickert, Audrey, et al. Impact of Juvenile Drug Courts on Drug Use and Criminal Behavior., Journal of Juvenile Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP), Volume 1, Issue 1, Fall 2011. It is important to note that the literature on recidivism rates for delinquent drug court can vary greatly. For this purpose we have used the most conservative rates. In one study of model programs, OJJDP literature indicate recidivism rates of 48% for example – see www.ojjdp.gov/mpg/progtypesdrugcourt.aspx.

Minimal Performance Indicators

Program	Caseload (per year)	Target Population	Minimal Performance Indicator	Peer Review Journals and Reports[4]
Adult Drug Court	180 court participants	Adult, non-violent felonies (post conviction), Palm Beach County Residents	50% graduation rate* 15% arrested and convicted within three years after graduation, reported every six months**	38% arrested after completing drug court program.
Civil Drug Court	100 court participants (treatment recommended and received)	Adults and Juveniles with substance abuse problems, Palm Beach County Residents	50% graduation rate* 15% arrested and convicted within three years after graduation, reported every six months	No studies found; however, local evaluation is on-going tracking arrest after program with FDLE criminal histories.
Delinquency Drug Court	14 court participants	Palm Beach County youth, ages 12-17, who are either on Probation with a pending violation; failed to complete the Youth Court Teen Drug Court component; or meet criteria under F.S. 985.345. (Please see Appendix B for more detail).	50% graduation rate* 25% arrested and found delinquent within three years after graduation, reported every six months	24% arrested after completing delinquent /juvenile drug court program.

[4] Kukec, Damir., Interim Report: Outcome Evaluations of Select Programs, March 26, 2012. For detail concerning program descriptions and outcomes please see the interim report.

Program	Caseload (per year)	Target Population	Minimal Performance Indicator	Prison and Jail Comparisons
RESTORE	200 adult felons	Adult felons returning to Palm Beach County from Florida Department of Corrections	15% convicted of a new crime and re-sentenced to DOC within three years after release reported every six months*	33 % arrested and return to Department of Corrections within three years after release.[5]
Non-Restore	250 adult ex-offenders	Adult misdemeanants and felons returning to Palm Beach County from Florida Department of Corrections or the County Jail	25% convicted of a new crime and returned to incarceration within three years after release reported every six months*	51% arrested and return to Palm Beach County Jail within three years after release.[6]

[5] For more information see www.dc.state.fl.us/oth/faq.html
[6] Kukec, Damir., Recidivism for Palm Beach County Jail Inmates., Research and Planning Brief. October 7, 2008.

Performance Indicators - Adult Drug Court

February 28, 2013

GOALS	OUTCOME	Additional Comments
Target Population: Adult, Palm Beach County Residents, with non-violent felony cases.	All current participants meet eligibility criteria per F.S. §948.08. All current participants are Palm Beach County residents. All current adult participants have non-violent, drug related charges.	
Goal: Caseload (per year) 180 participants	FY12 average caseload was 203 participants. To date, FY13 average caseload is 189 participants.	Oct. 1, 2011 - Sept. 30, 2012 Oct. 1, 2012 - Feb. 28, 2013
Goal: 50% Graduation rate	Since November 2000, 57% of the participants who entered the program (signed contracts) have successfully completed and received a Nolle Prosse.	3,166 contracts signed/ 1,350 graduates
Goal: 15% (or less) of the graduates are not arrested and convicted of a serious crime within three years after graduation	Since November 2000, 10% of the graduates have been arrested and convicted of a serious crime within three years after their graduation.	135 arrests and convictions/ 1,350 graduates

City of Riviera Beach Civil Drug Court

Program	Caseload (per year)	Target population	Minimal Performance Indicator	Performance outcomes (October 1,2012 to February 28, 2013)	Cumulative Percentage
Civil Drug Court	100 court participants (treatment recommended and received.)	Palm Beach County Residents (Adults and Juveniles with substance abuse problems.)	50% graduation rate. 15% arrest and convicted within three years after graduation.	25 Petitions filed (21) incomplete* (2) Dismissed (1) successful completion (1) Failed *Represents that the case/client is either: in treatment, p/u order issued, "show cause" hearing pending or has been re-set for a later date.	 84.0 8.0 4.0 4.0 Total 100.0

Delinquency Drug Court – Performance Indicators

March 2013

GOAL	PERFORMANCE INDICATOR	OUTCOME	ADDITIONAL COMMENTS
Caseload (per year)	Delinquency Drug Court will serve fourteen (14) participants per year	12.2 per year since inception (May 2008)	*calendar year: 1/1 – 12/31
Graduation rate	Fifty percent (50%) of Delinquency Drug Court participants will successfully complete the program	43% since inception	*3 participants pending
Recidivism	Seventy-five percent (75%) of Delinquency Drug Court participants will not be arrested and found delinquent within three (3) years after graduation	16% since inception	*excludes pending arrests and criminal traffic cases; includes adult convictions

For clarification:

- Define "per year" – is this calendar year (1/1/20-- to 12/31/20--) or County fiscal year (10/1/20—to 9/30/20--)?

- Is this for ALL arrests:
  - Misdemeanor and felony?
  - Any charge – NOT drug-related?

- "25% arrested and found delinquent" – do you mean arrested **and** adjudicated delinquent; should adult convictions be included?

RESTORE Outcomes

As of January 15, 2013

Agency	# of Assigned RESTORE Clients	Active at some point- post rel.	Rearrested Total	Rearrested Active	Returned to DOC	Successful Completion	Currently Active
The Lord's Place	72	56	13	9	0	3	28
Goodwill	66	40	13	2	4	4	22
Riviera Beach	38	27	11	2	1	2	17
TOTAL	176	123	37	13	5	9	67

69.89%	Were active at some point Post-Release
21.02%	Rearrest Rate - for those who finished Pre-Release services = (# assigned to RESTORE Clients)
10.57%	Rearrest Rate (Active) - for those clients who were active at some point Post-Release that have been rearrested
2.84%	Recidivism Rate (Returned to DOC) for those who finished Pre-Release services
2.27%	Recidivism Rate (Returned to DOC) for those who were active at some point Post-Release
0.00%	Recidivism Rate (Returned to DOC) for those who completed all services
11.40%	Baseline Recidivism Rate (Return to DOC)
26.00%	Re-arrest Rate for those who were never active post-release
6.25%	One Year Recidivism Rate