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Establishing Evidence-Based Juvenile Violence Prevention Programs in Oregon: A Report on the Implementation and Outcomes of Functional Family Therapy and Multi Systemic Therapy Model Programs

FY 2001-2005

What have we learned after four years?

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Background

Introduction

This report presents the findings from a four-year evaluation of the implementation and outcomes of two evidence-based family therapy programs: Functional Family Therapy (FFT) and Multisystemic Therapy (MST). The evaluation was conducted by Program Design and Evaluation Services of the Oregon Department of Human Services and sought to answer these basic questions: to what extent were these evidence-based programs implemented as designed and what impact did the programs have of the subsequent behavior of participants?

Background and Context

In 1996, the Criminal Justice Services Division of the Oregon State Police (now Office of Homeland Security) created a partnership with evaluation researchers in Program Design and Evaluation Services (PDES) of the Health Division of the Oregon Department of Human Services. The immediate objective of this partnership was to incorporate evaluation criteria into the selection and monitoring of Byrne funded programs aimed at reduction of juvenile violence. The long-term objective of this partnership was to promote funding and replication of programs known to be effective.

In 2001, PDES presented the general findings from the evaluation of the FY 1996-2000 Byrne funded juvenile violence prevention and treatment programs to the Governor's Drug and Violent Crime Advisory Board and made recommendations for optimizing the effectiveness of future Byrne funds. PDES noted that:

- The most effective Byrne funded programs were those that were based on well-researched interventions that had previously been subjected to rigorous experimental design evaluations, and had been found to be effective.

- Replications of programs that were previously successful in other communities did not guarantee similarly positive results in the new setting. Programs needed guidance to ensure that they identified and duplicated the features of a program that were specifically responsible for the program's success.

PDES made the following recommendations for future program selection:

- *Future Byrne funded programs should be based on well-researched best practices models, or promising program models that address violence or*

known correlates of violence and that lend themselves to rigorous evaluation.

- *Future Byrne funded programs should be expected to adhere to strict implementation standards and provide documentation of such implementation to ensure high quality program content, delivery, and evaluability.*

Following the presentation, the Criminal Justice Services Division (CJSD) and the Governor's Drug and Violent Crime Advisory Board directed that programs funded with Byrne dollars be evidence-based. The Office of Juvenile Justice and Delinquency Prevention's (OJJDP's) Blueprints for Violence Prevention initiative was used as a guide for identifying evidence-based programs. The Blueprints initiative overarching goal is to identify effective, research-based programs. After reviewing more than 600 violence prevention programs, the Blueprints initiative identified 11 model programs and 21 promising programs. Blueprint programs must: (1) show evidence of a significant deterrent effect on violence, delinquency, or drug use using a strong research design, (2) demonstrate a sustained effect, and (3) provide evidence of multiple-site replication. Programs meeting all three of these criteria are classified as "model" programs, whereas programs meeting at least the first criterion but not all three are considered "promising."

CJSD selected four FFT programs and two MST programs for funding in 2001. Agencies were selected based on their ability to implement FFT or MST with fidelity and willingness to implement an evaluation component. The four FFT agencies selected were ADAPT, Parrott Creek Child and Family Services, Homestead Youth and Family Services, and Jackson County Health and Human Services. The two MST agencies selected were Multnomah County Department of Community Justice and Youth Contact, Inc. A list of programs within each model, the type of program, the name of the program, the name of the agency, and the area within Oregon that the program served can be found in Table 1.

Table 1. Program Information				
Model Program	Type of Program	Name of Program	Agency	Area Served
FFT	Family Therapy Substance Abuse and Mental Health Treatment Drug Court	A Family-Focused Approach to Juvenile Violence Prevention	ADAPT	Douglas County
	Family Therapy	Functional Family Therapy Project	Parrott Creek Child & Family Services	Clackamas County
	Family Therapy Case Management Drug Court	Youth Turnaround Project	Jackson County Health & Human Services	Jackson County
	Family Therapy Case Management	Marigold Program	Homestead Youth & Family Services	Umatilla County
MST	Family Therapy Foster Care	Multisystemic Therapy Treatment Foster Care	Multnomah County Department of Community Justice	Multnomah County
	Family Therapy	Home Works	Youth Contact	Washington County

Model Program Descriptions

Functional Family Therapy (FFT)

FFT is a short-term, family-based prevention and intervention program that has been successfully applied in a variety of contexts to treat high-risk youth and their families from different backgrounds. FFT targets youths 11 to 18 years old at risk of or already demonstrating delinquency, violence, substance use, conduct disorder, oppositional defiant disorder, or disruptive behavior disorder. FFT focuses on the domains and systems within which adolescents and their families live. By developing family strengths and sense of efficacy, FFT provides the family with a platform for change and future functioning that extends beyond the direct support of the therapist and other social systems. Families enter feeling angry, hopeless, and resistant to treatment. FFT does not proceed with treatment until the family is motivated to change. The primary way this occurs is through the effort of the therapist to show respect by understanding the family and to reframe patterns of negative interactions into positive attempts to keep the family together. When change occurs in the family domain, it can be generalized outside the family.

FFT is delivered by family therapists who engage the entire family in skills training in family communication, parenting skills, and conflict management skills in order to change maladaptive behaviors and strengthen positive behaviors. On average, participating youth and families attend 12 one hour sessions spread over three

months; more difficult cases require 26 to 30 hours of direct service. Therapists' caseloads average 12 to 16 families.

Assessment is an integral component of FFT and occurs at program intake, throughout therapy, and at program exit. FFT requires the use of a series of assessment instruments that allow therapists to measure individual and family functioning, and changes in such functioning, over time. Assessments are completed using the Clinical Services System (CSS), a client tracking and monitoring database that is a required component of implementing Functional Family Therapy. The CSS provides a very structured framework for therapists to record data and features a series of easily generated reports. The CSS requires that the therapist complete a Client Case History at the beginning of services. This form provides information about the family and youth's background and demographics. After each session, the therapist records information about what was done during the session. A report can then be generated that indicates how many sessions the family has had and which phase of treatment they are in. The family is asked to complete a Counseling Process Questionnaire (CPQ) at the beginning of the second session and every third session thereafter. The CPQ measures a variety of therapist behaviors and is intended to assess fidelity to FFT as well as client satisfaction. FFT also requires that the family and youth complete the Youth Outcome Questionnaire, the Youth Outcome Questionnaire –Self Report and the Outcome Questionnaire at the initial session and again when counseling is completed. The Outcome Questionnaire, both youth and parent versions, measures clients' progress in therapy focusing on three aspects: (1) subjective discomfort (anxiety disorders, affective disorders, adjustment disorders, and stress-related illness), (2) interpersonal relationships, and (3) social role performance.

The FFT model consists of three phases: engagement and motivation, behavior change, and generalization. Using the FFT model, therapists determine when families are ready to advance through the FFT phases, with the applied therapeutic interventions determined by the phase.

The focus of Phase 1 (Engagement and Motivation) is to address any issues that might inhibit families' full and productive engagement with therapy and to build on those individual and family strengths that will contribute to successful therapy. This is the most important phase and often the longest for families who demonstrate resistance. During this phase, therapists work to create a shared understanding of the presenting problems and build trust with the family members. A therapeutic alliance is formed between the family and the therapist. The family completes assessment procedures and develops focus. Negativity is reduced and patterns and themes are reframed into positive efforts.

During Phase 2 (Behavior Change) the therapist works with the family to create and implement short- and long-term behavior change plans tailored to each family member's needs and perspective. In this phase the therapist develops and implements individualized change plans that address parenting skills, delinquency behavior, and communication skills. The therapist teaches the family new ways to interact and talk to each other. Negative relational sequencing is changed. The

therapist is active in instructing, modeling, and directing session activities with the goal of changing the family's negative relational sequencing. Sequencing behavior is a method used by the therapist to assess what happens and who does what within a family. Sequencing or circular questioning is usually done around the specifics of a presenting problem. Because it is drawn out in a circular fashion it is visually easier to see the context in which behavior occurs. This information is rich in knowledge about all of the participants, the action each took, and the meaning of each participant's behavior.

During Phase 3 (Generalization) the therapist helps the family apply positive behavior change techniques to additional situations and potential problems that could arise in the future. The focus shifts to relapse prevention and providing necessary community resources to support change. At this point the therapist becomes more of a case manager and works to assure stabilization of new skills. To ensure long-term support of changes, FFT links families with available community resources. At closure the family is also offered three booster sessions if needed in the future.

Evidence of Effectiveness

Program success with a wide range of interventionists, including paraprofessionals and trainees with various professional degrees, has been demonstrated and replicated for more than 25 years. Multiple clinical trials, with follow-up periods of one, three, and five years have demonstrated significant and long-term reductions in the proportion of youths who re-offended, ranging from 25 percent to 60 percent. Diffusion effects on the siblings of target youths have also been observed, with significantly fewer siblings of FFT youths than control youths having juvenile court records 2.5 to 3.5 years after the program (Alexander et al., 2000). FFT has also been demonstrated to be cost effective (Aos et al., 2001).

Multisystemic Therapy (MST)

MST is an intensive family-oriented, home-based program that targets chronically violent, substance-abusing juvenile offenders 12 to 17 years old. The underlying premise of MST is that criminal conduct is multi-determined; therefore, effective interventions must recognize this fact and address the multiple sources of criminal influence. These sources are found not only in the youth (values and attitudes, social skills, biology, etc.) but also in the youth's social ecology: the family, school, peer group, and neighborhood. While the initial MST involvement may be intensive, perhaps daily, the ultimate goal is to empower the family to take responsibility for making and maintaining gains. An important activity of therapists is fostering parents' ability to advocate for their children and themselves with social service agencies. In other words, parents are encouraged to develop the requisite skills to solve their own problems rather than rely on professionals.

MST uses the family preservation model of service delivery which specifies that services are home-based, goal-oriented, and time-limited. MST focuses on the present situation seeking to identify and extinguish behaviors that are of concern

not only to referring agents but to the family as well. The entire family participates in the MST program. MST involvement typically lasts between four and six months. Collaboration with community agencies is a crucial part of MST practices. MST views the school as a key partner, hence therapists may be in daily contact with teachers and administrators. MST therapists also work in close partnership with probation officers who in many cases are the referral source.

A central feature of the MST treatment model is its integration of empirically tested treatment approaches, which have historically focused on a limited aspect of the youth's social ecology (e.g., the individual youth, the family), into a broad-based ecological framework that addresses a range of pertinent factors across family, peer, school, and community contexts. The choice of modality used to address a particular problem is based largely on the empirical literature concerning its efficacy. As such, MST interventions are usually adapted and integrated from pragmatic, problem-focused treatments that have at least some empirical support. These include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavioral therapies. In addition and as appropriate, biological contributors to identified problems are identified and psychopharmacological treatment is integrated with psychosocial treatment.

A crucial aspect of MST is its emphasis on promoting behavior change in the youth's natural environment. As such, the overriding goal of MST is to empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems. "Parent" and "family" are broadly defined to include the adult(s) who serves as the youth's primary parent figure or guardian. Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family for responsible behavior.

Initial therapy sessions identify the strengths and weaknesses of the adolescent, the family, and their transactions with extra-familial systems (e.g., peers, friends, school, parental workplace). Problems identified both by family members and the therapists are explicitly targeted for change and the strengths of each system are used to facilitate such change. Although specific strengths and weaknesses can vary widely among families, several problem areas are typically identified for serious juvenile offenders and their families.

Within the family, parents and adolescents frequently display high rates of conflict and low levels of affection. Similarly, parents (or guardians) frequently disagree regarding discipline strategies, and their own personal problems (e.g., substance abuse, mental illness) often interfere with their ability to provide necessary parenting. Family interventions in MST often attempt to provide the parent(s) with the resources needed for effective parenting and for developing increased family structure and cohesion. Such interventions might include introducing systematic monitoring, reward, and discipline systems; prompting parents to communicate effectively with each other about adolescent problems; problem solving day-to-day

conflicts; and developing indigenous social support networks with friends, extended family, church members, and so forth.

A frequent goal of treatment is to decrease the youth's involvement with delinquent and drug-using peers and to increase his or her association with pro-social peers (e.g., through church youth groups, organized athletics, after-school activities). Interventions for this purpose are optimally conducted by the youth's parents, with the guidance of the therapist, and might consist of active support and encouragement of associations with positive peers (e.g., providing transportation and increased privileges) and substantive discouragement of associations with deviant peers (e.g., applying significant sanctions).

MST is a flexible intervention tailored to each family's situation. There is no one recipe for success. Instead, there are nine guiding principles:

1. The primary purpose of assessment is to understand the "fit" between the identified problems and their broader context.
2. Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change.
3. Interventions should be designed to promote responsible behavior and decrease irresponsible behavior among family members.
4. Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.
5. Interventions should target sequences of behavior within or between multiple systems that maintain the identified problems.
6. Interventions should be developmentally appropriate and fit the developmental needs of the youth.
7. Interventions should be designed to require daily or weekly effort by family members.
8. Intervention efficacy is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.
9. Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

Although MST therapists' design and implement MST interventions based on adherence to the core treatment principles, MST is a dynamic treatment model that is always in active refinement. Each therapist is assigned a small caseload of no more than six to eight clients, which allows the therapist to meet several times per week with each client and his or her family in addition to consulting with other systems in which the child is involved (e.g., the school and juvenile justice

systems). Clients also have access to 24-hour crisis intervention services from an on-call therapist. The average duration of treatment is about four months, which includes approximately 60 hours of therapist-family contact.

Evidence of Effectiveness

MST has been evaluated in multiple clinical trials. These program evaluations have demonstrated 25 to 70 percent reductions in long-term rates of re-arrest, and 47 to 64 percent reductions in out-of-home placements. Moreover, families who received MST demonstrated extensive improvements in family functioning and decreases in youth's mental health problems. Positive results were maintained for nearly four years after treatment ended (Henggeler et al., 2001). The program has been demonstrated to be cost-effective (Aos et al., 2001). However, a recent systematic review of the evidence for MST effectiveness conducted by the Campbell Collaboration suggests that MST has limited effectiveness. The review found no significant differences between MST and usual services in restrictive out-of-home placements and arrests or convictions using an intent-to-treat analysis. Pooled results from eight randomized controlled trials of MST with data of varying quality tend to favor MST, but these relative effects are not significantly different from zero. The sample size is small and the effects are not consistent across studies; hence, it is not clear whether MST has clinically significant advantages over other services. The reviewers conclude that there is inconclusive evidence of the effectiveness of MST compared with other interventions for youth (Littell et al., 2005).

Methods

Evaluation Questions

The evaluation addressed two basic questions:

To what extent were the FFT and MST models implemented as designed? The process evaluation used quantitative and qualitative data to assess the extent to which the sites implemented the programs as intended.

To what extent did the FFT and MST model programs affect the subsequent delinquent/criminal involvement of participants? The basic question addressed in the outcome evaluation was whether the FFT and MST model programs achieved their primary goal of reducing delinquent/criminal activity among program participants.

Evaluation Strategy

To answer these questions, Program Design and Evaluation Services (PDES) adopted an enhanced evaluation strategy that focused on demonstrating that the model programs were implemented with fidelity and included appropriate outcome measures to assess program effectiveness. In consultation with PDES, the six model program sites were required to participate in a series of evaluation activities designed to enhance their evaluation capacity. Each grantee was required to employ an external evaluator, create a Comprehensive Evaluation Plan, and complete a series of specific evaluation steps that were implemented in a stepwise fashion over the four-year Byrne grant period. During the first year of the program, grantees were required to develop their capacity to conduct evaluation activities. Capacity building steps included the development of a detailed program description, a logic model, and an evaluation measurement plan that outlined the program's goals and objectives, along with plans for measurement, data collection, and analysis. During the second year, grantees were required to conduct a process evaluation. The process evaluation described the population served, the quantity and quality of services delivered, and the barriers to program implementation. During the third and fourth years, grantees focused on program outcomes as well as continued process evaluation. Grantees were required to develop and implement an outcome monitoring system based on the program goals, objectives, performance indicators, and measurement plans developed in the capacity building phase.

Throughout the four years, PDES provided technical assistance and evaluation monitoring to the six model program sites. In order to guide programs in their evaluation, PDES developed a series of forms to capture data on youth and program characteristics. These forms include a detailed Program Description,

Logic Model and Evaluation Measurement Plan that together formed the basis of the evaluation capacity building process. The Program Description set forth the program's rationale, described the program participants, the services they receive, and the program's resources. The Logic Model linked the program goals and activities to the outputs and outcomes expected. The Evaluation Measurement Plan set forth the measurement of outputs and outcomes and detailed the data collection methods and data management procedures to be used in the evaluation. In the second year, sites received guidance on the process evaluation. Sites were requested to address three key questions in their process evaluation: (1) did the program reach the appropriate target population, (2) was the delivery of program services consistent with program design specifications, and (3) was the training received from FFT or MST trainers sufficient to impart the necessary skills needed to deliver the program? In the third year, sites received guidance on conducting the outcome monitoring needed to assess program effectiveness. Sites were directed to collect data on referrals, allegations, and severity of referrals for program participants during the year prior to entering FFT or MST and during the year following exit from the FFT or MST program. The Appendix (beginning on page 55) provides copies of all the forms developed by PDES to assist sites with evaluation activities.

Implementation

The primary goal of the process evaluation was to document and assess the extent to which sites implemented the programs as intended. The process evaluation used quantitative and qualitative data to assess whether the programs served the appropriate target population and whether program participants received interventions that were consistent with model program design specifications. Sites were required to receive training and technical assistance from the FFT or MST program designers and their designated technical assistance providers as a condition of the grant award. To a large degree, the process evaluation is an assessment of how well these technical assistance providers were able to assist sites in replicating the key features of these model programs. As part of the process evaluation, sites were required to collect data on the quality of the training and technical assistance received from the program designers.

Recidivism

The primary question addressed in the outcome evaluation was whether and to what extent the model programs reduced delinquent/criminal activity among program participants. The question is of paramount importance because recidivism reduction is the central purpose of the FFT and MST model programs and constitutes the core goal of their implementation in all six sites.

To assess the impact of FFT and MST programs on subsequent offending, PDES compared the recidivism rates of program participants in the year following their

exit from the program to their rates in the year prior to entering the program. A consensus has emerged among researchers that there is no one best measure of recidivism. Instead, the use of multiple outcome indicators is preferred. Consequently, PDES used the following recidivism measures:

- Number and rate of referrals to juvenile justice, including violent felony referrals, felony referrals, criminal referrals (i.e., felony or misdemeanor), and status and violation referrals.
- Number and rate of offenses for the various types of referrals.
- Mean severity of the most serious referral and mean severity of all offenses.

All youth were tracked for recidivism using JJIS, the Juvenile Justice Information System. JJIS tracks and integrates statewide information on juvenile involvement with juvenile justice departments. Youth were not tracked into the adult system.

Findings

Implementation

Overview

This section focuses on the nature and extent of FFT and MST model program implementation in the six sites. The assessment of the degree of program implementation is critical to understanding and interpreting outcome findings. While successful implementation of a model program does not guarantee a positive impact on outcomes, weak or partial implementation clearly diminishes the likelihood that program goals will be attained.

The implementation section addresses three key questions:

- Did the model programs serve the appropriate target populations?
- Was the training received from the program developers sufficient to impart the skills needed to deliver the program?
- Was the delivery of program services consistent with program design specifications? If not, what were the barriers to delivering the program as designed?

The section concludes with a summary assessment of implementation at each site. Each model program is given an overall implementation rating and a table provides an evaluative overview of the implementation of various program components in each site.

Background

The Criminal Justice Services Division (CJSD) in conjunction with the Governor's Drug and Violent Crime Advisory Board directed that beginning in 2001 programs funded with Byrne dollars be evidence-based. The six program agencies described in this report had similar motivations and goals in adopting these model programs. They all contended with high rates of juvenile crime and recidivism and had reservations about the effectiveness of individual treatment programs. In this context, the family-based treatment approach of the FFT and MST model programs was particularly timely. The models carried considerable conceptual appeal for agency administrators and staff and gave each of the agencies an opportunity to address pressing issues with financial assistance from CJSD and technical assistance from the designers of the models.

Each of the six agencies used either the FFT or MST national model as a framework for developing their proposal to CJSD; however, they had the flexibility to operationalize the various components of the model in a way that best fit local circumstances and therefore maximized the possibility of successful

implementation. This resulted in the development of programs that all adhered to the basic tenets of the FFT or MST national models but looked quite different from each other in terms of design and operations. All the programs, however, had a common and clearly articulated goal, to reduce juvenile crime and recidivism.

Population Served

Did the model programs serve the appropriate target populations?

Program Participants

The six model programs served a total of 995 youth and their families over the four years of funding. A total of 58 percent of those served were male and 42 percent were female; 11 percent were age 12 or under and 89 percent were between ages 13 and 18; 79 percent were white, 9 percent were Hispanic, 6 percent were black and 6 percent were other races/ethnicities. Demographic profiles for each program are found in Table 2.

Table 2. Demographic Profiles

Descriptive Characteristics of Juvenile Violence Prevention Program Participants	*ADAPT*	*Parrott Creek*	*Marigold*	*Jackson*	*Multnomah MST TFC*	*Home Works*
Total Number of Clients Served	172	265	172	148	133	105
Gender (%)						
Male	71	60	22	58	79	65
Female	29	40	78	42	21	35
Unknown	0	0	0	0	0	0
Age Range (%)						
0-12	1	14	24	10	0	10
13-18	99	86	72	90	100	90
Unknown	0	0	4	0	0	0
Race/Ethnicity (%)						
American Indian/Alaskan Native	2	1	1	1	4	0
Asian	0	1	1	0	2	1
Black or African American	0	1	1	1	35	5
White	96	85	80	89	44	67
Hispanic	2	6	5	8	13	27
Multi-racial	0	3	2	1	1	0
Unknown	0	3	10	0	1	0

Client Eligibility

The basic eligibility criteria for the FFT programs and the MST programs were the same across sites for FFT and MST programs respectively.

FFT eligibility criteria were:

- Youth aged 11 – 18
- At risk for and/or presenting with delinquency

MST eligibility criteria were:

- Youth aged 12 – 17
- Chronic, violent, or substance abusing juvenile offenders
- At high risk of out-of-home placement

Within these parameters, each program targeted a different client population for service. The ADAPT Family-Focused Approach to Juvenile Violence Prevention targeted male and female youth, aged 17 and younger who had committed delinquent criminal acts and were dually diagnosed with both chemical dependency and mental illness. The Parrott Creek Child and Family Services FFT Program targeted youth aged 11 to 18 who were at risk of involvement in delinquency activity or who had committed delinquent acts. The Homestead Youth and Family Services Marigold Program targeted girls between the ages of 12 and 18 who were at risk of involvement in juvenile delinquency. The Jackson County Health and Human Services Youth Turnaround Project targeted male and female youth, aged 11 to 17 who had, or whose parents/guardians had, substance abuse issues and who were at risk of involvement in juvenile crime or who had committed delinquent acts. The Multnomah County Department of Community Justice MST Treatment Foster Care Program targeted male and female youth, aged 12 to 16 who had been adjudicated, were on probation, had been identified as high to medium risk to re-offend and who had alcohol and drug problems or were gang involved. The Youth Contact Home Works Program targeted male and female youth aged 12 to 17 who were at risk of involvement in delinquency activity or who had committed delinquent acts.

All of the programs used the Oregon Juvenile Crime Prevention (JCP) Risk Screen Assessment to determine eligibility. The JCP is an assessment tool that categorizes risk factors into five domains: school issues, peer relationships, behavior issues, family functioning, and substance abuse. To be eligible for FFT services, youth were required to be at risk in a minimum of two domains; to be eligible for MST services youth were required to be at risk in a minimum of three domains. Youth are rated as at risk in a domain if they exhibit at least one risk factor in that domain.

<u>ADAPT Family Focused Approach to Juvenile Violence Prevention</u>

ADAPT served a total of 172 youth over the four years of funding. Over the grant period, data demonstrate that the program served the intended population. All youth served met the basic eligibility criteria (they were between ages 11 – 18 and at risk for and/or presenting with delinquency) and most also had both a high risk of substance abuse/dependence and a risk for mental illness (identified by a potential or existing DSM-IV diagnosis). A small number of youth were accepted into the program who had either a risk of substance abuse or mental illness. Overall, 89 percent of youth served were substance users.

Parrott Creek Functional Family Therapy Project

Parrott Creek served a total of 265 youth over the four years of funding. Of the 265 youth served, 57 percent were involved with the Clackamas County Juvenile Department (CCJD) at the time of intake and thus considered "delinquent" youth; 43 percent had not had prior involvement with CCJD and were considered "non-delinquent". A total of 93 youth were on probation and 54 were in diversion at the time they began FFT services, three youth had been involved with OYA, and two were on parole. The target population for the Parrot Creek FFT program was youth between the ages of 11-18 with risk factors in two of the five JCP domains. Over the grant period, data demonstrate that the program served the intended population. All but three clients served were within the appropriate age range; three clients served (one percent) were age ten. Almost all clients (97 percent) were at risk in at least two of the five risk domains; nine clients (three percent) had less than two risk domains. On average, clients served during the reporting period exhibited 3.25 risk factors each. The frequency of risk factors (in descending order) for all clients participating in FFT was family functioning (93 percent of youth), school issues (86 percent), peer relationships (62 percent), anti-social issues (61 percent), and drug and alcohol abuse (53 percent).

Homestead Youth & Family Services Marigold Program

Marigold served a total of 172 youth over the four years of funding. Initially, the Marigold program targeted adolescent girls between the ages of 11 and 18 who exhibited risk in at least two of the five JCP risk domains. During the second year, due to lower than expected referrals of girls, Marigold expanded its services to include boys. However the program strived to keep at least 75 percent of its case load for girls to maintain the focus on this population. Over the grant period, data demonstrate that 78 percent of the youth served by Marigold were girls. All youth served had risk factors in at least two of the five JCP domains. The frequency of risk factors (in descending order) for all clients participating in FFT was family functioning (98 percent), anti-social issues (78 percent), peer relationships (70 percent), school issues (64 percent), and drug and alcohol abuse (34 percent).

Jackson County Youth Turnaround Project

The Jackson County Youth Turnaround Project served a total of 148 youth over the four years of funding. The project was designed to serve primarily youth under the authority of the Juvenile Court or the Juvenile Department who had a history of

felony or misdemeanor convictions. A small number of youth served were to be pre-offenders in KARE, the Jackson County Pre-offender Service program. Over the grant period, data demonstrate that the program served the intended population. The youth in the Family Drug Court all had histories of both substance abuse and juvenile crime. The direct referrals from the Juvenile Department had a history of juvenile crime but not necessarily substance abuse. The youth referred from KARE all had risk factors in at least three of the five JCP risk domains. Of the total population served during the grant period, 52 percent were direct referrals from the Juvenile Department, 40 percent were referrals from the Family Drug Court and eight percent were KARE referrals.

Multnomah County MST Treatment Foster Care

The Multnomah County MST Treatment Foster Care program served a total of 133 youth over the four years of funding. Of the 133 youth served, 98 percent were classified as high to medium risk by the Multnomah County Juvenile Court and 100 percent were considered to be at immediate risk for out-of-home placement. The age range of youth served was 13 to 18. A total of 66 percent of youth served had a substance abuse issue, 23 percent of youth served were gang-affected or gang-involved, and 11 percent of youth served had both substance abuse issues and were gang-affected or involved. Overall, during the grant period, the Multnomah MST Treatment Foster Care program provided services to its intended population.

Youth Contact Home Works Program

The Youth Contact Home Works Program served a total of 105 youth over the four years of funding. The population targeted included youth who were at risk of out-of-home placement due to delinquency, adjudicated youth returning from out-of-home placement, chronic or violent juvenile offenders, seriously emotionally disturbed youth involved in the juvenile justice system, and substance abusing youth in the juvenile justice system. All youth had to have risk in three or more of the five JCP domains to be eligible for services. Over the grant period, data demonstrate that the program served the intended population. All youth were between the ages of 12 and 17. All youth served had risk factors in at least three of the five JCP domains; 26 percent were at risk in all five domains, 29 percent were at risk in four domains, and 45 percent were at risk in three domains. A total of 87 percent had a least one risk indicator in the School Domain; 80 percent had one or more risk factors in the Peer Relationships Domain; 70 percent had risk factors in the Behavioral Issues Domain; almost all (94 percent) were at risk in the Family Functioning Domain; and 50 percent had at least one risk factor in the Substance Abuse Domain. A total of 25 percent of the program's clients demonstrated serious emotional problems in addition to their delinquent behaviors, including victimization, depression, and suicidality and/or other self-harming behaviors.

Program Enrollment Rates

The number of youth enrolled in these six evidence-based programs was lower than expected. Table 3 (page 19) presents enrollment data for the six programs. The first three rows show the number of youth agencies proposed to serve in their

applications for funding followed by the number actually served and the percent. Overall, the four FFT programs proposed to serve 1,284 youth over the four years of funding. A total of 757 were served or 59 percent of the number proposed. The two MST programs proposed to serve 400 youth over the four years of funding. They served 238 or 60 percent of the number proposed. Reasons for lower than expected enrollment rates include the following:

- ***Delays in hiring***. Programs delayed hiring for a variety of reasons. In some instances, programs misunderstood the FFT or MST requirements and thought they could use therapists employed at the agency in a dual capacity (for example, use residential therapists to provide therapy to youth in residential treatment and follow them into family treatment when they were released) that the program developers felt was inappropriate. In other instances, programs misunderstood the model and proposed inappropriate non-therapist staff positions in place of therapist positions. Both MST and FFT require programs to maintain teams of therapists. FFT requires a minimum of three therapists and no more than eight in a team; MST requires teams of three to four therapists. Programs typically found out about the team requirement at the initial program developer orientation meeting and then had to delay training until they hired the required number of therapists. Finally, programs sometimes took extra time in hiring in an attempt to hire bi-lingual therapists to serve the Hispanic population. These recruitments proved especially difficult and were largely unsuccessful.

- ***Delays in scheduling the initial therapist training***. FFT and MST program developers faced increased demand for their services at the time of Byrne program implementation. As a result of this sharp increase in demand and their limited training resources, programs had to wait for initial training and were unable to serve clients until receiving the training.

- ***Therapist turnover***. All programs experience turnover in therapist positions. When this occurred, the position had to be advertised, applicants interviewed, and the therapist hired sent to replacement training before they could begin serving clients. Replacement training was offered on an infrequent basis, necessitating some delays in serving clients.

- ***Budget reductions***. In a few instances a program reduced the number of therapists employed due to loss of other grant funds. Byrne implementation took place during a time of severe budget restraints in Oregon and in instances where programs created their therapy teams using a mix of Byrne funds and other dollars, reductions in other grant funding resulted in layoff of therapists.

- ***Philosophical differences***. Both FFT and MST are short-term interventions. Some agencies felt that the time frame for these programs

was too short and choose to keep clients in the program longer than FFT or MST program developers felt was needed.

- ***Fewer referrals than expected***. Referral agencies often wanted more information about clients than the FFT or MST models would provide. As family therapy programs, therapists were limited by program developers in what information they could share. Referral agencies accustomed to individual treatment models found this to be difficult to understand and subsequently referred fewer clients.

Program Completion Rates

The number of youth who completed these six evidence-based programs was lower than expected. Table 3 presents program completion data for the six programs. The last two rows show the percent of youth who completed and failed to complete each of the six model programs. Overall, 677 youth exited the four FFT programs over the four years of funding. A total of 411 or 61 percent completed the program. A total of 210 youth exited the two MST programs over the four years of funding. A total of 152 or 72 percent completed the program. Program developers expect 80 percent or more to complete these programs. Reasons for lower than expected completion rates include the following:

- ***Therapist turnover***. All six of the model programs experienced a high degree of therapist turnover. When therapists resigned, clients faced establishing a relationship with a new therapist. This proved difficult even under the best of circumstances and many families choose to discontinue therapy rather than work with a new therapist.

- ***Mandated vs. non-mandated clients***. The FFT and MST models were developed and tested using court or juvenile department mandated clients. The six model programs implemented in Oregon served a mix of mandated and non-mandated clients. Some clients were referred from family/drug court or from probation officers at juvenile departments. These mandated clients had higher rates of completion. Other clients were self-referred or referred from other treatment agencies. These non-mandated clients typically had lower rates of program completion.

Table 3. Enrollment Data for Programs						
	Program					
Number Served	*ADAPT*	*Parrott Creek*	*Marigold*	*Jackson*	*Multnomah MST TFC*	*Home Works*
Total proposed to serve	344	340	400	200	200	200
Total served	172	265	172	148	133	105
Total served as a percent of total proposed to serve	50%	78%	43%	74%	67%	53%
Number active clients at end of program	18	31	17	14	9	19
Number clients not active at end of program	154	234	155	134	124	86
Number who completed program	105	147	78	81	82	70
Number who failed to complete program	49	87	77	53	42	16
Completion Rate						
Percent who completed program	68%	63%	50%	60%	66%	81%
Percent who failed to complete program	32%	37%	50%	40%	34%	19%

Program Developer Training

Was the training received from the program developers sufficient to impart the skills needed to deliver the program?

When implementing any evidence-based program with empirical evidence of efficacy, developing and maintaining fidelity to the original model is crucial. To insure fidelity, CJSD required the four FFT programs and the two MST programs to contract with FFT Inc. and MST Services Inc. respectively to conduct training and supervision.

FFT Quality Assurance Process

FFT has a systematic training, consultation and licensing process that is designed to insure that agencies adopting FFT implement the model with fidelity. These functions are conducted by FFT Inc., a private, for-profit corporation created in 1999 to oversee FFT dissemination. As part of its dissemination mission, the staff at FFT Inc. is responsible for quality assurance of FFT delivery. The process begins with a two-day on site implementation training during which an FFT representative explains the core elements of the FFT program, reviews research on the program's effectiveness, discusses the eligibility criteria for the program, reviews the site's screening and referral process, identifies any challenges the site might face in implementing the program and reviews the requirements for implementing FFT with fidelity. This initial meeting includes all program staff and all stakeholders. On the second day, the FFT representative installs the FFT Clinical

Services System (CSS) database on agency computers and trains staff in the use of all assessment instruments included in the database. The CSS is designed to help therapists adhere to the FFT model and is used to monitor implementation fidelity. The critical elements for FFT implementation include:

- Therapists operate in teams of no fewer than three and no more than eight therapists (including the clinical supervisor).
- Caseloads for therapists do not exceed 15 families per therapist at any given time. Each therapist to serve a minimum average of five FFT cases at any given time.
- The expected duration of treatment to be approximately three months or 12 sessions, with case termination based on outcome attainment within the FFT model.
- Therapists will be full-time Masters-level or equivalent-trained, seasoned mental health professionals assigned to the FFT program solely.
- FFT clinical supervisors will be members of the FFT team who have completed the first phase of FFT clinical training and attended FFT externship training to assume clinical supervision responsibilities.
- Therapists will use the FFT Model, Assessment Protocols, and the Clinical Services System, to apply training.
- Supervision practices will conform to the following format: weekly FFT group consultation, weekly telephone clinical supervision by an FFT consultant. Supervision to focus particularly on individual cases and model adherence.

FFT Training Process

Once an agency decides to implement FFT, they enter into a contract with FFT Inc. for training. Agencies are assigned an FFT consultant and therapists attend a three-day on site clinical training for treatment providers and supervisory staff covering FFT treatment principles and their application. This training is provided by one of the two principal developers of FFT. Following completion of the training, the team members begin taking cases under FFT supervision. The FFT consultant provides the team telephone supervision on a weekly basis and three two-day trainings on site during the year. These trainings cover areas in which the team may need additional training. At the end of the first year, one member of the team is selected to receive additional training in order to assume the clinical supervision of the team. In the second year, this person attends three trainings off site to prepare to assume the clinical supervision of the team. Over the year, this person receives a total of eight full days of training. Training is provided by one of the two principal developers of FFT and includes working with clients while being observed through a one-way mirror. The principal developer provides feedback on clinical

performance following observation. During the second year, the FFT consultant transitions from providing clinical supervision to the team to providing clinical supervision only to the person selected to assume the clinical supervision role. Weekly supervision is transferred to this person and the FFT consultant provides feedback to him/her on their supervision of the team. The FFT consultant also conducts three two-day on site trainings to the team on issues needing additional training. At the end of year two the site's performance is reviewed based on data from the Clinical Services System database, observations by the FFT consultant, and observations by one of the FFT program developers. If the review is positive, the site is certified as providing FFT with fidelity. If the site is not certified, they may continue to receive additional training.

FFT Program Summaries

ADAPT Family Focused Approach to Juvenile Violence Prevention

ADAPT encountered a number of difficulties in working with program developers to implement clinical training for their therapists. ADAPT initially intended their FFT trained therapists to also serve as alcohol and drug counselors. FFT Inc. informed ADAPT that this would violate the fidelity of the model but that ADAPT could provide substance abuse and mental health treatment concurrently with FFT. The FFT consultant assured ADAPT and PDES that doing so was within the parameters of the model. However, in the third year, the program developer notified ADAPT that this practice was not model adherent and that the program would have to be redesigned to incorporate all substance abuse and mental health counseling into the FFT program. In addition, the program developer reviewed the progress of the team and concluded that they were not implementing FFT with fidelity. A number of changes followed including the resignation of the program manager, the replacement of the FFT consultant, the replacement of the team lead therapist, and the requirement that the team receive additional training before the site was certified. In years three and four the program successfully completed FFT training requirements. However, ADAPT believes that during the first two years, FFT Inc. consultants and the program developer did not provide the ADAPT therapists with a consistent interpretation of their progress in implementing the FFT model and that the feedback they received from FFT prior to year three did not provide them with specific guidelines on how to improve clinically and maintain model adherence.

Parrott Creek Functional Family Therapy Project

The staff at Parrott Creek found the clinical supervision and training they received from FFT Inc. to be of high quality and believe that the opportunity to work directly with the developers of the FFT model ensured that their therapists implemented FFT with fidelity. Parrott Creek staff felt that the amount of training offered in the first two years proved to be excellent for achieving a good understanding of the model and the implementation strategy. However they note that training opportunities dropped off dramatically in the last two years and that the potential for model drift was increasing. FFT, Inc. experienced a tremendous amount of growth

in the four years of Byrne funding. This growth made it difficult to meet demand from agencies. At times, communication with the FFT, Inc. was quite difficult. Phone calls and e-mails frequently were not returned.

Homestead Youth & Family Services Marigold Program

Marigold staff found the implementation of the FFT program to be a considerable challenge in the first two years of program operation and believe the ongoing support they received from FFT was critical to their success. Without this support and training, Marigold staff believes drift from the model would have occurred. The initial training from FFT provided a tremendous amount of information that was initially difficult to apply with model fidelity. It was only through practice and ongoing support from FFT that fidelity increased. Working directly with the developers of FFT was helpful in many respects. For example, having access to the model developers for training or consultation allowed therapists the opportunity to hear the thinking and rationale for various facets of the model; being able to watch a developer of the model implement the model with a family (as occurs at externship) was a remarkably helpful experience. However, the FFT model developers became less accessible over the four years of Marigold's operation and when access did occur it was occasionally disheartening or unhelpful. This reduced access also slowed the process of having questions answered. Sometimes, answers arrived from FFT sources that appeared contradictory or were confusing. On occasion, the direction from FFT regarding implementation was very difficult to follow in an agency setting or small community. For example, FFT requires teams that have lost more than 50 percent of their original members to begin the site certification process again- and pay for it. Staff turnover is unavoidable in an agency setting and a small, non-profit agency such as Homestead Youth and Family Services cannot absorb this cost more than once. Marigold has been able to overcome some of the challenges of working directly with the model developers since the team lead became an FFT National Implementation Consultant during the second year of the program's operation. She has been able to access FFT administration and developers via this role. Prior to taking on this role, her efforts were not nearly so successful.

Jackson County Youth Turnaround Project

Youth Turnaround Project staff found the clinical supervision and training they received from FFT Inc. to be of high quality and believe that the opportunity to work directly with the developers of the FFT model ensured that their therapists implemented FFT with fidelity. They note that their experience with FFT Inc. has been positive and that FFT Inc. has been responsive in directing the on-site supervision to ensure model fidelity. The initial FFT consultant was not a good fit for the program and was quickly replaced at Youth Turnaround's request with a consultant who proved to be a better match for the program. Youth Turnaround found the subsequent clinical supervisors to be patient, clear and very knowledgeable about the model. They found the feedback they received from the FFT supervisors is applicable and valuable. However, they note that well into the third year of model implementation, they were still gathering new information,

correcting previous assumptions or incorrect understandings of the requirements and costs of sustaining certification in the FFT model. For example, during the third year, three of the four FFT therapists resigned. At that time, the program learned that FFT Inc. requires programs to restart the site certification process from the beginning when a majority of the initially trained therapists have been replaced. Youth Turnaround management notes that if FFT Inc. had informed them of this requirement initially, they would have selected and managed initial staff differently.

MST Quality Assurance Process

MST has a systematic training, consultation and licensing process that is designed to insure that agencies adopting MST implement the model with fidelity. These functions are conducted by MST Services Inc., a private, for-profit corporation created in 1996 to oversee MST dissemination. As part of its dissemination mission, the staff at MST Services Inc. is responsible for quality assurance of MST delivery. The process begins with an assessment of the local conditions before MST begins and a review of the requirements for implementing MST with fidelity. The critical elements for MST implementation include:

- Therapists operate in teams of no fewer than two and no more than four therapists (plus the clinical supervisor) and use a home-based model of service delivery.
- Caseloads for therapists do not exceed six families per therapist with a normal range being four to six families. Each therapist to serve approximately 15 families per year.
- The expected duration of treatment to be three to five months.
- Therapists will be full-time Masters-level or equivalent-trained, seasoned mental health professionals assigned to the MST program solely.
- MST clinical supervisors will be either Ph.D. level or experienced Masters level professionals.
- MST clinical supervisors will be assigned to the MST program a minimum of 50 percent (full-time is preferable) per MST team to conduct weekly team clinical supervision, facilitate the weekly telephone consultation, and be available for individual clinical supervision for crisis situations.
- Supervision practices will conform to the following format: weekly MST group consultation, weekly group clinical supervision, and individual supervision only as needed due to case crises, or to implement clinician-specific training.
- MST clinical supervisor will have credible authority over the MST clinicians (e.g. provide feedback relevant to performance reviews and salary decisions.

- Therapists will be accessible at times convenient to their clients and, in times of crisis, very quickly.

- The MST program will have a 24 hours per day, seven day per week on-call system to provide coverage when therapists are on vacation or taking personal time. The on-call system will be staffed by professionals who know the details of each case and understand MST principles.

MST Training Process

Once an agency decides to implement MST, they enter into a contract with MST Services Inc. for training. Agencies are assigned an MST consultant and therapists attend a five-day orientatin session, the objectives of which are to:

- Familiarize participants with the scope, correlates and causes of serious criminal behavior

- Describe the theoretical and empirical underpinnings of MST

- Describe the family, peer, school and individual intervention strategies used

- Train participants to conceptualize cases and interventions in terms of principles of MST, and

- Provide participants with practice in delivering MST interventions.

After that initial week of training, the next phase of training begins. The therapists are assigned a caseload and apply the MST principles to families, with rigorous monitoring by the MST consultant and the on-site clinical supervisor. Therapists complete detailed case summaries and forward them to the MST consultant. Therapists participate in weekly conference calls with the consultant for case-specific feedback, review of case summaries, and supervision. Four times a year, therapists meet on-site with the MST consultant for one and a half day booster training sessions.

MST Program Summaries

Multnomah County MST Treatment Foster Care

The Multnomah County MST program was an established MST site prior to obtaining Byrne funding. However they had not achieved the reductions in recidivism expected from MST programs. Following Byrne funding, the staff of the Multnomah County MST Treatment Foster Care program continued to receive telephone consultation and quarterly booster sessions from MST Services. The staff at Multnomah County found the supervision and training they received to be valuable and they believe that the opportunity to work directly with MST Services ensured that therapists implemented MST with fidelity. Unfortunately, due to budget cuts, the program had to terminate its contract with MST Services in

January 2003. Responsibility for training and supervision for the remainder of the Byrne grant period fell solely to the program's clinical supervisor. PDES evaluators expressed concerns about adherence to the model under these circumstances and in consultation with CJSD, arranged for a one-year independent study of therapist treatment adherence. The results of that study indicate that therapists were not adherent to the MST model.Treatment Foster Care

Youth Contact Home Works Program

There was considerable frustration among Home Works program staff, supervisors, and administrators regarding the training received from MST Services. Although Home Works believed that MST generally met all contract expectations, Home Works staff found the training and supervision provided by MST often fell short of what was needed to enable them to deliver the program as specified. A good deal of the content of training was perceived to be rather general, and trainings were not always well organized. Furthermore, advice from MST consultants seemed unhelpful at times and to conflict with MST program theory and treatment principles. Home Works staff found the initial training provided by MST to be inadequate. The training included a brief overview of the MST model, but few details on how to replicate the program. In addition, staff at Home Works also believed that booster trainings were not well organized. For example, Home Works shared booster-training sessions with the MST team from Multnomah County for a time. At one of the joint training events, a scheduled hour-long lunch break turned into three hours, as the Home Works staff waited for the MST consultant to return from lunch with a therapist from the Multnomah County team. Furthermore, according to Home Works staff, the content of supervision provided by MST conflicted at times with MST program theory and treatment principles. For example, a primary goal of MST is to prevent out-of-home placement. However, the MST consultant to Home Works frequently recommended placement for clients even when the Home Works team believed that all possible interventions had not been exhausted. On other occasions, the MST consultant recommended interventions that would clearly be offensive and demeaning to parents, despite the idea, also emphasized in MST, that parents should be empowered to help their children. For example, the consultant suggested that a therapist tell a parent who was often late to sessions, "You are late again. This sets a bad example for your child." Another example involved attempts by Home Works staff to engage a family that, apparently, was not ready to be engaged. The MST consultant recommended that one of the therapists hide in the bushes outside the family's home, a suggestion that seemed unhelpful, if not an invasion of the family's rights and privacy. As a result of these events, Home Works administration obtained the agreement of CJSD to discontinue MST consultation in September 2003.

Program Implementation

Was the delivery of program services consistent with program design specifications? If not, what were the barriers to delivering the program as designed?

When implementing a model program with empirical evidence of efficacy, developing and maintaining fidelity to the original model is crucial. As noted above, CJSD required all model program sites to contract with FFT Inc and MST Services Inc. respectively to conduct training and supervision of the model program. It was assumed that contracting with the program developers would ensure fidelity to the model. In essence, the evaluation tested both the effectiveness of these model programs and the effectiveness of the program developers in disseminating their models. The six model programs were funded for four years by the Byrne initiative beginning in October 2001 and ending in September 2005. The first two years of implementation are best characterized as a developmental and training period for each of the sites as they undertook the incremental process of translating program design into daily operational reality. Each of the programs was quite successful in implementing certain key aspects of the model they adopted, but each also struggled with other programmatic features. Although each of the programs had weak spots in their implementation, they all operated FFT or MST programs that successfully incorporated most of the core features of the national models. For example, in each program:

- High-risk, program-eligible youth were identified using an empirically based risk assessment instrument – the Juvenile Crime Prevention Risk Assessment.
- Therapists operated in appropriate sized teams.
- Caseloads for therapists were consistent with the national models. The duration of treatment for clients was consistent with the national models.
- Clinical supervision practices conformed to the national models specifications.
- Most therapists demonstrated adherence to model practices. One program, Multnomah County MST Treatment Foster Care, failed to maintain therapist adherence to the model.

Barriers to Implementation

Although key features of the FFT and MST models were generally well implemented, the six programs encountered several barriers to the delivery of the program as designed.

Program Adaptations

Ensuring that agencies understand and implement the core program components and dosage that are necessary for success is a serious challenge to program developers and disseminators. The original trials (efficacy studies) of programs are typically under the maximum control of the designer and under optimal conditions with high levels of finding, motivation, and support. The researcher generally exercises extreme care to ensure that the program is thoroughly understood and implemented with a high degree of quality. As programs are proven effective and implemented in settings under less favorable conditions (effectiveness studies), the chances for key program components to be modified and program delivery to be inconsistent become more likely (Dane and Schneider, 1998).

All four FFT programs and one of the two MST programs made modifications to the original models. Modifying or adding components to a program can present a serious threat to program fidelity. Efforts to introduce elements into already proven programs may backfire and result in a reduction of program benefits that might have otherwise been expected. Modifications were made by some sites with full understanding of the program in an effort to adapt the program to local needs. For example, the Multnomah County MST Treatment Foster Care Program added a Foster Care component in an effort to reduce out-of-home placements and the Jackson County Youth Turnaround project added Family Court and Case Management components in an effort to provide integrated treatment services. In other instances, adaptations were made because the site did not have a thorough understanding of the program and its underlying causal mechanism. For example, the Parrott Creek Functional Family Therapy Project attempted to use residential therapists in a dual capacity as individual treatment therapists for youths and family therapists for the youths' families, a violation of a basic FFT treatment principle. In a similar fashion, the ADAPT Family Focused Approach to Juvenile Violence Prevention program attempted to use staff in a dual role as family therapists and drug and alcohol counselors to youth.

Was fidelity compromised by these adaptations? We don't really know. Because efficacy studies generally include youth who are receiving all available program components, one can only conclude that a program works if implemented in its entirety. If specific components are omitted or modified and if one of these components is the mechanism causing much of the change in behavior, it is possible that program effects could be diminished. For example, two of the four FFT programs added a case management component. FFT may be effective because of the strong bond forged between the therapist and the family. If adding a case manager to the mix, however well intentioned, dilutes this bond it may reduce the program effects found in the efficacy studies.

Communication Issues

All of the programs reported communication difficulties with program developers. In some cases, programs received conflicting and contradictory advice from program developer representatives. In other instances, program developer representatives were unresponsive when sites attempted to communicate and did not return phone

calls and e-mails. In other instances, sites found developer representatives to be less than competent and questioned the quality of the training they were receiving. When problems arose, FFT sites felt that FFT Inc. was unresponsive while MST sites felt that MST Services gave them no mechanism to provide feedback.

FFT sites reported communication difficulties with referral agencies. The FFT model limits the amount of information therapists may share with referral agencies. These referral agencies wanted more information about their client's progress than is allowed under the FFT model. As a result, over time referrals decreased from some referral agencies. FFT therapists found that they had to be proactive in providing information to referral sources and explaining to them the boundaries set by the FFT model. At a minimum, therapists need to (1) acknowledge the referral by phone call, (2) let the referring agent know when the family has started therapy and when they plan to end therapy, and (3) provide the referring agent in a timely manner a closing summary of services received.

Therapist Turnover

One of the most challenging features of the implementation of these model programs was the high degree of therapist turnover. Not one team remained intact for the entire four years. A large amount of training time and cost is invested in each FFT or MST therapist. When a therapist leaves, the program has to make the investment again. In addition, the families who were in process with the therapist who left often have a difficult time transitioning and some will drop out of the program. There are also delays in serving new families as the replacement therapist must be trained before initiating a new caseload and FFT Inc. and MST Services offer replacement trainings on an infrequent basis.

Most of the FFT and MST programs experienced a good deal of turnover since their inception. Table 4 details the turnover by program.

Table 4. Turnover by Program

	Program					
Program Information	*ADAPT*	*Parrott Creek*	*Marigold*	*Jackson*	*Multnomah MST TFC*	*Home Works*
Size of Team	4	3	3	5	5	3
Number Therapists from Initial Team who remained on Team when Program Ended	2	1	1	1	3	0
Total Number of Therapists who Served on the Team over the Four Years of the Program	5	5	7	9	7	11

There were a total of 23 therapist positions in the six programs; of the original 23 therapists, eight (35 percent) remained on their team throughout the four-year period and 15 (65 percent) did not. These therapists were replaced and often the replacements were replaced. As a result, the 23 therapy positions were held by a total of 54 therapists over the four years of program implementation.

Implementation Assessment and Ratings

The implementation section concludes with a summary qualitative assessment of implementation at each site. Each of the six model programs is given an overall implementation rating and a following table rates the six programs' implementation for each of 16 discrete program components.

Rating Criteria

Three ratings were used to rank the overall level of implementation and the individual program components—weak, moderate, and strong. Descriptions of these categories follow:

- **Weak**. The component was not implemented or program practices rarely approached the level of functioning that the national model specified. For the overall program ranking, "weak implementation" means that although strong implementation may have existed in some areas, this was outweighed by program shortcomings to the extent that the intended functioning of the model was significantly diluted and implementation can be considered only partial.

- **Moderate**. Program practices in relation to components generally reflected the model and met expectations, but some aspects of the component (or some incidents during implementation) demonstrated significant shortcomings. A "moderate" rating means that the areas of weaknesses were substantial enough to have a negative impact on the overall quality of implementation for the component. For the overall ranking, "moderate implementation" means that generally the model was well-implemented and that program strengths far outweighed the weaknesses. However, areas of weakness were significant enough that implementation cannot be characterized as strong.

- **Strong**. The degree of implementation typically reflected the model and met expectations. "Typically" means that almost everyone was doing what they were supposed to be doing, doing it reasonable well, and doing it most of the time. For the overall program ranking, "strong implementation" means that for almost all program components, a high and consistent level of congruence existed between design and practice. While areas of weakness may be found, these did not subtract significantly from the overall level of implementation.

Overall Program Ratings

In assessing each model program on the overall level of implementation, it was necessary to take into account the ratings given the individual design components, the relative importance of the various components to the overall functioning of the model, and the extent to which identified weaknesses were or were not offset by program strengths. Essentially, the overall rankings reflect what PDES believes to be the "big picture" with respect to implementation. In other words, all things considered, how well did the program achieve fidelity between practice and program intent and design?

FFT Programs

ADAPT Family Focused Approach to Juvenile Violence Prevention

Overall Rating: Moderate tending toward Weak Implementation

The ratings shown in Table 5 toTable 7 (pages 32-34) make it clear that ADAPT had a moderate level of implementation. Overall, ADAPT received five "strong" ratings, five "moderate" ratings and six "weak" ratings. ADAPT received "strong" ratings in four of the five areas under treatment services, mixed ratings on training services implementation and weak ratings on four of the six organizational components. The first two years of implementation were characterized by failed management, budget cuts, and miscommunication with program developers. In the final two years of Byrne funding, the program made significant progress in correcting the problems that plagued its first two years.

Parrott Creek Functional Family Therapy Project

Overall Rating: Moderate tending toward Strong Implementation

The implementation at Parrott Creek was rated as "moderate" but the program had "strong" ratings on two of the three components. Overall, Parrott Creek received ten "strong" ratings, four "moderate" ratings and only two "weak" ratings. Parrott Creek received "strong" ratings in four of the five areas under treatment services, in four of the five areas under training services implementation and mixed ratings on the six organizational components.

Homestead Youth & Family Services Marigold Program

Overall Rating: Moderate Implementation

The implementation at Marigold was rated as "moderate" but the program had "strong" ratings on two of the three components. Overall, Marigold received eleven "strong" ratings, one "moderate" rating and four "weak" ratings. Marigold received "strong" ratings in all five areas under treatment services, in four of the five areas under training services implementation and mixed ratings on the six organizational components.

Jackson County Youth Turnaround Project

Overall Rating: Moderate Implementation

Overall, the Youth Turnaround Project received six "strong" ratings, seven "moderate" ratings and three "weak" ratings. The Youth Turnaround Project received "strong" ratings in four of the five areas under treatment services, mixed ratings on training services implementation and mixed ratings on organizational components implementation.

MST Programs

Multnomah County MST Treatment Foster Care

Overall Rating: Moderate Implementation

The ratings shown in Table 8 toTable 10 (pages 35-37) make it clear that the Multnomah County MST Treatment Foster Care program had a moderate level of implementation. Overall, the MST Treatment Foster Care program received seven "strong" ratings, six "moderate" ratings and three "weak" ratings. The program received "strong" ratings in four of the five areas under treatment services, mixed ratings on training services implementation and mixed ratings on organizational components implementation.

Youth Contact Home Works Program

Overall Rating: Moderate Implementation

Overall, the Home Works Program received eight "strong" ratings, four "moderate" ratings and three "weak" ratings. The Home Works Program received "strong" ratings in four of the five areas under treatment services, mixed ratings on training services implementation and "strong" ratings on four of the six organizational components.

Specific Component Ratings

PDES rated the extent of implementation of design components by taking into account the degree to which each site's practice reflected the intent and requirements of the national model. Primary considerations were whether the site in fact did what it said it was going to do, how closely site practices matched what the national model promised to deliver, and how consistently the component (both across staff and over time) was delivered as intended.

The following series of matrices (Table 5 to Table 10) organize the 16 design components into three groups: organizational components, training services, and treatment services. The matrices show the various design components in the first column and, in the following columns, how each site's implementation was rated for each component. The rating for each site's component implementation is accompanied by a brief narrative that provides a rationale for the rating. Separate tables are provided for FFT and MST programs.

FFT Programs Implementation Summary

Table 5. Organizational Components

Design Component	ADAPT	Parrott Creek	Marigold	Jackson
Management: Model indicates need for strong administrative commitment to support FFT.	Implementation: Moderate	Implementation: Moderate	Implementation: Strong	Implementation: Strong
	Initial administrator's weak and ineffective execution hurt the project. Strong commitment by subsequent agency administrator in final two years helped project get back on track.	Minimal engagement by agency administrator placed management burden primarily on the FFT lead supervisor.	Strong commitment by agency administrator who also served as FFT lead supervisor	No turnover among key administrators and strong commitment by administrators at both Jackson County and On Track.
Resources: Model requires sufficient and stable funding to maintain the integrity of the treatment team.	Implementation: Weak	Implementation: Strong	Implementation: Strong	Implementation: Moderate
	Program lost grant funding due to budget cuts and had to reduce its FFT team from 4 to 3 therapists.	Program maintained stable funding during the Byrne grant period.	Program maintained stable funding during the Byrne grant period.	Program maintained stable funding during the Byrne grant period but lost 4 of 5 therapists in 3rd year due to low salaries.
Staffing: Model indicates need for flexible, creative, and committed staff.	Implementation: Weak	Implementation: Moderate	Implementation: Weak	Implementation: Weak
	Staff had difficulty grasping the model. Significant staff turnover	Well-trained, committed staff. Significant staff turnover	Early difficulties maintaining staff. Significant staff turnover.	Well-trained staff but resignations forced agency to restart training. Significant staff turnover.
Community collaboration: Model stresses need to maintain community connections by involving outside people/agencies in program development.	Implementation: Weak	Implementation: Strong	Implementation: Weak	Implementation: Moderate
	Collaboration between agency and Drug Court severed following judge's charge that agency not providing court cases adequate treatment. Program collaborated well with Juvenile Department.	Close working relationship between the Juvenile Department and agency administrators created strong program.	Early difficulties collaborating with schools. On-going difficulties collaborating with Tribes. Weak commitment from Juvenile Department	Regular team meetings with staff from Family Court worked well. On-going difficulties collaborating with Juvenile Department due to personnel turnover that disrupted the linkages program was trying to establish.
Referral sources: Model stresses the need for early and ongoing communication with referral sources.	Implementation: Moderate	Implementation: Moderate	Implementation: Moderate	Implementation: Moderate
	Communication with Drug Court liaison failed. Juvenile Department became program's primary referral source. Agency maintained strong communication with Juvenile Department.	Close collaboration with Juvenile Department facilitated referrals from probation officers. However, referral sources wanted more information about client's progress than is allowed under the FFT model.	Early difficulties communicating FFT principles to community referral agencies reduced the number of referrals to the program. Over time, agency was able to increase referrals by providing enhanced community education to referral agencies.	Communication in team meetings facilitated referrals from Family Court. Program had to redevelop linkages with the Juvenile Department to maintain an effective referral system due to system level changes at the Juvenile Department.
Communication with program developer: Variety of implementation issues requires ongoing access to program developers.	Implementation: Weak	Implementation: Weak	Implementation: Weak	Implementation: Weak
	FFT Inc. did not provide the agency with clear and consistent guidelines for implementing FFT in a substance abuse treatment agency	FFT Inc. did not provide the agency with timely responses to communication. At times, phone calls and e-mails were not returned.	FFT Inc. became less accessible over the four years of funding. Responses to questions were sometimes contradictory and confusing.	FFT Inc. did not provide the agency with clear and consistent guidelines for implementing FFT in a substance abuse treatment agency

Table 6. Training Services				
Design Component	**ADAPT**	**Parrott Creek**	**Marigold**	**Jackson**
Therapist qualifications: Therapists will be full-time Masters-level or equivalent-trained, seasoned mental health professionals assigned to the FFT program solely.	Implementation: Moderate Therapists were Masters-level. However, in order to meet the FFT minimum team requirement, not all therapists were full-time.	Implementation: Strong Therapists were full-time Masters-level professionals assigned to the FFT program solely.	Implementation: Strong Therapists were full-time Masters-level professionals assigned to the FFT program solely.	Implementation: Moderate Therapists were Masters-level but not all were assigned full-time to the FFT program.
Therapist training: Therapists will receive three-day initial clinical training and weekly telephone supervision and quarterly booster trainings by national developers.	Implementation: Strong Therapists received three-day clinical training from program developer and regular quarterly booster sessions.	Implementation: Strong Therapists received three-day clinical training from program developer and regular quarterly booster sessions.	Implementation: Strong Therapists received three-day clinical training from program developer and regular quarterly booster sessions.	Implementation: Strong Therapists received three-day clinical training from program developer and regular quarterly booster sessions.
Clinical supervision: National developers will provide experienced clinical supervisor during training phase to conduct weekly supervision.	Implementation: Moderate Turnover in clinical supervisors. Initial clinical supervisor was not competent to provide FFT supervision in drug treatment agency. Replacement supervisor provided strong supervision.	Implementation: Strong Clinical supervisor provided by FFT gave clear, consistent, and appropriate clinical training.	Implementation: Strong Clinical supervisor provided by FFT gave clear, consistent, and appropriate clinical training.	Implementation: Moderate Turnover in clinical supervisors. Initial clinical supervisor was not competent to provide FFT supervision in drug treatment agency. Replacement supervisor provided strong supervision.
Supervision: Model requires weekly FFT group consultation with experienced FFT clinician followed by transition to supervision by team member.	Implementation: Weak Initial supervision by FFT contradicted by FFT developer. Transition from FFT supervisor to team member failed and had to be repeated with new team member at cost to team morale.	Implementation: Strong Smooth transition from FFT supervision to team member supervision. Strong supervision by team member.	Implementation: Strong Smooth transition from FFT supervision to team member supervision. Strong supervision by team member who subsequently became a national FFT clinical supervisor and provided supervision to other sites.	Implementation: Moderate Turnover in clinical supervisors provided by FFT. Following initial supervisor, quality of FFT supervision was high. Team supervisor resigned and program had to repeat process of developing a team supervisor.
Assessment: Model requires use of FFT assessment protocols and their entry in the Clinical Services System (CSS).	Implementation: Weak Initial CSS did not work properly and data entered into the system could not be retrieved. FFT revised CSS and developed a web-based system that resolved problems of lost entry. However, the system was difficult for therapists to retrieve information from on a client by client basis. Midway through the four year grant period, FFT revised their assessment protocols and dropped two of them from further use.	Implementation: Weak Initial CSS did not work properly and data entered into the system could not be retrieved. FFT revised CSS and developed a web-based system that resolved problems of lost entry. However, the system was difficult for therapists to retrieve information from on a client by client basis. Midway through the four year grant period, FFT revised their assessment protocols and dropped two of them from further use.	Implementation: Weak Initial CSS did not work properly and data entered into the system could not be retrieved. FFT revised CSS and developed a web-based system that resolved problems of lost entry. However, the system was difficult for therapists to retrieve information from on a client by client basis. Midway through the four year grant period, FFT revised their assessment protocols and dropped two of them from further use.	Implementation: Weak Initial CSS did not work properly and data entered into the system could not be retrieved. FFT revised CSS and developed a web-based system that resolved problems of lost entry. However, the system was difficult for therapists to retrieve information from on a client by client basis. Midway through the four year grant period, FFT revised their assessment protocols and dropped two of them from further use.

Table 7. Treatment Services				
Design Component	**ADAPT**	**Parrott Creek**	**Marigold**	**Jackson**
Client identification: Model requires targeting high-risk youth for FFT participation.	Implementation: Strong	Implementation: Strong	Implementation: Strong	Implementation: Strong
	Program used JCP empirically based risk assessment tool to determine eligibility.	Program used JCP empirically based risk assessment tool to determine eligibility.	Program used JCP empirically based risk assessment tool to determine eligibility.	Program used JCP empirically based risk assessment tool to determine eligibility.
Staffing: Model requires small, FFT-specific caseloads that do not exceed 15 families per therapist at any given time. Each therapist to serve a minimum average of five FFT cases at any given time.	Implementation: Strong	Implementation: Strong	Implementation: Strong	Implementation: Strong
	Throughout the four years of the Byrne grant, therapist caseloads remained at or below FFT design ratio of 1:15. Minimum averages were maintained as well.	Throughout the four years of the Byrne grant, therapist caseloads remained at or below FFT design ratio of 1:15. Minimum averages were maintained as well.	Throughout the four years of the Byrne grant, therapist caseloads remained at or below FFT design ratio of 1:15. Minimum averages were maintained as well.	Throughout the four years of the Byrne grant, therapist caseloads remained at or below FFT design ratio of 1:15. Minimum averages were maintained as well.
Treatment duration: Treatment is expected to last approximately three months or 12 sessions.	Implementation: Strong	Implementation: Strong	Implementation: Strong	Implementation: Strong
	Throughout the four years of the Byrne grant, treatment duration remained at the FFT design duration.	Throughout the four years of the Byrne grant, treatment duration remained at the FFT design duration.	Throughout the four years of the Byrne grant, treatment duration remained at the FFT design duration.	Throughout the four years of the Byrne grant, treatment duration remained at the FFT design duration.
Adherence: Model requires therapists to implement the model with fidelity.	Implementation: Moderate	Implementation: Strong	Implementation: Strong	Implementation: Moderate
	In the first two years of implementation, therapist adherence was weak. Following the redesign of the program and a change in management, adherence improved greatly.	All therapists were rated as adherent and competent according to FFT rating tools.	All therapists were rated as adherent and competent according to FFT rating tools.	The initial therapists were rated as adherent and competent according to FFT rating tools. Following resignations of 4 of the 5 therapists in the 3rd year, replacement therapists are currently in FFT training and making good progress.
Family involvement: Model requires that therapists engage parents, provide parental support, improve parenting skills, and address family problems.	Implementation: Strong	Implementation: Moderate	Implementation: Strong	Implementation: Strong
	Data is unavailable for the first two years of the program. Following the program redesign, 100% of families served improved their family functioning.	75% of families completing FFT improved their family functioning.	94% of families completing FFT improved their family functioning.	97% of families completing FFT improved their family functioning.

MST Programs Implementation Summary

Table 8. Organizational Components		
Design Component	**MST Treatment Foster Care**	**Home Works**
Management: Model indicates need for strong administrative commitment to support MST.	Implementation: Moderate	Implementation: Strong
	Initially, management split between two agencies which limited effectiveness. Subsequent consolidation of management in one agency was hurt by turnover among managers. Mixed support among a series of administrators.	No turnover among key administrative staff. Consistent commitment by management to the project.
Resources: Model requires sufficient and stable funding to maintain the integrity of the treatment team.	Implementation: Weak	Implementation: Strong
	Budget cuts forced reduction of therapists and ending of contract with MST Services for training.	Program maintained stable funding during the Byrne grant period.
Staffing: Model indicates need for flexible, creative, and committed staff.	Implementation: Moderate	Implementation: Moderate
	Committed, experienced staff but budget cuts and turnover reduced team cohesion.	Well trained and committed staff but program had a high degree of therapist turnover.
Community collaboration: Model stresses need to maintain community connections by involving outside people/agencies in program development.	Implementation: Strong	Implementation: Strong
	Ecological perspective of the model enhanced collaboration between program and community partners.	Ecological perspective of the model enhanced collaboration between program and community partners.
Referral sources: Model stresses the need for early and ongoing communication with referral sources.	Implementation: Strong	Implementation: Strong
	Ecological perspective of the model facilitated communication between therapists and probation officers.	Ecological perspective of the model facilitated communication between therapists and schools.
Communication with program developer: Variety of implementation issues requires ongoing access to program developers.	Implementation: Moderate	Implementation: Weak
	Program was part of a replication study conducted by MST Services. In exchange for fee-free training services, program received limited feedback on training and implementation issues.	Program expressed frustration at being unable to provide feedback to MST Services about their concerns regarding the training and supervision of therapists. MST Services provided no mechanism for program feedback.

Table 9. Training Services		
Design Component	**MST Treatment Foster Care**	**Home Works**
Therapist qualifications: Therapists will be full-time Masters-level or equivalent-trained, seasoned mental health professionals assigned to the MST program solely.	Implementation: Strong	Implementation: Strong
	Therapists were Masters-level and assigned to MST program solely.	Therapists were Masters-level and assigned to MST program solely.
Therapist training: Therapists will receive five-day initial clinical training and weekly telephone supervision and quarterly booster trainings by national developers.	Implementation: Moderate	Implementation: Moderate
	Initially, therapists received five-day clinical training, telephone supervision, and booster session from program developer. Following budget cuts, replacement therapists did not receive training from MST Services; instead they were trained by the site clinical supervisor.	Initially, therapists received five-day clinical training, telephone supervision, and booster session from program developer. Following dissatisfaction with training received from program developer, program was granted permission by CJSD to end their training contract. After the contract was terminated, replacement therapists were trained by the MST Treatment Foster Care site clinical supervisor.
Clinical supervision: National developers will provide experienced clinical supervisor during training phase to conduct weekly telephone supervision.	Implementation: Moderate	Implementation: Weak
	Program reports that the clinical supervisor provided by MST Services provided therapists with appropriate clinical training	Program reports that the clinical supervisor provided by MST Services provided therapists with inappropriate and inadequate clinical training
Supervision: Model requires a local MST clinical supervisor assigned a minimum of 50 percent (full-time is preferable) to the MST team to conduct weekly team clinical supervision, facilitate the weekly telephone consultation, and be available for individual clinical supervision for crisis situations.	Implementation: Moderate	Implementation: Moderate
	Program contracted for local clinical supervision on a half time basis. This limited therapist access for supervision. There was no turnover in the supervisory position.	Program provided half time supervision of team by agency staff member. Clinical supervision was consistent throughout the four years of the project. There was no turnover in the supervisory position.
Assessment: Model requires therapists to complete detailed case summaries and forward them to the MST consultant. Consultant to provide case-specific feedback and review of case summaries.	Implementation: Weak	Implementation: Weak
	Therapists completed detailed summaries but the one-hour weekly telephone supervision provided insufficient time to review the detail in these summaries.	Therapists completed detailed summaries but the one-hour weekly telephone supervision provided insufficient time to review the detail in these summaries.

Table 10. Treatment Services		
Design Component	**MST Treatment Foster Care**	**Home Works**
Client identification: Model requires targeting high-risk youth for MST participation.	Implementation: Strong	Implementation: Strong
	Program used JCP empirically based risk assessment tool to determine eligibility.	Program used JCP empirically based risk assessment tool to determine eligibility.
Staffing: Model requires caseloads that do not exceed six families per therapist at any given time. Each therapist to serve approximately 15 families per year.	Implementation: Strong	Implementation: Strong
	Throughout the four years of the Byrne grant, therapist caseloads remained at the recommended levels for MST programs.	Throughout the four years of the Byrne grant, therapist caseloads remained at the recommended levels for MST programs.
Treatment duration: Treatment is expected to last approximately three to five months.	Implementation: Strong	Implementation: Moderate
	Throughout the four years of the Byrne grant, treatment duration remained at the MST design duration.	The program disagreed with MST treatment duration principles and often kept clients in the program longer than MST recommends.
Therapist availability: The model requires therapists to be accessible at times convenient to their clients and in times of crisis, very quickly. Programs will have a 24 hour, seven day per week on-call system to facilitate therapist availability. Treatment services will be home-based.	Implementation: Strong	Implementation: Strong
	Program provided home-based services at convenient to client times and a 24 hour, seven days per week on-call system.	Program provided home-based services at convenient to client times and a 24 hour, seven days per week on-call system.
Adherence: Model requires therapists to implement the model with fidelity.	Implementation: Weak	Implementation: Strong
	An independent study commissioned by CJSD following the ending of contracted services from MST found that therapists were not adherent to the model.	Using the MST validated Therapist Adherence instrument, evaluators found that therapists maintained adherence to the model throughout the four year of Byrne funding.

Outcomes

Overview

This section focuses on the central issue of the outcome evaluation: whether and to what extent the six FFT and MST model programs reduced recidivism among program participants. Reduction in recidivism is the clearly articulated primary goal of these model programs. As a result, the comparative recidivism rate (one-year before to one-year after participation) in these programs is the primary criterion on which the assessment of the efficacy of these programs should be based. Recidivism is defined here as the change in the aggregate level of crime for all participants of the program in the year following their exit in comparison to their aggregate level of crime in the year prior to their entry into the program.

Recidivism data are based on officially reported arrests in the juvenile justice system that occurred during the 12 month period following each youth's exit from participation in FFT or MST in comparison to their reported arrests during the 12 month period prior to enrollment in FFT or MST. All data were gathered from official juvenile records using the Oregon Youth Authority Juvenile Justice

Information System (JJIS) which tracks and integrates statewide information on juvenile involvement with juvenile justice departments. Three types of data were collected: referral data, offense data, and severity data.

Referrals

The Oregon Youth Authority defines a referral as a law enforcement report to a juvenile department alleging one or more felony, misdemeanor, violations and/or status offenses. A referral can include more than one offense. Referrals are classified based on the severity score and type of offense. In JJIS, when a referral is comprised of multiple offenses, the allegation with the highest severity score determines the referral's type. For example, if a referral has two offenses and one is a class C Felony with a severity score of 12, and the second is a Class B Misdemeanor with a score of 9, the referral is classified as a felony referral with a severity score of 12.

Offenses

The Oregon Youth Authority refers to offenses as allegations. An allegation is an individual alleged offense. There are three types of allegations; crimes, violations and status offenses. A crime is an offense (misdemeanor or felony) that, if the offender were an adult, would be punishable by a sentence to jail or prison. A violation is an offense that is not punishable by a jail or prison sentence. For example, receiving a traffic ticket is considered a violation. A status offense is a violation of the law that can only be committed by juveniles e.g. curfew violation, smoking tobacco, running away and so on. Status offenses are the least serious of all offenses.

Severity Scores

The Oregon Youth Authority ranks all offenses for severity. All allegations in JJIS receive a severity score. The severity scale ranges from the most severe score of 19 (murder) to least severe of 1 (non-criminal status offenses like running away etc.) When a referral has multiple allegations, a severity score is assigned to each offense. The score is based on criminal codes in the Oregon Revised Statutes (ORS). The most serious allegation is identified and determines the severity score for that referral. Severity scores are determined using the following severity scale.

Table 11. Severity Scale		
Crime Category	**Class and Type**	**Severity Score**
Person	Murder	19
Person	A Felony	18
Person	B Felony	17
Person	C Felony	16
Person	U Felony	15
Property Other Criminal (Behavioral)	A Felony	14
Property Other Criminal (Behavioral)	B Felony	13
Property Other Criminal (Behavioral)	C Felony	12
Property Other Criminal (Behavioral)	U Felony	11
Person	A Misdemeanor	10
Person	B Misdemeanor	9
Person	C Misdemeanor	8
Person	U Misdemeanor	7
Property Other Criminal (currently named behavioral)	A Misdemeanor	6
Property Other Criminal (currently named behavioral)	B Misdemeanor	5
Property Other Criminal (currently named behavioral)	C Misdemeanor	4
Property Other Criminal (currently named behavioral)	U Misdemeanor	3
Non Criminal	Violation	2
	Status Offense	1

Because researchers are in general agreement that there is no single best measure of recidivism, we examine three key questions:

- Were referrals to juvenile justice reduced?
- Was the frequency of crime reduced?
- Was the severity of crime reduced?

Functional Family Therapy Programs

Referrals to Juvenile Justice

Table 12 presents referral data from the four FFT programs. Data is presented for the 12 months prior to entering FFT and for the 12 months following exit from FFT. The total number of referrals is provided and followed by the rate of referral. The referral rate is defined as the average referral rate per youth and is determined by the number of referrals for 12 months divided by the number of FFT participants during that same time. For example, the first two columns show the number of

referrals and the rate for participants from ADAPT. There were 131 youth who exited the program and were at least 12 months post participation on June 30, 2006. If we look across the rows, the first row indicates that these 131 youth had 18 referrals for violent felonies in the year prior to entering the FFT program and 5 referrals for violent felonies in the year following their exit from the program. The second row provides the violent felony referral rate per youth. In this case, the change from .14 to .04 represents a 71 percent reduction in the rate of violent felony referrals. A similar pattern can be seen for felony referrals. The change from .43 to .17 represents a 60 percent reduction in felony referrals. The reduction for criminal referrals is 64 percent and the reduction for referrals of any type is 63 percent.

In general, the data in Table 12 show that reductions in referrals were large for youth in all four sites. These reductions range from 56 to 71 percent for violent felony referrals, from 47 to 69 percent for felony referrals, from 45 to 71 percent for criminal referrals and from 26 to 67 percent for referrals of any type.

Table 12. FFT Referrals

	FFT Program							
	ADAPT		*Parrott Creek*		*Marigold*		*Jackson*	
Outcome Measure	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Total number violent felony referrals	18	5	4	3	5	3	10	4
Violent felony referral rate	**.14**	**.04**	*	*	*	*	**.09**	**.04**
Total number felony referrals	57	22	18	10	27	12	53	16
Felony referral rate	**.43**	**.17**	**.17**	**.09**	**.28**	**.12**	**.49**	**.15**
Total number criminal referrals	150	54	81	23	72	40	211	67
Criminal referral rate	**1.15**	**.41**	**.76**	**.22**	**.74**	**.41**	**1.94**	**.61**
Total number any referrals	260	96	132	63	90	67	329	110
Referral rate any referrals	**1.98**	**.73**	**1.25**	**.59**	**.93**	**.69**	**3.02**	**1.01**

Criminal referral = felony and/or misdemeanor.
Any referral = felony, misdemeanor, status, and violation.
* Rate not computed if fewer than 10 events in 12 months prior to program entry.

Frequency of Crime

Table 13 presents offense data from the four FFT programs. Data is presented for the 12 months prior to entering FFT and for the 12 months following exit from FFT. The total number of offenses is provided and followed by the rate of offense. The offense rate is defined as the average offense rate per youth and is determined by the number of offenses for 12 months divided by the number of FFT participants during that same time. For example, the first two columns show the number of offenses and the rate for participants from ADAPT. There were 131 youth who exited the program and were at least 12 months post participation on June 30, 2006. If we look across the rows, the first row indicates that these 131 youth had

18 violent felony offenses in the year prior to entering the FFT program and 7 violent felony offenses in the year following their exit from the program. The second row provides the violent felony offense rate per youth. In this case, the change from .14 to .05 represents a 64 percent reduction in the rate of violent felony offenses. A similar pattern can be seen for felony offenses. The change from .43 to .24 represents a 44 percent reduction in felony offenses. The reduction for criminal offenses is 34 percent and the reduction for offenses of any type is 55 percent.

In general, the data in Table 13 show that reductions in the frequency of offenses were large for youth in all four sites. These reductions range from 64 to 75 percent for violent felony offenses, from 22 to 78 percent for felony offenses, from 34 to 67 percent for criminal offenses and from 35 to 66 percent for offenses of any type.

Table 13. FFT Offenses

	FFT Program							
	ADAPT		*Parrott Creek*		*Marigold*		*Jackson*	
Outcome Measure	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Total number violent felony offenses	18	7	4	6	8	3	17	4
Violent felony offense rate	**.14**	**.05**	*	*	*	*	**.16**	**.04**
Total number felony offenses	57	31	29	22	47	15	84	19
Felony offense rate	**.43**	**.24**	**.27**	**.21**	**.48**	**.15**	**.77**	**.17**
Total number criminal offenses	151	100	116	44	128	63	291	96
Criminal offense rate	**1.15**	**.76**	**1.09**	**.42**	**1.32**	**.65**	**2.67**	**.88**
Total number any offense	371	165	181	90	159	103	436	148
Offense rate any offense	**2.83**	**1.26**	**1.71**	**.85**	**1.64**	**1.06**	**4.0**	**1.36**

Criminal offense = felony and/or misdemeanor.
Any offense = felony, misdemeanor, status, and violation.
* Rate not computed if fewer than 10 events in 12 months prior to program entry.

Severity of Crime

Table 14 presents severity data from the four FFT programs. Data is presented for the 12 months prior to entering FFT and for the 12 months following exit from FFT. Two measures of severity are presented. The first is the average severity of referrals. JJIS assigns each referral a severity score based on the offense with the highest severity score in the referral. The second measure is the average severity of all offenses across all referrals. For example, the first two columns show pre and post severity data for participants from ADAPT. There were 131 youth who exited the program and were at least 12 months post participation on June 30, 2006. If we look across the rows, the first row indicates that these 131 youth had an average severity score for their referrals of 5.1 in the year prior to entering the FFT program and 2.5 in the year following their exit from the program. This represents a

51 percent reduction in the severity of referrals. The second row provides the average severity for all offenses. In this case, the change from 2.6 to 1.6 represents a 38 percent reduction in the average severity for all offenses.

In general, the data in Table 14 show that reductions in the severity of referrals and offenses were large for youth in all four sites. These reductions range from 41 to 61 percent for referrals and from 14 to 61 percent for all offenses.

Table 14. FFT Severity

	FFT Program							
	ADAPT		*Parrott Creek*		*Marigold*		*Jackson*	
Outcome Measure	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Average severity of all referrals	5.1	2.5	4.5	1.9	2.9	1.7	10.2	4.0
Average severity of all offenses	2.6	1.6	3.5	1.4	6.3	5.4	10.6	4.1

Multisystemic Therapy Programs

Analysis of outcomes is limited for the two MST programs. Neither program collected severity score data and one of the two programs (Homeworks) failed to collect data for the 12 month period prior to entering the program. Consequently, we report only referral and offense data for the Multnomah County MST program (Table 15). In general, the pattern of results is similar to that reported for the FFT programs. There was a 49 percent reduction in violent felony referrals, a 48 percent reduction in felony referrals, a 54 percent reduction in criminal referrals and a 53 percent reduction in referrals of any type. There was a 38 percent reduction in violent felony offenses, a 63 percent reduction in felony offenses, a 53 percent reduction in criminal offenses and a 54 percent reduction in offenses of any type.

Table 15. MST Treatment Foster Care Program		
Outcome Measure	Pre	Post
Referrals		
Total number violent felony referrals	57	29
Violent felony referral rate	**.55**	**.28**
Total number felony referrals	99	52
Felony referral rate	**.96**	**.50**
Total number criminal referrals	233	108
Criminal referral rate	**2.26**	**1.05**
Total number any referrals	315	148
Referral rate any referrals	**3.06**	**1.44**
Offenses		
Total number violent felony offenses	90	56
Violent felony offense rate	**.87**	**.54**
Total number felony offenses	184	123
Felony offense rate	**1.79**	**.67**
Total number criminal offenses	516	244
Criminal offense rate	**5.01**	**2.37**
Total number any offenses	668	310
Offense rate any offenses	**6.49**	**3.01**

Conclusions

The data presented above suggest that these model programs achieved their primary goal of reducing delinquent and criminal activity among program participants. It should be noted that the data presented includes all youth the programs intended to treat whether they completed the program or dropped out. Including all those who were initially enrolled presents a more realistic picture of the effect of these programs on delinquency and criminal activity than simply analyzing results for program completers. The results are impressive. On all measures of recidivism, the model programs report results that meet or exceed those reported in the literature. On average, previous FFT studies report reductions of 25 to 60 percent in youth who re-offend and previous MST studies report 25 to 70 percent reductions in rates of re-arrest. The four FFT programs generally exceeded the results reported in the literature while the MST program reported results that fall within the range reported in previous MST studies. Furthermore, the programs reported results that met or exceeded those reported in the literature across all three measures of recidivism. Youth who participated in these model programs had fewer referrals to juvenile justice in the year following their participation, committed fewer crimes, and if they did commit crimes, committed less severe crimes.

Sustainability

Sustainability refers to the continuation of the program(s) after the initial funding has ended. A substantial investment in economic and human resource terms was made to develop these six evidence-based programs in Oregon. In this section of the report we address two key questions:

- What factors enabled programs to continue after their Byrne funding ended?
- What is the current status of these evidence-based programs originally funded by this Byrne initiative nine months after Byrne funding ended?

Factors Sustaining Programs

The six model programs demonstrated significant reductions in delinquency for youth participating in the programs. Nine months after the end of Byrne funding, three programs continue and three have ended. Three factors seemed to be most important for sustaining programs: (1) a program champion at the agency who understood the project and was invested in its success, (2) the ability to secure funds by obtaining grants and/or local contracts, and (3) community support from other agencies and government entities. Of these three factors, the presence of a program champion appeared to be the key factor in program sustainability. When there was a program champion they served as a catalyst to developing grants and channeling community support into agency collaborations that worked to support program funding.

Program Summaries

ADAPT Family Focused Approach to Juvenile Violence Prevention

The Family Focused Approach to Juvenile Violence Prevention Project ended in May of 2006. ADAPT had secured an annual contract for up to $40,000 of billable services on an hourly basis for youth involved with the Oregon Youth Authority but the unanticipated resignation of the team leader meant that ADAPT would have to pay FFT Inc. between $5,000 and $11,000 to train a new team leader. Faced with such high reoccurring costs for training, ADAPT elected to end the program and adopt a new treatment approach with similar features to FFT. The program they are adopting is called the Community Reinforcement Approach.

Parrott Creek Functional Family Therapy Project

The Functional Family Therapy Project ended with the termination of Byrne grant funding. Parrott Creek attempted to identify additional sources of funding but ultimately was unsuccessful in obtaining sufficient funds to continue the project. Parrott Creek secured an annual contract for up to $40,000 of billable services on

an hourly basis for youth involved with the Oregon Youth Authority and a $30,000 contract with Clackamas County Juvenile Department for services under their wrap around services program. However, because of the sheer dollar amount needed to maintain a team of three therapists, these secured funds were insufficient to maintain the project. All three therapists were laid off September 30th 2005.

Homestead Youth & Family Services Marigold Program

Marigold staff has been dedicated to sustaining the program beyond funding from the Edward G. Byrne Memorial Grant. Initially, the agency intended to bill on an ability to pay basis for the services of the program. However, this complicated funding and the request for reimbursement process with Byrne. Thus, the program opted not to pursue any payment from referents or clients. Throughout the four-year period of support from Byrne, Marigold staff wrote grants and sought funding that helped make the agency "match" portion of the budget. With this experience, Marigold staff were equipped to begin writing larger grants and seeking out more funding options for the program. Byrne's requirement for an external evaluator proved critical to securing additional funding. Being able to write a grant that includes empirical data about the program's outcomes has been a key factor to some of the funding Marigold has secured. At this point, Marigold staff salaries are largely funded for the next two years through a Meyer Memorial Grant. Additionally, the Oregon Youth Authority is supporting statewide implementation of FFT. Marigold has been awarded a contract through the OYA to provide FFT on a fee for service basis. A second contract was awarded for Marigold staff to provide statewide implementation coordination and quality assurance services for the OYA. These contracts, along with grants, will help Marigold be sustainable for the next several years as it establishes a broader fee for service structure.

Jackson County Youth Turnaround Project

The Youth Turnaround Project continued after the termination of Byrne funding. The program secured grant funding for secured treatment services from both a federal justice grant and the Jackson County Community Justice Department. FFT services are embedded in the grant and will provide potentially ongoing funding. Because three of the four FFT therapists resigned in the third year of Byrne grant funding, the program had to restart the FFT certification process and is not currently certified. As a result, the program is not eligible for Oregon Youth Authority funding. The program is applying to local foundations to cover the ongoing site certification and staff training costs to become FFT certified.

Multnomah County MST Treatment Foster Care

The MST Treatment Foster Care Program continued after the termination of Byrne funding. Following the expiration of he Byrne Grant, program administrators secured County general funds to continue funding the treatment foster care component of the program at its Byrne funded level of two dedicated treatment foster care beds. MST therapists are funded through re-imbursements from Medicaid as the program is considered a Federally Qualified Health Center. The program has increased therapist caseloads from four to five families to increase revenue. The clinical supervisor position was terminated following the end of the

Byrne grant but because therapists were not adherent (based on the Byrne funded study), the County plans to use general funds to contract with MST Services for additional training.

Youth Contact Home Works Program

The Home Works Program ended with the termination of Byrne funding. Youth Contact tried to secure funding to continue the program through grant applications but none of their applications were funded. The Home Works Program finished service to families that were close to completion and referred the other families to appropriate programs at Youth Contact. Because Youth Contact's therapeutic orientation is similar to MST treatment, families continued to receive similar services. However, with the end of the Byrne grant, Youth Contact can no longer afford to send therapists out to the homes of families.

Recommendations

Conclusions

Although information on FFT and MST model programs has been developed and disseminated at the federal level, information alone is not enough. Information about the dissemination of model programs is only a first step. The next step is gathering information on the experiences and problems encountered in replicating these programs when they are taken from the laboratory setting into the field. Agencies experience a number of problems when they begin to implement a model program. If these problems are not overcome, the result may be poor implementation or program failure. Identifying methods for sustaining quality implementation is extremely important. The model programs funded by CJSD were adopted and implemented in different setting with different populations and encountered widely varying problems and process outcomes. The lessons learned from these programs may be of use to those intending to implement model programs in the future as well as to designers of programs and funding agencies.

Implementation was generally a success across all six programs. The appropriate youth were enrolled in the programs, the core elements of the FFT and MST models were put into place, and the enrolled youth received the treatment services specified by the FFT and MST models. All six programs successfully implemented most of the core features of the FFT and MST programs although there were some problems as well. In general, programs did very well implementing treatment service components. Most received strong ratings in that area with the exception of Multnomah MST Treatment Foster Care therapists who were not adherent to the model. Results were mixed but generally positive for implementing training services components. Problems in this area were primarily failures by FFT Inc. and MST Services to deliver training as promised in their model guidelines. Both FFT Inc. and MST Services had difficulty providing sites with assessment services, competent clinical trainers, and consistent implementation standards. Results in implementing organizational components were mixed and generally problematic. Agencies had difficulty in a wide range of areas including management, staffing, collaboration, resource levels, and communication with program developers. Programs implementing FFT had more difficulty in this area than programs that implemented MST. FFT is a more prescriptive model than MST in what it allows regarding staffing, community collaboration, and sharing of information with referral sources. Agencies were often unprepared to address the restrictions imposed by the FFT model when they encountered them.

Assessing youth recidivism was the major focus of the outcome assessment. Contacts with the Juvenile Department were tracked during the 12-month period prior to entry into the program and for the 12-month period following exit from the program for all participants. The aggregate contacts for participants prior to program entry were compared to their aggregate contacts following program

completion. The number of referrals, the number of offenses, and the severity of referrals and offenses were all tracked. The results show that the programs were successful in reducing participants' recidivism. Reductions in referrals across programs ranged from 49 to 71 percent for violent felony referrals, from 47 to 69 percent for felony referrals, from 45 to 71 percent for criminal referrals and from 26 to 67 percent for referrals of any type. Reductions for offenses ranged from 38 to 75 percent for violent felony offenses, from 22 to 78 percent for felony offenses, from 34 to 67 percent for criminal offenses and from 35 to 66 percent for offenses of any type. Reductions in the severity of referrals ranged from 41 to 61 percent and reductions in the severity of offenses ranged from 14 to 61 percent.

Recommendations

Although information on evidence-based programs has been developed and disseminated at the federal level, this dissemination is only the initial step. It must be followed by efforts to promote the adoption of evidence-based programs. Unfortunately, there is little concrete information available on the factors that result in successful or unsuccessful program adoption when replicating an evidence-based program. Consequently, it is extremely important to document and disseminate the experiences and problems encountered in replicating evidence-based programs if we are to sustain effective programs and facilitate their spread. The six model programs funded by CJSD were adopted and implemented in different setting with different populations and encoutered widely varying problems and process outcomes. The lessons learned from these programs may be of use to those intending to implement model programs in the future as well as to designers of programs and funding agencies.

Recommendations for Agencies Adopting Model Programs

Develop Administrative Support

Administrative support is crucial to implementation efforts because decision-making authority exists at this level. Our experience with the six Byrne funded programs is that the project administrator plays a vital role that is quite different from that of the clinical supervisor or site leader. We found that implementation was more successful when this person had a basic understanding of the clinical model and had participated in the initial training provided by the developer. The program administrator is in a position to instigate changes in the organization, allocate money and resources, and communicate a vision for the agency (and how the new program fits into that vision). The program administrator must maintain an objective administrative position when it comes to monitoring the progress of the program but be sufficiently knowledgeable to address problems in model adherence as they occur.

Identify and Foster the Development of a Program Champion

Every program needs a "champion" who is responsible for directing or coordinating the program. The program champion is the motivator behind the program, guiding

its day-to-day operations, fostering communication, and serving as a support to staff. The champion needs to have enough power in the organization to garner the necessary resources and help establish needed policy or work routine changes and must have good rapport and communication with all staff. In the FFT model, this person is typically the lead therapist, in MST it is typically the clinical supervisor.

Create an Organizational Structure that Promotes Training and Fidelity

Training and fidelity are key components of successful implementation. While the six Byrne funded programs contracted with the developers for initial training, it became clear that more was needed particularly in the later years as contact with the developers decreased. Agencies need to develop an ongoing training plan that provides therapists with the necessary skills, confidence, and motivation to succeed. Managers as well as treatment providers should be trained to ensure agency understanding and support. Training practices should be designed to promote fidelity. Feedback should be provided to treatment providers continually on their adherence to treatment principles.

Recommendations for Designers of Model Programs

Develop the Internal Capacity to Disseminate the Program

Both FFT and MST created corporations to deliver training services to sites. However, the six programs funded by Byrne consistently expressed frustration about working with FFT Inc. and MST Services. Programs reported they had difficulty communicating, that they were not provided with information they needed to efficiently implement their program, that they sometimes received contradictory advice, and that assessment problems went unresolved for lengthy periods of time.

Develop the Capacity to Assess Site Implementation

Our experience with these six Byrne funded programs suggests that program designers generally were good at training therapists but were not sufficiently involved with the programs to identify and correct implementation problems when they occurred. While both FFT Inc. and MST Services required sites to complete a site readiness assessment form, it was not sufficiently detailed to identify all implementation problems. For example, FFT Inc. was unaware that Parrott Creek intended to use residential therapists in a dual role as youths' treatment counselor and as the family therapist until the CJSD evaluation team pointed it out. Once training was underway, the programs' contact was primarily through the clinical trainer who focused specifically on training issues. Implementation problems were not confronted as they arose because the designers were unaware of them and had no mechanism in place to identify them.

Support Implementation Research

The causes of program failure are often associated with poor implementation. However, when implementing FFT, MST, or any other evidence-based program, we only have evidence that the program works if it is implemented with all core components and with the prescribed dosage achieved in the research trials.

Research should be conducted to determine which core components are necessary to achieve successful outcomes and which components may be more adaptable. Determining the dosage threshold required to obtain results is also important. These cannot be subjective judgements, but must be determined empirically. Studies should be conducted to identify the factors that influence fidelity of implementation. For example, studies could examine how differences in training and technical support, implementer characteristics, and organizational support systems affect implementation.

Develop Training Programs that Facilitate Site Independence

Few programs have the resources to pay for training and technical assistance indefinitely. Dissemination programs should promote site independence within a reasonable time period. Given the high rate of turnover that our six programs experienced and the costs of training replacement therapists, a better way has to be found if these programs are to be disseminated widely. Developers need to work towards creating a system that allows programs to train new staff efficiently and economically.

Recommendations for Funders

Fund Evidence-Based Programs

Funders should support the replication of programs that have been evaluated and proven effective. The six model programs funded by Byrne demonstrate that when implemented as designed, the programs produce reductions in recidivism consistent with the program developers' experience.

Fund Programs Large Enough to Absorb Staff Turnover

If programs are small they are vulnerable to failure if key staff leaves. There needs to be sufficient size in agency staff to hold the program together should turnover occur. The six model programs funded by Byrne experienced considerable therapist turnover. A large amount of training time and cost is invested in each FFT or MST therapist and when a therapist leaves the investment has to be made again. In addition, families find transitioning from one therapist to another difficult and often discontinue treatment when a therapist leaves, resulting in lower program completion rates. There is also a delay in enrolling new families for treatment while the new therapist is hired and trained, resulting in a lower number of clients being served. Agencies with sufficient resources to develop larger teams of therapists are better positioned to absorb staff turnover, mitigate the negative consequences of turnover, and maintain model fidelity.

Facilitate Access to Ongoing Program Funding

As our findings demonstrate, even successful replication projects have no guarantee of continuing. The gap between successful outcomes and funding opportunities is large and defies logic. Three of the six model programs funded by Byrne did not continue. As one program administrator of a discontinued program noted,

"In conversations with other FFT sites in the state, we have learned that some FFT projects have discontinued their relationship with FFT. One of the reasons reported has been the limited ability to raise the funds for sustainability. This has mirrored our own experience. As a result of FFT's requirement for ongoing involvement with them (at considerable expense) and the requirement for maintaining a caseload of 12-15, we have realized that client fees will not cover the expense of maintaining an FFT treatment project. Many of our clients do not have private insurance and reimbursement from other sources will not cover the cost of providing the therapy. What a Loss!!!"

Funders and state legislators who want to implement evidence-based programs in Oregon, must recognize the limitations of local programs to raise external funds for ongoing program support. Successful models, based on well-developed outcomes, need general support to sustain further development.

Facilitate Collection of Outcome Data

Programs should continue to collect data on youths' contacts with the juvenile justice system. Oregon is fortunate to have a system in place to provide this information. The Juvenile Justice Information System (JJIS) is a valuable tool for assessing program outcomes. However, it takes time to assess these program outcomes. We typically must look out a year or more to see the impact of a program on a youth's criminal activity. This time frame conflicts with the funders' need to demonstrate program effectiveness in a short period of time. Nevertheless, what society really wants to know is whether a particular program will succeed in transforming troubled youth into productive adults. Funders should set aside funds to track youth contacts with the juvenile justice system and conduct this tracking in a manner independent from program funding. Our experience collecting JJIS data in concert with the six Byrne funded programs was difficult at best. We found that programs often had to rely on the good will of their Juvenile Department to collect the data and that there were often misunderstandings and resistance to collecting the data. A better way would be to fund an independent evaluator to collect the data for all programs and have this person certified to use the JJIS system.

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APENDIX

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Comprehensive Evaluation Plan

Grantees will be expected to work collaboratively with the CJSD external evaluation team to develop a Comprehensive Evaluation Plan (CEP) that will be implemented in stepwise fashion over the full four years of the Byrne funding period. The CEP will build on the preliminary evaluation approach developed by each grantee in the application for Byrne funding. The CEP will consist of specific phases, with each phase providing the foundation for the next. Grantees will be required to document progress toward completion of each phase of the CEP as part of the quarterly, annual, and cumulative reports.

For grantees implementing "model" programs, the CEP will include building evaluation capacity, process evaluation, and outcome monitoring. For grantees implementing "promising" or other programs, the CEP will include building evaluation capacity, process evaluation, outcome monitoring, and outcome evaluation employing control or comparison groups.

Phase 1 – Building Evaluation Capacity

The CJSD external evaluation agency will assist applicants in developing the capacity to evaluate their programs. During the initial period immediately following notification of grant awards, grantees and their evaluators will develop a detailed program description and program logic model. The CJSD external evaluation agency will then work with grantees and their evaluators to develop a CEP. The CEP will include a description of the evaluation design, the target population, a clear set of goals, objectives and program outcomes, specific indicators to measure objectives and outcomes, measurement instruments, methods used to collect data (baseline and at regular intervals thereafter), and procedures for data management and analysis.

Concurrent with the development of the CEP, grantees will recruit and train program staff and test the program implementation design to identify problems in service delivery. During this trial period of program delivery, grantees will keep a record of identified problems, solutions tried, and results. To address identified problems, grantees will conduct problem-solving meetings with program staff and evaluators and revise the program design, logic model, objectives, and outcomes as needed. It is expected that at the completion of this phase, programs will be operating as intended and evaluation activities will be integrated with program delivery.

Phase 2 -- Process Evaluation

Process evaluation information is used to: a) assess whether a program is delivered as intended to the targeted recipients, b) provide a context for interpreting program outcomes by revealing what program components contribute to the outcomes achieved, and c) provide detailed information on how to replicate a successful program.
Although implementing a program concept may seem straightforward, in practice it is often very difficult. Newly developed programs typically must contend with many unanticipated factors that may compromise program design. The result can be substantial discrepancies between the program as intended and the program as actually implemented. Programs can fail to show positive effects because the intended program is not fully implemented. Therefore, the second

phase of each grantee's CEP will involve the development and implementation of process evaluation.

The CJSD external evaluation agency will assist grantees and their evaluators in developing a process evaluation that determines: (a) the actual client population served, in order to assess the program's ability to provide services to its target population; (b) the amount, type, and quality of program services delivered, in order to assess how closely the services provided correspond to program design; and (c) the barriers to program implementation, in order to assess if program services are appropriately designed for the targeted population.

Phase 3 -- Outcome Monitoring

While process evaluation can reveal *why* participants may or may not experience the intended benefits of the program, outcome monitoring can reveal *whether* participants are experiencing these benefits. Outcome monitoring requires regular measurement and reporting of indicators of outcome-oriented results. The outcome indicators selected by grantees should reflect changes in violence and crime-related behavior, or changes in known correlates of violence and crime-related behavior, for individuals and families as a result of the program.

The CJSD external evaluation agency will assist grantees and their evaluators in developing and implementing an outcome monitoring system. The outcome monitoring system will be based on the program goals, objectives, and performance indicators developed in the capacity building phase. Both intermediate and longer-term outcomes that reflect benefits or changes for individuals or families during or after participating in program activities will be monitored.

Although outcome monitoring can track whether (and how many) participants achieve the desired outcomes, it does not prove that the program, and the program alone, caused the outcomes. Outcome evaluation must be used to attribute the changes observed in program participants to the program alone. For model programs, where positive outcomes have previously been shown to be directly attributable to the program, outcome monitoring will be the third and final phase of the CEP. For promising and other programs, outcome monitoring will be followed by outcome evaluation.

Phase 4 -- Outcome Evaluation

Outcome evaluation will be conducted for all but model programs. Outcome evaluation is used to confirm that the outcomes or results of a program can be directly attributable to the program itself, rather than to other factors external to the program. Outcome evaluation requires the use of an experimental or quasi-experimental study design that compares an equivalent treatment group (who receives the intervention) and a control or comparison group (who does not receive the intervention). Equivalence between groups is based on random assignment to the treatment or to the control group (experimental design) or on statistical adjustment (quasi-experimental design). Comparison of equivalent treatment and control/comparison groups rules out the possibility that other factors are the cause of changes observed. Measures of the targeted outcomes are taken for both groups prior to beginning the program and after completion of the program. Data on the targeted outcome(s) are then computed and compared for the two groups.

If the treatment and the control/comparison groups are truly comparable, then the only differences between them will be due to the intervention.

The CJSD external evaluation agency will assist grantees and their evaluators in identifying suitable control or comparison groups, specifying assignment procedures to treatment and control/comparison groups, identifying measurement instruments for assessing program outcomes, and selecting analytic techniques for comparing outcomes between the two groups.

PROGRAM DESCRIPTION GUIDANCE

I. Program Overview

Purpose:

- Why is the program needed?

Program Goals

- What are the goals of the program? *Program goals are general statements of what your program hopes to accomplish*.

Program Theory

- Explain why the activities of this program would result in the achievement of these goals?

II. Program participants

Target group

- Who is the program intended for?
- What is the expected number of participants over a one-year period?

Eligibility criteria

- What are the eligibility criteria for program participation?

Recruitment/screening Process

- Describe the referral process by which clients are recruited to the program.
- Describe the screening process to establish a client's eligibility for the program.

III. Service delivery

Describe the program by identifying the components of the program and the activities that are part of each component.

Program components

- What are the main components of the program? *A component is a part of a program consisting of a set of related activities directed toward reaching some common objective.*

Program activities

- Describe the activities that comprise each component of the program.
- Describe the services that a client would receive if they successfully completed the program.

Collaboration

- Who are the key stakeholders? *Stakeholders are individuals, groups, or organizations that have a significant interest in how well a program functions.*

- What are the roles of the key stakeholders in the program?
- Describe how stakeholders collaborate with the program.

IV. Program Resources

Funding

- What is the program budget?
- What is the budget for evaluation activities?

Staffing

- List all staff involved in service delivery.
- List all staff involved in conducting evaluation activities.
- What are the roles, responsibilities, and qualifications (training, experience) of each staff member involved in service delivery or evaluation?

Logic Model[1]

Process ***Outcome***

Resources	Activities	Outputs	Outcomes	Goal(s)
Program Inputs. Elements or ingredients that constitute the program	**Methods for providing the program. Specific processes or events undertaken.**	**Units of service or product units. How many, how often, over what duration?**	**Short term, intermediate, or longer-term changes anticipated in participants' lives and/or in organization or community conditions.**	**Ultimate impact(s) expected to occur, usually beyond what one program alone can achieve.**

[1] This was adapted from page 31, Outcomes for Success 2000 Edition by Evaluation Forum, Organizational Research Services, Inc. and Clegg and Associates.

EVALUATION MEASUREMENT PLAN GUIDELINES

The Evaluation Plan for Byrne funded projects is described in Appendix II of the Application for Byrne Grant Funds booklet. The Evaluation Plan consists of a set of written documents to guide the evaluation process. You can think of the Evaluation Plan as the instructions for the evaluation. The plan can be used to guide you through each step of the evaluation process because it details the practices and procedures for successfully conducting your evaluation.

Most grantees have completed two of the Evaluation Plan documents, a detailed Program Description and a Logic Model. The Program Description set forth the program's rationale, described the program participants, the services they receive, and the program's resources. The Logic Model linked the program goals and activities to the outputs and outcomes expected. The third Evaluation Plan document is the Evaluation Measurement Plan. The six elements of the Measurement Plan are described below.

Address each of the six Evaluation Measurement Plan elements, as instructed under each element. For any of the Measurement Plan elements that your program is unable to specifically address, as instructed, at this time: (1) discuss the progress of your program toward developing the element, (2) address any issues or problems encountered, and (3) discuss the steps that will be taken and timelines for resolving the issues and problems identified.

I. Program Overview

Using your Program Description and Logic Model documents, restate the following:

- *Program Purpose*: Describe the purpose of the program. Programs are developed to address particular problems or needs. For Byrne funded projects, these problems or needs are related to the prevention, reduction, and elimination of delinquent behavior or domestic violence.
- *Program Goals*: List the goals of the program.
- *Target Population*: Describe the population that is targeted by this program.

II. Target Population Measurement

Identify the characteristics of the target population(s) that should be measured and describe how you will measure these characteristics. For example, one program might target young status offenders while another might target chronic and serious offenders. The first program needs to identify how it will measure age and status offense; the second program how to measure chronic and serious offense. Your Measurement Plan should identify (1) the key characteristics of the target group and (2) how you will measure these characteristics.

III. Program Objectives Measurement

State your program objectives in measurable terms. Defining objectives in measurable terms identifies the information you will need to evaluate your program activity. You should state objectives for both outputs (what is delivered as a result of program activities) and outcomes (what is achieved as a result of program activity). You should also specify standards for success for both outputs and outcomes. For example, a program that provides youth on probation with counseling services to prevent future criminal activity might set an output success standard of attendance of ten counseling sessions and an outcome success standard of a fifty percent reduction in recidivism.

You should identify indicators to measure each program output and outcome. Indicators are the concrete, observable things that will be measured to see if the program is reaching its objectives. To be useful, an indicator must be clear. This makes it possible to measure. A clear indicator includes the following elements:

- Reference to the target group to which the indicator will be applied;
- Specification of the unit(s) of measurement to be used for the indicator;
- A specific timeframe over which the indicator will be monitored;
- Reference to a baseline/benchmark for comparison (if applicable).

For example, if our outcome objective is a fifty percent reduction in recidivism as stated above, a clear indicator would (1) reference the target group (youth on probation enrolled in the counseling program); (2) specify the unit of measurement used (examples of units of measurement for recidivism include subsequent police contact, arrest, formal referral to juvenile court and formal adjudication); (3) specify the timeframe (recidivism could be examined at six months, a year, or two years after program completion); and (4) reference the comparison (youth enrolled in the program could be compared to youth on probation who are not enrolled in the program or to a benchmark standard based on a review of results from other counseling programs).

IV. Comparisons

If your program is comparing what happens to the participants in your program to another group of people or to the previous status of your participants, please indicate:

- The type of comparison being made. Examples of comparisons include a control group, a comparison group, pre/post analysis and benchmarking.
- The selection criteria for the comparison.

V. Data Collection Methods

Once measures have been decided upon, data must be collected to determine whether the program's objectives have been met. For each program objective, specify:

- The type of data/information that needs to be collected to determine if an objective is being attained.
- The method(s) that will be used to collect the needed information. Examples of methods include record reviews, existing databases, interviews, questionnaires, and observations.
- When and how often data will be collected.
- From whom data will be collected.

Please include copies of all data collection instruments that will be used. Indicate whether you are using an existing instrument (identify the source) or have developed your own instrument.

VI. Data Management Procedures

Once you decide what type of instrument(s) you will use to collect evaluation information, you must establish a set of procedures to ensure that this information will be collected in a consistent and systematic manner. Your Evaluation Measurement Plan should specify:

- Who will collect data;
- The training data collectors have or will receive;
- Procedures for administering data collection instruments;
- Procedures to ensure quality control of collected data;
- Who will supervise data collection.
- How data will be prepared for analysis.

FFT Process Evaluation

The Evaluation Plan for Byrne funded projects is described in Appendix II of the Application for Byrne Grant Funds booklet. The Evaluation Plan consists of a set of written documents to guide the evaluation process. You can think of the Evaluation Plan as the instructions for the evaluation. The plan can be used to guide you through each step of the evaluation process because it details the practices and procedures for successfully conducting your evaluation.

In the second year of funding, Grantees should conduct a process evaluation. The process evaluation report is used to assess whether your program is delivered as intended to the targeted recipients and provides information on how to replicate a successful program.

There are three key questions that your process evaluation should address: (1) Is the program reaching the appropriate target population, (2) Is the delivery of program services consistent with program design specifications, and (3) Is the training received from FFT sufficient to impart the necessary skills needed to deliver the program.

(1) Is the program reaching the appropriate target population?

Referrals
- Number referred
- Number referred who are eligible for program
- Number of eligible referrals who participate in program
- Source of Referral by number

Target Population
- Number served
- Number active cases
- Number complete the program
- Number who fail to complete the program
- Risk Screen Data
- Demographics
- Family Criminal Justice and Substance Abuse History

What distinguished those who refuse to participate, from those who accept?
What distinguishes those who dropout from those who complete the program?
What are the barriers to participating in the program?

(2) Is the delivery of program services consistent with program design specifications?

Was treatment fidelity maintained in the delivery of the program?
- Did the therapists adhere to the FFT model?
- Did the clinical supervisor adhere to the FFT model?

Was the quality of service delivered consistent with program design specifications?

What were the barriers to implementing the FFT program and how were these problems addressed?

(3) Is the training received from FFT sufficient to impart the necessary skills needed to deliver the program?

Did FFT meet contract and program theory expectations?

Was the quality of training and supervision received from FFT sufficient to successfully replicate the program?

Was the training and supervision received from FFT sufficient to insure that the therapists adhere to the FFT model?

Was the training and supervision received from FFT sufficient to insure that the clinical supervisor adhere to the FFT model?

Was the FFT data collection system (the Clinical Services System) sufficient to insure that needed data was collected?

What were the barriers to implementing the FFT training model?

What were the barriers to integrating replacement therapists into the program and training them in the FFT model?

EDWARD BYRNE MEMORIAL FORMULA GRANT PROGRAM
FFT Quarterly Program Activities Report

Program Name:

Quarter:

	This Quarter	Grant to Date
ADMISSIONS		
Number of new youth admitted to FFT program		
UTILIZATION		
Total number of families served (includes cases opened prior to this quarter)		
EXITS		
Number of youth terminated from FFT		
Number of youth terminated who completed FFT		
Number of youth terminated who dropped out of FFT		
OUTCOMES		
Number of youth terminated from FFT now 6 months post discharge (includes both completed and dropped out)		
Number of youth terminated from FFT now 12 months post discharge (includes both completed and dropped out)		
Number of youth terminated who completed FFT now 6 months post discharge		
Number of youth terminated who completed FFT now 12 months post discharge		

MST Process Evaluation

The Evaluation Plan for Byrne funded projects is described in Appendix II of the Application for Byrne Grant Funds booklet. The Evaluation Plan consists of a set of written documents to guide the evaluation process. You can think of the Evaluation Plan as the instructions for the evaluation. The plan can be used to guide you through each step of the evaluation process because it details the practices and procedures for successfully conducting your evaluation.

In the second year of funding, Grantees should conduct a process evaluation. The process evaluation report is used to assess whether your program is delivered as intended to the targeted recipients and provides information on how to replicate a successful program.

There are three key questions that your process evaluation should address: (1) Is the program reaching the appropriate target population, (2) Is the delivery of program services consistent with program design specifications, and (3) Is the training received from MST sufficient to impart the necessary skills needed to deliver the program.

(1) Is the program reaching the appropriate target population?

Referrals
- Number referred
- Number referred who are eligible for program
- Number of eligible referrals who participate in program
- Source of Referral by number

Target Population
- Number served
- Number active cases
- Number complete the program
- Number who fail to complete the program
- Risk Screen Data
- Demographics
- Family Criminal Justice and Substance Abuse History

What distinguished those who refuse to participate, from those who accept?
What distinguishes those who drop-out from those who complete the program?
What are the barriers to participating in the program?

(2) Is the delivery of program services consistent with program design specifications?

Was treatment fidelity maintained in the delivery of the program?
- Did the therapists adhere to the MST model?
- Did the clinical supervisor adhere to the MST model?

Was the quality of service delivered consistent with program design specifications?

What were the barriers to implementing the MST program and how were these problems addressed?

(3) Is the training received from MST sufficient to impart the necessary skills needed to deliver the program?

Did MST meet contract and program theory expectations?

Was the quality of training and supervision received from MST sufficient to successfully replicate the program?

Was the training and supervision received from MST sufficient to insure that the therapists adhere to the MST model?

Was the training and supervision received from MST sufficient to insure that the clinical supervisor adhere to the MST model?

What were the barriers to implementing the MST training model?

What were the barriers to integrating replacement therapists into the program and training them in the MST model?

EDWARD BYRNE MEMORIAL FORMULA GRANT PROGRAM
MST Quarterly Program Activities Report

Program Name:

Quarter:

	This Quarter	Grant to Date
ADMISSIONS		
Number of new youth admitted to MST program		
UTILIZATION		
Total number of families served (includes cases opened prior to this quarter)		
EXITS		
Number of youth terminated from MST		
Number of youth terminated who completed MST		
Number of youth terminated who dropped out of MST		
OUTCOMES		
Number of youth terminated from MST now 6 months post discharge (includes both completed and dropped out)		
Number of youth terminated from MST now 12 months post discharge (includes both completed and dropped out)		
Number of youth terminated who completed MST now 6 months post discharge		
Number of youth terminated who completed MST now 12 months post discharge		

MST Therapist Adherence Measure Benchmarks

The following chart provides information concerning the relationship between questions from the Therapist Adherence Measure and their representative factors.

Factor Name*	Target Score	Item(s) from Therapist Adherence Measure
Adherence	above +0.40	1, 2, 5, 6, 7, 11, 12, 13, 14, 21, 22, 23, 24, 25
Nonproductive Sessions	below -0.00	15, 16, 17, 26
Therapist-Family Problem Solving Effort	above +0.20	3, 4, 7, 10
Therapist Attempts to Change Interactions	above +0.25	8, 9
Lack of Direction**		17, 18, 19
Family-Therapist Consensus	above +0.20	7, 10, 12, 13, 14

** The factors most strongly predictive of long-term outcomes based on data collected to date are the factors Adherence, Nonproductive Sessions, and Therapist Attempts to Change Interactions.*

*** No target range has been specified for this factor at this time. Data are still being collected to determine the relationship between the items on this factor and outcomes.*

TAM DATA REPORTING

Average Adherence Scores by Site By Month

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Adherence												
Nonproductive Sessions												
Therapist-Family Problem Solving Effort												
Therapist Attempts to Change Interactions												
Lack of Direction												
Family-Therapist Consensus												

Average Adherence Scores by Quarter

Average Adherence Scores for the entire year

Guidelines for Collecting Data on Youth Involvement in Juvenile Justice from the Juvenile Justice Information System (JJIS)

Background

There are currently eight juvenile crime prevention programs across Oregon that are funded, at least in part, by the Byrne Memorial Fund. While there are some differences among the programs, there are some important commonalities:

- All the programs serve at risk juveniles and their families.
- Most of the programs use the Multi-systemic Therapy (MST) or Functional Family Therapy (FFT) models for family intervention.
- All programs are gathering data on youth involvement with juvenile justice.

The fact that all of the programs are gathering data on youth involvement with juvenile justice presents us with a unique opportunity. We have the chance to gather a substantial amount of important information about the effectiveness of interventions on youth crime prevention.

We are also fortunate that all programs have access to the Juvenile Justice Information System (JJIS) which tracks and integrates statewide information on juvenile involvement with juvenile justice departments. In fact, it is the vision of the Oregon Youth Authority (OYA) that JJIS aid "…in the overall planning, development and evaluation of programs designed to reduce juvenile crime;"[2]

Definitions

In our research on the kind of outcome data available through the JJIS system, it became clear that several terms needed defining so that all programs are gathering equivalent data.

"referral"

OYA defines a "referral" as a law enforcement report to a juvenile department alleging one or more felony, misdemeanor, violations and/or status offenses. A referral can include more than one "allegation."

Referrals are classified based on the severity score and type of allegation. In JJIS, when a referral is comprised of multiple allegations, the allegation with the highest severity score determines the referral's type. For example, if a referral has two allegations—one is a class C Felony with a severity score of 12, and the second is a Class B Misdemeanor with a score of 9-- the referral is classified as a felony referral.

[2] http://www.oya.state.or.us/jjis.htm

"allegation"

An allegation is an individual alleged offense. There are three kinds of allegations—crimes, violations and status offenses.

"severity"

All allegations in JJIS receive a severity score. The severity scale ranges from the most severe score of 19 (murder) to least severe of 1 (non-criminal status offenses like running away etc.)

The rationale for assignment of severity score to a particular offense by JJIS is not always immediately clear from the class of the allegation. For example, there are unique situations in which a misdemeanor can be assigned a higher severity score than a felony. In these cases a felony allegation will not show up at the referral level unless one looks at the individual allegations. This is important to consider when gathering data on felony referrals.

"crime"

A crime is an offense (misdemeanor or felony) that, if the offender were an adult, would be punishable by a sentence to jail or prison. Technically, juveniles commit "delinquent acts", not "crimes."

"delinquency"

Commission of an act by a juvenile that would be considered a crime, if it had been committed by an adult. Delinquency does not include violations or status offenses.

"violation"

A violation is an offense that is not punishable by a jail or prison sentence. For example, receiving a traffic ticket is considered a violation.

"status offense"

Status offenses are violations of the law that can only be committed by juveniles e.g. curfew violation, smoking tobacco, running away and so on. Status offenses are the least serious of all offenses.

"violence"

There is no standard definition of "violent" crime. From our consultation with juvenile justice departments and a review of Oregon Revised Statutes, we have assembled a list of "violent" crimes. While this list isn't exhaustive, it strikes a good balance of covering most violent crimes without requiring an extensive and burdensome list of individual statutes. For the purposes of the juvenile crime prevention Byrne funded programs "violent" crimes are any of the following:

- All person to person crimes (ORS 163000 to ORS 163999)
- Robbery (ORS 164395 to ORS 164770)
- Menacing behavior (ORS 163190)

Overall Example

For the sake of clarity we offer the following example which uses many of the terms defined above: A youth runs away from home, commits a burglary and a robbery, and is caught by the police after midnight after having a run a red light. The police bring the youth into the local juvenile department, making one referral with five separate allegations.

In this example, there are three different types of offenses— running away and breaking curfew are status offenses; the burglary and robbery are crimes; and running the red light is a violation. Also, there is one "violent" offense (the robbery) and four non-violent offenses.

Outcome Data

All Byrne Formula Grant programs should collect data on youth juvenile justice involvement at the level of the individual youth. **The individual level data should be stored in such a way that it can be accessed for future analyses.** While data is collected at the individual level, for the purposes of the Byrne Memorial Grant, we would like your program to report youth outcome data at the aggregate level as described below.

Referrals

- Total number of referrals (includes misdemeanor & felony crimes, violations and status offenses)
- Number of delinquent referrals (misdemeanor and felony crimes only)
- Number of referrals with at least one felony allegation
- Number of referrals with at least one violent[3] allegation ("violent" as defined above)

Allegations

- Total number of allegations (includes misdemeanor & felony crimes, violations and status offenses)
- Number of delinquent allegations (misdemeanor and felony crimes only)
- Number of felony allegations
- Number of violent allegations

OYA Placements

- Number of OYA placements

Populations

Report outcome data for the following populations:

- Population 1: All youth who are admitted to the program regardless of their status at discharge.

[3] Note that the categories of delinquent, felony and violent are not mutually exclusive categories—there may be considerable overlap among them.

- Population 2: The subset of youth who "successfully" completed the program (based on your program's definition of "success.")

For each of these populations, report outcome totals separately for the following population subsets

- Offenders: youth admitted to the program who had at least one delinquency referral prior to admission (delinquency does not including status offenses or violations).
- Non-offenders: youth admitted to the program who did not have a delinquency referral prior to admission.

Report outcome totals at 6 months and 12 months after youth is discharged from the program

Attached you will find an Excel spreadsheet. You can, but are not required to, enter your data directly into this spreadsheet and return it with the rest of the annual report.

EDWARD BYRNE MEMORIAL GRANT
YOUTH JUVENILE JUSTICE INVOLVEMENT

	6 Months After Program Completion							
	Referrals							
			Delinquent Acts				Violations	Status
			Misdemeanor		Felony			
	Number of Youth	Total all Referrals	Misdemeanor	Misdemeanor-Violent	Felony	Felony - Violent		
All youth								
Offenders								
Non-offenders								
Successful Completers								
Offenders								
Non-offenders								

	12 Months After Program Completion							
	Referrals							
			Delinquent Acts				Violations	Status
			Misdemeanor		Felony			
	Number of Youth	Total all Referrals	Misdemeanor	Misdemeanor-Violent	Felony	Felony - Violent		
All youth								
Offenders								
Non-offenders								
Successful Completers								
Offenders								
Non-offenders								

EDWARD BYRNE MEMORIAL GRANT
YOUTH JUVENILE JUSTICE INVOLVEMENT

6 Months After Program Completion									
	Allegations								OYA Placement
			Delinquent Acts				Violations	Status	
			Misdemeanor		Felony				
	Number of Youth	Total all Allegations	Misdemeanor	Misdemeanor-Violent	Felony	Felony - Violent			
All youth									
Offenders									
Non-offenders									
Successful Completers									
Offenders									
Non-offenders									

12 Months After Program Completion									
	Allegations								OYA Placement
			Delinquent Acts				Violations	Status	
			Misdemeanor		Felony				
	Number of Youth	Total all Allegations	Misdemeanor	Misdemeanor-Violent	Felony	Felony - Violent			
All youth									
Offenders									
Non-offenders									
Successful Completers									
Offenders									
Non-offenders									

Severity Scores by Offense Category

ORS #	ORS Description	ORS Class	ORS Category	Offense Type	Severity
0	Municipal Code Violation	U	Non-Criminal	Violation	0
33015	Contempt of Court	U		Misdemeanor	
1366111B	Material Witness Warrant		Non-Criminal		
1614052	Attempted Treason	A	Behavioral	Felony	14
1614052A	Attempted Murder	A	Person	Felony	18
1614052B	Attempted A/Felony	B		Felony	
1614052C	Attempted B/Felony	C		Felony	
1614052D	Attempted C/Felony	A		Misdemeanor	
1614052E	Attempted A/Misdemeanor	B		Misdemeanor	
1614052F	Attempted B/Misdemeanor	C		Misdemeanor	
1614052G	Attempted C/Uncl Misdemeanor	U	Non-Criminal	Violation	
1614352A	Solicitation Murder/Trea	A	Behavioral	Felony	14
1614352B	Solicitation Of A/Fel	B	Behavioral	Felony	13
1614352C	Solicitation Of B/Fel	C	Behavioral	Felony	12
1614352D	Solicitation Of C/Fel	A	Behavioral	Misdemeanor	6
1614352E	Solicitation Of A/Mis	B	Behavioral	Misdemeanor	5
1614502A	Conspiracy Commit A/Felony	A	Behavioral	Felony	14
1614502B	Conspiracy Commit B/Fel	B	Behavioral	Felony	13
1614502C	Conspiracy Commit C/Fel	C	Behavioral	Felony	12
1614502D	Conspiracy Commit A/Mis	A	Behavioral	Misdemeanor	6
1615652	Viol Treatment	U	Non-Criminal	Violation	
161565AM	Viol Treatment/Attempted A MIS	U	Non-Criminal	Violation	2
161565BM	Viol Treatment/Attempted B MIS	U	Non-Criminal	Violation	2
161565C2	Violation Treatment of Misdem	U	Non-Criminal	Violation	2
161565CF	Viol Treatment/Attempted C FEL	U	Non-Criminal	Violation	2
161705	Misdemeanor Treatment/Felony	A	Behavioral	Misdemeanor	6
162015	Bribe-Giving	B	Behavioral	Felony	13
162025	Bribe-Receiving	B	Behavioral	Felony	13
162065	Perjury	C	Behavioral	Felony	12
162075	False Swearing	A	Behavioral	Misdemeanor	6
162085	Unsworn Falsification	B	Behavioral	Misdemeanor	5
162145	Escape-3	A	Behavioral	Misdemeanor	6
162155	Escape-2	C	Behavioral	Felony	12
162165	Escape-1	B	Behavioral	Felony	13
162175	Aid Unauth Departure	A	Behavioral	Misdemeanor	6
162175A	Unauthorized Departure	A	Behavioral	Misdemeanor	6
162185	Supply Contraband	C	Behavioral	Felony	12
1621851B	Poss Contraband confined at YCF/St.Hosp.	C	Behavioral	Felony	12
162195	Failure To Appear-2	A	Behavioral	Misdemeanor	6
162205	Failure To Appear-1	C	Behavioral	Felony	12
162235	Obstruct Govt Admin	A	Behavioral	Misdemeanor	6
162245	Refuse Assist Police Ofcr	U	Non-Criminal	Violation	2
162247	Interfering w/Peace Office	A	Behavioral	Misdemeanor	6
162255	Refuse Assist Fire Fighter	U	Non-Criminal	Violation	2
162265	Bribing A Witness	C	Behavioral	Felony	12
162275	Bribe-Receiving By Witness	C	Behavioral	Felony	12
162285	Tamper W/Witness	C	Behavioral	Felony	12
162295	Tamper W/Phys Evidence	A	Behavioral	Misdemeanor	6
162305	Tamper W/Publ Record	A	Behavioral	Misdemeanor	6
162315	Resist Arrest	A	Behavioral	Misdemeanor	6
162325	Hinder Prosecution	C	Behavioral	Felony	12

ORS #	ORS Description	ORS Class	ORS Category	Offense Type	Severity
162335	Compound Felony	A	Behavioral	Misdemeanor	6
162355	Simulate Legal Process	B	Behavioral	Misdemeanor	5
162365	Criminal Impersonation	A	Behavioral	Misdemeanor	6
162367	Crim Impersonation of Officer	C	Behavioral	Felony	12
162369	Poss False Law Enforc ID Card	A	Behavioral	Misdemeanor	6
162375	Initiate False Report	C	Behavioral	Misdemeanor	4
162385	False Info To Police On Cit	A	Behavioral	Misdemeanor	6
162405	Official Misconduct-2	C	Behavioral	Misdemeanor	4
162415	Official Misconduct-1	A	Behavioral	Misdemeanor	6
162425	Misuse Confidential Info	B	Behavioral	Misdemeanor	5
162455	Interf W/Legis Oper	U	Behavioral	Misdemeanor	3
162465	Unlawful Legis Lobby	B	Behavioral	Misdemeanor	5
163005	Criminal Homicide	A	Person	Murder	19
163095	Aggravated Murder	A	Person	Murder	19
163115	Murder	A	Person	Murder	19
1631151	Murder by Abuse	A	Person	Murder	19
1631151A	Murder/Intentional	A	Person	Murder	19
1631151B	Murder in the course of Crime	A	Person	Murder	19
163118	Manslaughter-1	A	Person	Felony	18
163125	Manslaughter-2	B	Person	Felony	17
163145	Criminal Negl Homicide	C	Person	Felony	16
163160	Assault-4	A	Person	Misdemeanor	10
1631603	Assault-4	C	Person	Felony	16
163165	Assault-3	C	Person	Felony	16
163175	Assault-2	B	Person	Felony	17
163185	Assault-1	A	Person	Felony	18
163190	Menacing	A	Person	Misdemeanor	10
163195	Recklessly Endanger Another	A	Person	Misdemeanor	10
163197	Hazing	U	Non-Criminal	Violation	2
163200	Criminal Mistreatment-2	A	Person	Misdemeanor	10
163205	Criminal Mistreatment-1	C	Person	Felony	16
163207	Female Genital Mutilation	B	Person	Felony	17
163208	Assault Pub Safety Ofcr	A	Person	Misdemeanor	10
163212	Unlawful ESG, T Gas, Mace 2	A	Person	Misdemeanor	10
163213	Unlawful ESG, T Gas, Mace 1	C	Person	Felony	16
163225	Kidnapping-2	B	Person	Felony	17
163235	Kidnapping-1	A	Person	Felony	18
163245	Custodial Interf-2	C	Person	Felony	16
163257	Custodial Interf-1	B	Person	Felony	17
163275	Coercion	C	Person	Felony	16
163355	Rape-3	C	Person	Felony	16
163365	Rape-2	B	Person	Felony	17
163375	Rape-1	A	Person	Felony	18
163385	Sodomy-3	C	Person	Felony	16
163395	Sodomy-2	B	Person	Felony	17
163405	Sodomy-1	A	Person	Felony	18
163408	Sexual Penetration in the Second Degree	B	Person	Felony	17
163411	Sexual Penetration in the First Degree	A	Person	Felony	18
163415	Sexual Abuse 3	A	Person	Misdemeanor	10
163425	Sexual Abuse 2	C	Person	Felony	16
163427	Sexual Abuse 1	B	Person	Felony	17

ORS #	ORS Description	ORS Class	ORS Category	Offense Type	Severity
163435	Contrib Sex Delinq Minor	A	Person	Misdemeanor	10
163445	Sexual Misconduct	C	Person	Misdemeanor	8
163455	Accost For Deviate Purp	C	Person	Misdemeanor	8
163465	Public Indecency	A	Person	Misdemeanor	10
163467	Private Indecency	A	Person	Misdemeanor	10
163483	Use Child Ovsn Sex Perf	C	Person	Felony	16
163485	Prom Obs Sex Perfm Child	C	Person	Felony	16
163515	Bigamy	C	Person	Felony	16
163525	Incest	C	Person	Felony	16
163535	Abandonment Of Child	C	Person	Felony	16
163545	Child Neglect 2	A	Person	Misdemeanor	10
163547	Child Neglect 1	B	Person	Felony	17
163555	Criminal Nonsupport	C	Person	Felony	16
163575	Endanger Welfare Minor	A	Person	Misdemeanor	10
1635752	Endanger Welfare of Minor/Mis	A	Person	Misdemeanor	10
1635753	Endanger Welfare of Minor-Vio	U	Non-Criminal	Violation	2
163577	Failing to Supervise a Child	U	Non-Criminal	Violation	2
163605	Criminal Defamation	A	Person	Misdemeanor	10
163670	Use Child Display Sex Conduct	A	Person	Felony	18
163672	Possess Depict of Child - Sex	C	Person	Felony	16
163673	Deal Depict Child Sex Conduct	B	Person	Felony	17
163675	Sell Photo Sex Cond By Child	C	Person	Felony	16
163677	Transport Child Porn to State	B	Person	Felony	17
163680	Pay To View Childs Sex Conduct	C	Person	Felony	16
163684	Encouraging Child Sex Abuse 1	B	Person	Felony	17
163686	Encouraging Child Sex Abuse 2	C	Person	Felony	16
163687	Encouraging Child Sex Abuse 3	A	Person	Misdemeanor	10
163688	Possess Child Sex Material 1	C	Person	Felony	16
163689	Possess Child Sex Material 2	D	Person	Felony	
163693	Fail Report Child Pornography	A	Person	Misdemeanor	10
163709	Point Lazer Light at Officer	A	Person	Misdemeanor	10
1637322A	Stalking - Misdemeanor	A	Person	Misdemeanor	10
1637322B	Stalking - Felony	C	Person	Felony	16
1637472A	Vio Off Stalking Ord - Mis	A	Person	Misdemeanor	10
1637472B	Vio Off Stalking Ord - Fel	C	Person	Felony	16
1637502A	Vio Ct Stalking Ord - Mis	A	Person	Misdemeanor	10
1637502B	Theft-3	C	Property	Misdemeanor	4
1637502B	Vio Ct Stalking Ord - Fel	C	Person	Felony	16
164045	Theft-2	A	Property	Misdemeanor	6
164055	Theft-1	C	Property	Felony	12
164057	Aggravated Theft/1st Degree	B	Property	Felony	13
164065	Theft of lost, mislaid property				
164075	Theft By Extortion	B	Property	Felony	13
164085	Theft by Deception				
164095	Theft by Receiving				
1641254A	Theft Of Services < $50.00	C	Property	Misdemeanor	4
1641254B	Theft of Services $50.-$499.	A	Property	Misdemeanor	6
1641254C	Theft of Services $500.-$9999.	C	Property	Felony	12
1641254D	Theft of Services $10000. +	B	Property	Felony	13
164132	Unlaw Distrib Cable TV Equip	B	Property	Misdemeanor	5
164135	Unauth Use Vehicle	C	Property	Felony	12

ORS #	ORS Description	ORS Class	ORS Category	Offense Type	Severity
1641404A	Crim Poss Rent Prop/$499-	A	Property	Misdemeanor	6
1641404B	Crim Poss Rent Prop/$500+	C	Property	Felony	12
164162	Mail Theft/Receipt of Stolen Mail	A	Property	Misdemeanor	6
164170	Laundering Monetary Instr	B	Property	Felony	13
164172	Unlawful Financial Activity	C	Property	Felony	12
164215	Burglary-2	C	Property	Felony	12
164225	Burglary-1	A	Property	Felony	14
164235	Poss Burglary Tool	A	Property	Misdemeanor	6
164243	Criminal Trespass by Guest	C	Property	Misdemeanor	4
164245	Criminal Trespass-2	C	Property	Misdemeanor	4
164255	Criminal Trespass-1	A	Property	Misdemeanor	6
164265	Crim Trespass W/Firearm	A	Property	Misdemeanor	6
164272	Unlawful Entry Motor Vehicle	A	Property	Misdemeanor	6
164315	Arson-2	C	Property	Felony	12
164325	Arson-1	A	Property	Felony	14
164335	Reckless Burning	A	Property	Misdemeanor	6
164345	Criminal Mischief-3	C	Property	Misdemeanor	4
164354	Criminal Mischief-2	A	Property	Misdemeanor	6
164365	Criminal Mischief-1	C	Property	Felony	12
164369	Interfere with Police Animals	A	Property	Misdemeanor	6
164373	Tamper W/Cable TV Equip	B	Property	Misdemeanor	5
1643772	Unlawful Use of a Computer	C	Property	Felony	12
1643773	Unlaw Damage Computer/Software	C	Property	Felony	12
1643774	Unauthorized Use Of Computer	A	Property	Misdemeanor	6
1643775B	Unauth Use of Lottery Computer	C	Property	Felony	12
164383	Unlawfully Applying Graffiti	U	Non-Criminal	Violation	2
164386	Unlawful Poss Graffitti Implmt	U	Non-Criminal	Violation	2
164395	Robbery-3	C	Person	Felony	16
164405	Robbery-2	B	Person	Felony	17
164415	Robbery-1	A	Person	Felony	18
1647751	Deposit Trash Near Water	B	Property	Misdemeanor	5
1647752	Deposit Trash In Water	B	Property	Misdemeanor	5
1647851	Place Pollut Sub In Watr	A	Property	Misdemeanor	6
1647852	Plac Poll Sub Highw/Prop	A	Property	Misdemeanor	6
164805	Offensive Littering	C	Property	Misdemeanor	4
164813	Cut/Trans Special Forest Prod	B	Property	Misdemeanor	5
164815	Transport Hay Unlawfully	C	Property	Misdemeanor	4
164825	Transport/Cut Trees Unlawfully	B	Property	Misdemeanor	5
164863	Unlawful Transp Animal Carcass	C	Property	Misdemeanor	4
164865	Unlawful Sound Recording	B	Property	Misdemeanor	5
164872	Unlawful Labeling of Videotape	C	Property	Felony	12
164875	Unlawful Video Tape Recording	B	Property	Misdemeanor	5
164885	Endangering Aircraft	C	Property	Felony	12
164887	Interfer with Agriculture Oper	A	Property	Misdemeanor	6
165007	Forgery-2	A	Behavioral	Misdemeanor	6
165013	Forgery-1	C	Behavioral	Felony	12
165017	Poss Forged Instr-2	A	Behavioral	Misdemeanor	6
165022	Poss Forged Instr-1	C	Behavioral	Felony	12
165032	Poss Forgery Device	C	Behavioral	Felony	12
165037	Criminal Simulation	A	Behavioral	Misdemeanor	6
165042	Fraud-Obtain Signature	A	Behavioral	Misdemeanor	6

ORS #	ORS Description	ORS Class	ORS Category	Offense Type	Severity
165047	Unlawful Use of Slugs	B	Behavioral	Misdemeanor	5
1650554A	Fraud-Credit Card/ less $750	A	Behavioral	Misdemeanor	6
1650554B	Fraud-Credit Card/ over $750	C	Behavioral	Felony	12
1650653A	Negotiating Bad Check-Misdemeanor	A	Behavioral	Misdemeanor	6
1650653B	Negotiating Bad Check-Felony	C	Behavioral	Felony	12
165070	Poss Fraud Commun Device	C	Behavioral	Felony	12
1650741A	Unlawful Factor Credit Card	C	Behavioral	Felony	12
1650741B	Solicit Unlaw Factor Credit Cd	C	Behavioral	Felony	12
1650741C	Solicit/Merch Unlaw Factor CC	C	Behavioral	Felony	12
165080	False Business Record	A	Behavioral	Misdemeanor	6
165085	Sports Bribery	C	Behavioral	Felony	12
165090	Sports-Bribe Receiving	C	Behavioral	Felony	12
165095	Misappl Entrusted Prop	A	Behavioral	Misdemeanor	6
165100	Issue False Financl Stmt	A	Behavioral	Misdemeanor	6
165102	Obtain Execute Doc Deception	A	Behavioral	Misdemeanor	6
165107	No Metal Purchase Records	B	Behavioral	Misdemeanor	5
165109	No Cedar Purchase Record	B	Behavioral	Misdemeanor	5
165114	Unlaw Sale-Educatn Assignmnts	U	Non-Criminal	Violation	2
165495	Refuse to Deliver Message	U	Behavioral	Misdemeanor	3
165520	Unath Open Read Pub Mail	U	Behavioral	Misdemeanor	3
165540	Obtain Contents Communication	A	Behavioral	Misdemeanor	6
165543	Interception Of Communication	A	Behavioral	Misdemeanor	6
165555	Unlaw Telephone Solicitation	C	Behavioral	Misdemeanor	4
165570	Improper Use of 911 System	A	Behavioral	Misdemeanor	6
165572	Interfering with Making a Report	A	Behavioral	Misdemeanor	6
165800	Theft of Identity	C	Behavioral	Felony	12
165805	Misrep Age By Minor	C	Behavioral	Misdemeanor	4
165825	Sale Of Drugged Horse	U	Behavioral	Misdemeanor	3
166005	Treason	A	Behavioral	Murder	
166015	Riot	C	Behavioral	Felony	12
166025	Disorderly Conduct	B	Behavioral	Misdemeanor	5
166025F	False Fire Alarm	B	Behavioral	Misdemeanor	5
166045	Loitering	C	Behavioral	Misdemeanor	4
166065	Harassment	B	Behavioral	Misdemeanor	5
1660651A	Harassment Physical	B	Behavioral	Misdemeanor	5
1660651E	Harassment Obscene Phone	B	Behavioral	Misdemeanor	5
1660654	Harassment Touch Intimate Part	A	Behavioral	Misdemeanor	6
166075	Abuse Venerated Obj	C	Behavioral	Misdemeanor	4
166076	Abuse of a Memorial	A	Behavioral	Misdemeanor	6
166085	Abuse of Corpse - 2nd Degree	C	Behavioral	Felony	12
166087	Abuse of Corpse - 1st Degree	B	Behavioral	Felony	13
166090	Telephonic Harassment	B	Behavioral	Misdemeanor	5
166095	Miscond Emerg Phone Call	B	Behavioral	Misdemeanor	5
166115	Interf With Public Transport	A	Behavioral	Misdemeanor	6
166155	Intimidation-2	A	Behavioral	Misdemeanor	6
166165	Intimidation-1	C	Behavioral	Felony	12
166180	Negl Wound Another	U	Behavioral	Misdemeanor	3
166190	Pt Firearm At Another	U	Behavioral	Misdemeanor	3
166220	Carry/Use Dangerous Weapon	C	Behavioral	Felony	12
1662201A	Unlaw use Weapon Agst Another	C	Behavioral	Felony	12
1662201B	Unlawful Discharge of Weapon	C	Behavioral	Felony	12

ORS #	ORS Description	ORS Class	ORS Category	Offense Type	Severity
166240	Carry Concealed Weapon	B	Behavioral	Misdemeanor	5
166250	Unlawful Possession Firearms	A	Behavioral	Misdemeanor	6
166270	Felon Possess Firearm	C	Behavioral	Felony	12
1662702	Felon Possess Restrictd Weapon	A	Behavioral	Misdemeanor	6
166272	Unlaw Poss Firearms/Silencer	B	Behavioral	Felony	13
166275	Poss Weapon Prison Inmate	U	Behavioral	Felony	11
166300	Poss Firearm After Homic	U	Behavioral	Misdemeanor	3
166320	Set Springgun Or Setgun	U	Behavioral	Misdemeanor	3
166330	Use Firearm Conbust Wad	U	Behavioral	Misdemeanor	3
166350	Unlaw Poss Armor Piercing Ammo	A	Behavioral	Misdemeanor	6
166370	Poss Firearm/Weapon Public Bldg	C	Behavioral	Felony	12
166382	Unlawful Possess Destruct Dev	C	Behavioral	Felony	12
166384	Unlawful Mfg Destruct Device	C	Behavioral	Felony	12
1663852	Possess Hoax Destructive Device (Mis)	A	Behavioral	Misdemeanor	6
1663853	Possess Hoax Destructive Devise (Felony)	C	Behavioral	Felony	12
166410	Unlaw Mfg/Sale/Poss Firearm	B	Behavioral	Felony	13
166416	Prov False Info-Handgun Trans	A	Behavioral	Misdemeanor	6
166420	Fl Register/Transfer Firearm	C	Behavioral	Felony	12
1664202	Use False Sig on Gun Register	U	Behavioral	Misdemeanor	3
1664203C	Compile/Maint Gun Purchase Inf	A	Behavioral	Misdemeanor	6
1664209	Dealer Violation Gun Regis Law	C	Behavioral	Felony	12
166425	Unlawful Purchase Firearm	A	Behavioral	Misdemeanor	6
166427	Register Transfer Used Firearm	C	Behavioral	Misdemeanor	4
166429	Furn Firearm/Furthering Felony	B	Behavioral	Felony	13
166440	Unlic Sale Conc Firearm	U	Behavioral	Misdemeanor	3
166450	Oblit Id Marks Firearm	U	Behavioral	Felony	11
166470	Unlawful Sell/Traffic Firearms	A	Behavioral	Misdemeanor	6
166480	Furn Expl/Firearm To Child	U	Behavioral	Misdemeanor	3
166510	Poss Slug/Stab Weapon	A	Behavioral	Misdemeanor	6
166630	Discharge Weapon Across Hwy	U	Non-Criminal	Violation	2
166635	Discharge Weapon At Train	U	Behavioral	Misdemeanor	3
166638	Dischg Weapon Across Airport	A	Behavioral	Misdemeanor	6
166645	Hunt In Cemetery	U	Behavioral	Misdemeanor	3
166649	Throw Object Off Overpass-2	A	Behavioral	Misdemeanor	6
166651	Throw Object Off Overpass-1	C	Behavioral	Felony	12
166660	Unlawful Paramilitary Activity	C	Behavioral	Felony	12
166663	Cast Light fr Veh/Poss Weapons	U	Non-Criminal	Violation	2
166720	Racketeering	A	Behavioral	Felony	14
167007	Prostitution	A	Behavioral	Misdemeanor	6
167012	Promote Prostitution	C	Behavioral	Felony	12
167017	Compel Prostitution	B	Behavioral	Felony	13
1670621	Sex Conduct Live Show	A	Behavioral	Misdemeanor	6
1670623	Presenting Live Sex Show	C	Behavioral	Felony	12
167065	Furnish Obscene Material to Minor	A	Behavioral	Misdemeanor	6
167070	Send Obscene Mat Minor	A	Behavioral	Misdemeanor	6
167075	Exhibit Obscene Perf To Minor	A	Behavioral	Misdemeanor	6
167080	Display Obscene Mat Minor	A	Behavioral	Misdemeanor	6
167087	Disseminate Obscene Material	A	Behavioral	Misdemeanor	6
167090	Pub Disp Nude Advertise	A	Behavioral	Misdemeanor	6
167122	Promote Gambling-2	A	Behavioral	Misdemeanor	6
167127	Promote Gambling-1	C	Behavioral	Felony	12

ORS #	ORS Description	ORS Class	ORS Category	Offense Type	Severity
167132	Poss Gambling Records-2	A	Behavioral	Misdemeanor	6
167137	Poss Gambling Records-1	C	Behavioral	Felony	12
167147	Poss Gambling Device	A	Behavioral	Misdemeanor	6
167164	Possesion of Gray Machine	C	Behavioral	Felony	12
167212	Tamper W/Drugs Records	C	Behavioral	Felony	12
167222	Freq Plc Cntrld Sub Used	A	Behavioral	Misdemeanor	6
167262AA	Use Minor/Mfg Cntrld Subst	A	Behavioral	Felony	14
167262AB	Use Minor/Mfg 5 Grams Marij	A	Behavioral	Misdemeanor	6
167262BA	Use Minor/Dist Cntrld Subst	A	Behavioral	Felony	14
167262BB	Use Minor/Dist 5 Grams Marij	A	Behavioral	Misdemeanor	6
167312	Research & Animal Interference	C	Behavioral	Felony	12
167315	Animal Abuse II	B	Behavioral	Misdemeanor	5
167320	Animal Abuse I	A	Behavioral	Misdemeanor	6
167322	Aggravated Animal Abuse I	C	Behavioral	Felony	12
167325	Animal Neglect II	B	Behavioral	Misdemeanor	5
167330	Animal Neglect I	A	Behavioral	Misdemeanor	6
167333	Sexual Assault of Animal	A	Behavioral	Misdemeanor	6
167340	Animal Abandonmnent	C	Behavioral	Misdemeanor	4
167355	Animal Fighting	A	Behavioral	Misdemeanor	6
167385	Unauthorized Use of Livestock	A	Behavioral	Misdemeanor	6
167390	Commerce of Dog/Cat Fur	A	Behavioral	Misdemeanor	6
167400	Possession of Tobacco By Minor	U	Non-Criminal	Violation	2
167401	Minor Purchase Tobacco	U	Non-Criminal	Violation	2
1678085a	Unlawful Inhalent Use	U	Non-Criminal	Violation	2
1678085b	Unlawful Inhalent Use 2nd Violation	B	Behavioral	Misdemeanor	5
167810	Creating A Hazard	B	Behavioral	Misdemeanor	5
167820	Conceal Birth Infant	A	Behavioral	Misdemeanor	6
167830	Employ Minor Pl Pub Entr	U	Behavioral	Misdemeanor	3
167850	Animal Cruelty	B	Behavioral	Misdemeanor	5
167860	Animal Cruelty Spec Acts	B	Behavioral	Misdemeanor	5
167870	Exhibit Person In A Trance	A	Behavioral	Misdemeanor	6
181599A	Fail to Report as Sex Offender - FELONY	C	Person	Felony	16
181599B	Fail to Report as Sex Offender - MIS.	A	Person	Misdemeanor	10
411630	Unlawful Obtain Public Asst	C	Behavioral	Felony	12
411640	Unlawful Receive Public Asst	C	Behavioral	Felony	12
411675	Submit Wrong Claim For Pay	C	Behavioral	Felony	12
411840	Unlawful Use Of Food Stamps	C	Behavioral	Felony	12
417030	Interstate Compact on Juveniles				
418140	Unlawful Share Public Assist	A	Behavioral	Misdemeanor	6
418215	Unlicensed Child Care Agency	A	Behavioral	Misdemeanor	6
418750	Fail To Rpt Child Abuse	U	Non-Criminal	Violation	2
419476	Juvenile Hold	U	Non-Criminal	Violation	2
419476E	Cond Detrim To Child	U	Non-Criminal	Violation	2
419517	Juvenile Contempt Of Court	U	Non-Criminal	Violation	2
419720	Minor in Public After Curfew	U	Behavioral	Misdemeanor	3
419B0051A	Victim of Physical Abuse			Dependent	
419B0051B	Mental Injury			Dependent	
419B100	Dependency Jurisdiction			Dependent	
419B100A	Beyond Parental Control			Status	
419B100B	Behavior Endangers Self/Others			Status	
419B100C	Cond/Circ Endangers Self/Other			Dependent	

ORS #	ORS Description	ORS Class	ORS Category	Offense Type	Severity
419B100D	Dependency			Dependent	
419B100EA	Custodial Neglect/Abuse - Abandonment			Dependent	
419B100EB	Fail to Provider Care or Education			Dependent	
419B100EC	Cruelty,Depravity,Unexplaind Phys.Injury			Dependent	
419B100ED	Fail to Provide Care,Guidance,Protection			Dependent	
419B100F	Runaway	U	Non-Criminal	Violation	2
419B100G	Emancipation				
419B175	Initial Disp. of child taken in custody		Non-Criminal	Dependent	
419B500	Termination of Parental Rights			Dependent	
419C005A	Dismissal of Wardship Petition				
419C0801b	Warrant			N/A	
419C145	Preadjudicated Detention:Grounds				
419C1451d	Probation/Parole Violation			N/A	
419C145A	Fugitive/Juvenile				
419C145e	Conditional Release Violation			N/A	
419C156	Runaway/Juvenile Out of State			Status	
419C478	COMMIT FOR CARE, PLACEMENT AND SUPERVSN			Dependent	
419C680	Curfew Offense	U	Non-Criminal	Violation	2
426460	Non Crim Intoxication	U	Non-Criminal	Violation	2
433365	No Rabies Vaccination	U	Behavioral	Misdemeanor	3
443725	Op Unlicensed Care Facility	C	Behavioral	Misdemeanor	4
4438811	Undue Influence/Resid Facility	C	Behavioral	Misdemeanor	4
453085	Hazardous Substance Viol	U	Non-Criminal	Violation	2
459205	No Disposal Site Permit	A	Behavioral	Misdemeanor	6
462080	Refusing to Leave Racetrack	U	Behavioral	Misdemeanor	3
466095	Unlaw Storage Hazardous Waste	A	Behavioral	Misdemeanor	6
4660951C	No Haz Waste Treat Site Permit	A	Behavioral	Misdemeanor	6
466100	Unlaw Disposal Hazardous Waste	A	Behavioral	Misdemeanor	6
466385	Fail Amend Comprehensive Plan	A	Behavioral	Misdemeanor	6
467020	Excessive Noise	B	Behavioral	Misdemeanor	5
467445	P U C Violation/Admin Rules	U	Behavioral	Misdemeanor	3
4687401	Dischg Waste/Estuary No Permit	U	Behavioral	Misdemeanor	3
468775	Deposit Motor Vehicle In Water	A	Behavioral	Misdemeanor	6
468922	Unlaw Handle Haz Waste 2nd Deg	B	Behavioral	Misdemeanor	5
468926	Unlaw Handle Haz Waste 1st Deg	B	Behavioral	Felony	13
468943	Water Pollution - 2nd Degree	B	Behavioral	Misdemeanor	5
468946	Water Pollution - 1st Degree	B	Behavioral	Felony	13
468951	Environmental Endangerment	U	Behavioral	Felony	11
468953	Supply False Info to Agency	C	Behavioral	Felony	12
468B080	Discharging Untreated Waste	A	Behavioral	Misdemeanor	6
471130	Fail Require Statement of Age	A	Behavioral	Misdemeanor	6
471135	False Statement Of Age	C	Behavioral	Misdemeanor	4
471143	Impr Use OLCC Card	U	Behavioral	Misdemeanor	3
471405	Unlic Sale Import Liquor	U	Behavioral	Misdemeanor	3
4714101	Furn Liquor Intox Person	A	Behavioral	Misdemeanor	6
4714102	Furn Liquor Minor	A	Behavioral	Misdemeanor	6
4714103	Furn Liquor Minor	U	Non-Criminal	Violation	2
471425	Maintain Disord Estab	U	Behavioral	Misdemeanor	3
4714301	Minor Possess/Purchase Liquor	U	Non-Criminal	Violation	2
4714303	Minor Enter Lic Prem	U	Non-Criminal	Violation	2
471440	Unlic Manuf Liquor	U	Behavioral	Misdemeanor	3

ORS #	ORS Description	ORS Class	ORS Category	Offense Type	Severity
471475	Unlic Serve Liquor	U	Behavioral	Misdemeanor	3
471478	Removal Of Keg Identif	A	Behavioral	Misdemeanor	6
471620	Maintain Common Nuisance	U	Behavioral	Misdemeanor	3
471990	Hinder OLCC Investigation	U	Behavioral	Misdemeanor	3
475525	Sale Drug Paraphernalia	U	Non-Criminal	Violation	2
475555	Seizure of Drug Paraphernalia	U	Non-Criminal	Violation	2
475805	Provide Hypodermic Dev/Minor	A	Behavioral	Misdemeanor	6
475950	Fail Rpt Precursor Sub Transac	A	Behavioral	Misdemeanor	6
475955	Fail Rpt Missing Precursor Sub	A	Behavioral	Misdemeanor	6
475960	Illegal Sale of Drug Equipment	A	Behavioral	Misdemeanor	6
475965	False Info Precursor Sub Rpt	A	Behavioral	Misdemeanor	6
475991	Del Imitation Control Sub	A	Behavioral	Misdemeanor	6
4759921A	Manu/Del Cntrld sub-SC 1	A	Behavioral	Felony	14
4759921B	Manu/Del Cntrld Sub-SC 2	B	Behavioral	Felony	13
4759921C	Manu/Del Cntrld Sub-SC 3	C	Behavioral	Felony	12
4759921D	Manu/Del Cntrld Sub-SC 4	B	Behavioral	Misdemeanor	5
4759921E	Manu/Del Cntrld Sub-SC 5	C	Behavioral	Misdemeanor	4
4759922A	Del Marijuana For Payment	B	Behavioral	Felony	13
4759922B	Del Marij 1 Oz-No Pay	A	Behavioral	Misdemeanor	6
4759922X	Del Marij 5 grams	U	Non-Criminal	Violation	2
4759923A	Mfg/Del Counterfeit Sub-SC 1	A	Behavioral	Felony	14
4759923B	Mfg/Del Counterfeit Sub-SC 2	B	Behavioral	Felony	13
4759923C	Mfg/Del Counterfeit Sub-SC 3	C	Behavioral	Felony	12
4759923D	Mfg/Del Counterfeit Sub-SC 4	B	Behavioral	Misdemeanor	5
4759923E	Mfg/Del Counterfeit Sub-SC 5	C	Behavioral	Misdemeanor	4
4759924A	Poss Controlled Sub 1	B	Behavioral	Felony	13
4759924B	Poss Controlled Sub 2	C	Behavioral	Felony	12
4759924C	Poss Cntrld Sub-SC 3	A	Behavioral	Misdemeanor	6
4759924D	Poss Cntrld Sub-SC 4	C	Behavioral	Misdemeanor	4
4759924E	Poss Cntrld Sub-SC 5	U	Non-Criminal	Violation	2
4759924F	Poss LT 1 Oz Marijuana	U	Non-Criminal	Violation	2
4759932A	Proh Acts/Ctr Sub/Sch I	C	Behavioral	Felony	12
4759932B	Proh Acts/Ctr Sub/Sch II	A	Behavioral	Misdemeanor	6
4759932C	Proh Acts/Ctr Sub/Sch III	B	Behavioral	Misdemeanor	5
4759932D	Proh Acts/Ctr Sub/Sch IV or V	C	Behavioral	Misdemeanor	4
475994	Obtain Cntrld Sub Unlaw	A	Behavioral	Misdemeanor	6
4759951	Del Cont Sub To Minor I&II	A	Behavioral	Felony	14
4759952	Del Cntrld Sub To Minor III	B	Behavioral	Felony	13
4759953	Del Cntrld Sub Minor IV	A	Behavioral	Misdemeanor	6
4759954	Del Cont Sub Minor V	B	Behavioral	Misdemeanor	5
4759955	Del Marijuana To Minor	A	Behavioral	Felony	14
475999	Del Cntrld Sub 1000 ft School	A	Behavioral	Felony	14
4759991A	Mfg/del Ctrld Sub 1000' School	A	Behavioral	Felony	14
4759991B	Del No Consid Marij Near Sch	C	Behavioral	Misdemeanor	4
4759992B	Possess LT 1oz Marij Near School	C	Behavioral	Misdemeanor	4
4763801	Fire-Burn W/out Permit	U	Behavioral	Misdemeanor	3
4763802	Fail Follow Fire Permit Instr	A	Behavioral	Misdemeanor	6
476715	Throw Lighted Material	U	Behavioral	Misdemeanor	3
477510	Unlawful Burning-Closed Season	U	Behavioral	Misdemeanor	3
477545	Entering Closed Forest	U	Behavioral	Misdemeanor	3
477550	Enter Restr Forest Area	U	Non-Criminal	Violation	2

ORS #	ORS Description	ORS Class	ORS Category	Offense Type	Severity
477625	No Permit Opr Pwr Machinery	U	Behavioral	Misdemeanor	3
477640	Improper Use Power Saw/Forest	U	Behavioral	Misdemeanor	3
477645	Unlawful Opr Combust Engine	U	Behavioral	Misdemeanor	3
477740	Unlawful Use Of Fire	B	Behavioral	Misdemeanor	5
4779931A	Fire Prevention 1st Offense	C	Non-Criminal	Infraction	2
4779931B	Fire Prevention 2nd Offense	B	Non-Criminal	Infraction	2
4779931C	Fire Prevention 3rd Offense	A	Non-Criminal	Infraction	2
4779934	Fire Prev INJ/Damage GT $10000	A	Behavioral	Misdemeanor	6
478960	Unlaw Burning Commercial Waste	U	Behavioral	Misdemeanor	3
479270	Fail to Maintain Smoke Alarms	U	Non-Criminal	Violation	2
480120	Unlawful Sale/Use Fireworks	U	Behavioral	Misdemeanor	3
480220	Poss Destr Device	B	Behavioral	Misdemeanor	5
496162	Fish & Game Violation	U	Non-Criminal	Violation	2
496162A	Fish & Game Misdemeanor	A	Behavioral	Misdemeanor	6
496162B	Fish & Game Felony	C	Behavioral	Felony	12
498002	Wildlife Violation	U	Behavioral	Misdemeanor	3
498006	Chasing/Harassing Wildlife	A	Behavioral	Misdemeanor	6
498042	Waste Wildlife	A	Behavioral	Misdemeanor	6
498142	Hunt W/Artifical Light	A	Behavioral	Misdemeanor	6
517130	Mineral Trespass	C	Behavioral	Misdemeanor	4
609095	Dog as Public Nuisance	U	Non-Criminal	Violation	2
647140	Trademark Conterfeit 3rd Deg	A	Behavioral	Misdemeanor	6
647145	Trademark Conterfeit 2nd Deg	C	Behavioral	Felony	12
647150	Trademark Conterfeit 1st Deg	B	Behavioral	Felony	13
6897657	Possession Federal Legend Drugs	U	Behavioral	Misdemeanor	3
690355	Applying a Tattoo without a License	A	Non-Criminal	Misdemeanor	
702032	Offering Value to Student Athlete	C	Behavioral	Felony	12
7029912	Viol Athlete Agnt 48Hr Notice	C	Behavioral	Felony	12
7029913	Conduct Busin as Agent w/o Per	A	Behavioral	Misdemeanor	6
7029914	Represent as Agent w/o Permit	A	Behavioral	Misdemeanor	6
7179051	Conduct Money Trans Busin	A	Behavioral	Misdemeanor	6
7179052	Filing False Financial Statemt	C	Behavioral	Felony	12
7179053	Money Tranmission w/o license	C	Behavioral	Felony	12
803300	Fail to Register Vehicle	D	Non-Criminal	Infraction	2
803455	Failure to Renew Vehicle Registration	D	Non-Criminal	Infraction	2
803505	Failure to Carry Registration Card	D	Non-Criminal	Violation	2
803540	Fail to Display License Plate	D	Non-Criminal	Infraction	2
803560	Improper Display Valid Sticker	B	Non-Criminal	Infraction	2
8035601	Registration Sticker-Expired	D	Non-Criminal	Infraction	2
806010	Driving Uninsured	A	Non-Criminal	Infraction	2
806012	Fail to Carry Proof of Financial Resp	B	Non-Criminal	Infraction	2
806300	Failure to Register Vehicle	D	Non-Criminal	Infraction	2
807010	Opr Vehicle or Violate Restrictions	B	Non-Criminal	Infraction	2
8070101	Opr Motor Veh No Drivers Lic	B	Non-Criminal	Infraction	2
807430	Misuse of ID Card	A	Behavioral	Misdemeanor	6
807500	Unlawful Production of Certain Documents	A	Behavioral	Misdemeanor	6
807510	Sale Doc Purpose Misrep	A	Behavioral	Misdemeanor	6
807530	False Application DL	A	Behavioral	Misdemeanor	6
807570	Fail Carry/Present License	C	Behavioral	Misdemeanor	4
807580	Use of Invalid License	A	Behavioral	Misdemeanor	6
807600	Use of Another's ODL	A	Behavioral	Misdemeanor	6

ORS #	ORS Description	ORS Class	ORS Category	Offense Type	Severity
807620	Give false Info to Police	A	Behavioral	Misdemeanor	6
811100	Viol Of Basic Rule	B	Non-Criminal	Infraction	2
811123A	Vio Max Speed/Urban Area	A	Non-Criminal	Infraction	2
811123B	Vio Max Speed/Urban Area	B	Non-Criminal	Infraction	2
811123C	Vio Max Speed/Urban Area	C	Non-Criminal	Infraction	2
811123D	Vio Max Speed/Urban Area	D	Non-Criminal	Infraction	2
811135	Careless Driving	B	Non-Criminal	Infraction	2
811140	Reckless Driving	A	Behavioral	Misdemeanor	6
811145	Failure to Yield to Emergency Vehicle	B	Non-Criminal	Violation	2
811170	Open Container in Vehicle	B	Non-Criminal	Infraction	2
811172	Improp Dispose of Human Waste	U	Behavioral	Misdemeanor	3
811175	DWS/Misdemeanor	A	Behavioral	Misdemeanor	6
8111754	Felony Driving While Suspended	C	Behavioral	Felony	12
8111823	DWS/Felony	C	Behavioral	Felony	12
8111823A	DWS/C Fel/Hab Offender	C	Behavioral	Felony	12
8111823B	DWS/C Fel/Homicide	C	Behavioral	Felony	12
8111823C	DWS/C Fel Commit Fel	C	Behavioral	Felony	12
8111823D	DWS/C Fel/Hit & Run	C	Behavioral	Felony	12
8111823E	DWS/C Fel/Reckless Driving	C	Behavioral	Felony	12
8111823F	DWS/C Fel/Eluding	C	Behavioral	Felony	12
8111823G	DWS/C Fel/DUII	C	Behavioral	Felony	12
8111823R	Driving While Revoked/Felony	C	Behavioral	Felony	12
8111824	DWS/Misdemeanor	A	Behavioral	Misdemeanor	6
8111824A	DWS/A MIS/Reckless Endangering	A	Behavioral	Misdemeanor	6
8111824B	DWS/A MIS/False Statement DMV	A	Behavioral	Misdemeanor	6
8111824C	DWS/A MIS/Refused Alcohol Test	A	Behavioral	Misdemeanor	6
8111824R	Driving While Revoked/Mis	A	Behavioral	Misdemeanor	6
811205	Carry Child External Part Veh	B	Non-Criminal	Infraction	2
811210	Fail to Use Seat Belts	D	Non-Criminal	Infraction	2
811265	Fail to Obey Traffic Control Dev	B	Non-Criminal	Infraction	2
811295	Fail To Drive On Right	B	Non-Criminal	Infraction	2
811335	Unlawful Or Unsignaled Turn	C	Non-Criminal	Infraction	2
811350	Make Dangerous Left Turn	B	Non-Criminal	Infraction	2
811370	Failure to Drive within Lane	B	Non-Criminal	Infraction	2
811385	Depriving Motorcycle/Moped of Full Lane	B	Non-Criminal	Violation	2
811400	No Signal to Turn Or Stop	B	Non-Criminal	Infraction	2
811425	Slow Driver-Fail Yield Rt-way	B	Non-Criminal	Infraction	2
811485	Following Too Close	B	Non-Criminal	Infraction	2
8115156A	Fail to Dim Headlamps Oncoming	B	Non-Criminal	Infraction	2
8115156B	Fail to Dim Headlamps Rear	B	Non-Criminal	Infraction	2
811520	Unlaw use/Fail Use Lights	B	Non-Criminal	Infraction	2
811535	Fail to Obey Police Officer	B	Non-Criminal	Violation	2
811540	Attempt To Elude Police	A	Behavioral	Misdemeanor	6
8115401A	Attempt Elude Police/Vehicle	C	Behavioral	Felony	12
8115401B	Attempt Elude Police on Foot	A	Behavioral	Misdemeanor	6
811700	Fail Perform Duties Driver/Pd	A	Behavioral	Misdemeanor	6
811705	Fail to Perform Duties Driver/Pi	C	Behavioral	Felony	12
811715	Fail to Perform Duties of Witness	B	Non-Criminal	Infraction	2
811725	Fail Report Accident-Driver	B	Non-Criminal	Infraction	2
813010	DUII	A	Behavioral	Misdemeanor	6
814020	Ped Fail obey Traffic Control Device	D	Non-Criminal	Infraction	2

ORS #	ORS Description	ORS Class	ORS Category	Offense Type	Severity
814040	Ped Fail Yield Right of Way	D	Non-Criminal	Infraction	2
814070	Improp Pos upon or Improp Proc alng HWY	D	Non-Criminal	Violation	2
814210	Operate Moped on Sidewalk or Bike Trail	D	Non-Criminal	Violation	2
814260	Fail to Wear Protect Headgear	C	Non-Criminal	Infraction	2
814269	FI Wear Protect Head Motorcyc	C	Non-Criminal	Infraction	2
814275	FI Wear Protect Head-Passenger	C	Non-Criminal	Infraction	2
814280	Endanger Motorcycle Passenger	C	Non-Criminal	Infraction	2
814320	Motorcycle FL Use Headlights	B	Non-Criminal	Infraction	2
814410	Unsafe Bicycle on Sidewalk	D	Non-Criminal	Infraction	2
814430	Improper Use of Lanes	D	Non-Criminal	Infraction	2
814485	Failure to Wear Protect Headgr/bicycle	U	Non-Criminal	Violation	2
815020	Operation of Unsafe Vehicle	B	Non-Criminal	Infraction	2
815280	Viol Bicycle Equip Requirement	D	Non-Criminal	Infraction	2
816330	Opr W/O Required Light Equip	C	Non-Criminal	Infraction	2
819300	Poss Stolen Vehicle	C	Behavioral	Felony	12
821110	Failure to Renew Snowmobile Registration	D	Non-Criminal	Violation	2
821142	FI Carry Out-of-St ATV Permit	D	Non-Criminal	Violation	2
821150	Operation of Snowmobile w/o Driving Priv	D	Non-Criminal	Violation	2
821170	Opr Class I All-Terrain W/O Driving Priv	D	Non-Criminal	Violation	2
821192	OpATV Closed-Restric Land	B	Non-Criminal	Violation	2
830185	Boating Speed Restriction	B	Non-Criminal	Infraction	2
830315	Boat - Reckless Operation	A	Behavioral	Misdemeanor	6
830325	Boat DUII	A	Behavioral	Misdemeanor	6
830365	Waterskiing in reckless manner	B	Non-Criminal	Infraction	2
F00010	Fed. Homicide Offense		Federal Crimes		
F00020	Fed. Assault Offense		Federal Crimes		
F00030	Fed. Criminal Sexual Abuse		Federal Crimes		
F00040	Fed. Kidnap,Abduct,Unlawful Restraint		Federal Crimes		
F00050	Fed. Air Piracy		Federal Crimes		
F00060	Fed.Threat/Harass Comm. Stalk Dom. Viol.		Federal Crimes		
F00070	Fed. Property Offense		Federal Crimes		
F00080	Fed. Public Official Offense		Federal Crimes		
F00090	Fed. Drug Offense		Federal Crimes		
F00100	Fed.Criminal Enterprise & Racket Offense		Federal Crimes		
F00200	Fed. Fraud or Deceit Offense		Federal Crimes		
F00300	Fed. Prostitution		Federal Crimes		
F00310	Fed. Sexual Exploitation of a Minor		Federal Crimes		
F00320	Fed. Obscenity		Federal Crimes		
F00400	Fed. Individual Rights Offense		Federal Crimes		
F00500	Fed. Administration of Justice Offense		Federal Crimes		
F00610	Fed. Explosives and Arson		Federal Crimes		
F00620	Fed. Firearms		Federal Crimes		
F00630	Fed. Mailing Injurious Articles		Federal Crimes		
F00710	Fed. Immigration		Federal Crimes		
F00720	Fed. Naturalization and Passports		Federal Crimes		
F00800	Fed. National Defense Offense		Federal Crimes		
F00900	Fed.Food,Drug,Agr.Prods,Odom.Law Offense		Federal Crimes		
F01000	Fed.Prison&Correctional Facility Offense		Federal Crimes		
F02000	Fed. Environment Offense		Federal Crimes		
F03000	Fed. Anti-trust Offense		Federal Crimes		