JUVENILE JUSTICE MONITORING UNIT

OFFICE OF THE ATTORNEY GENERAL

QUARTERLY REPORT AND INDIVIDUAL FACILITY UPDATES

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INTRODUCTION

Over the past fifteen years, researchers have substantially expanded the body of knowledge regarding what works to rehabilitate juvenile offenders.

Why is youth rehabilitation important? In part, because it is a bedrock principle of the juvenile justice system. While adolescents should be held accountable for wrongdoing, juvenile justice theory posits that government and society should also do their best to help youthful offenders become successful members of society.

There are other, more practical reasons to rehabilitate juvenile offenders. Rehabilitation is the only way to improve long-term public safety. In jurisdictions with high recidivism rates, youth cycle through ineffective juvenile programs and continue to commit new offenses after release. Rehabilitation of youth protects the public and improves the lives of both the families and communities of troubled youth.

Rehabilitation of youth blocks the "pipeline" to the adult criminal system and saves taxpayer dollars. Many research-proven rehabilitative programs reduce repeat offending by more than half and save millions of dollars each year.

This Quarterly Report examines Maryland's efforts to rehabilitate youth in residential placements. The report was developed by reviewing data and interviewing staff and youth at the seven committed care programs operated by the Maryland Department of Juvenile Services (DJS):

1. Victor Cullen Center - Frederick County

2. Waxter Girls Center – Anne Arundel County

3. William Donald Schaefer House – Baltimore City

4. Youth Centers
   - o Backbone Mountain – Garrett County
   - o Green Ridge – Allegany County
   - o Meadow Mountain - Garrett County
   - o Savage Mountain - Garrett County

The report discusses four aspects of rehabilitative programming:

- Treatment Model and Therapeutic Services
- Treatment Service Plans
- Vocational Programming
- Aftercare Planning

Although academic education is a critical aspect of rehabilitative programming, it is beyond the scope of this report. Later reports will address education programs in DJS facilities.

As the report discusses, strength of aftercare services (those services provided to youth after their release from residential placement) is directly linked to recidivism and other measures of youth success. The report discusses aftercare planning that occurs while youth are in residential placement, but the actual delivery of these services in the community is also beyond the scope of this report.

We did interview some youth released from the programs in the past six months to develop a general sense of the consistency and quality of aftercare services. While the youth made powerful statements about the challenges they face post-release, we leave for another time a statistical evaluation of aftercare services.

This report is written differently than past JJMU reports. For the most part, its focus is not on whether programs comply with specific standards. Its goal is to enhance knowledge among decision makers about what works to rehabilitate youth in residential programs and what services Maryland programs offer today.

As Maryland undertakes juvenile system reform, one of the first steps must be to improve basic living conditions and safety for youth in residential placements. The

current DJS Administration has focused intensively on these issues, and rightly so.

As the State moves forward with reform efforts, we hope this report will enhance discussions about what works to rehabilitate youth. These discussions should include the many stakeholders in the juvenile justice system – youth and their families, government, victims of youth crime, advocates and neighborhoods, and the broader community of people interested in youth.

EXECUTIVE SUMMARY

RECIDIVISM

While not a perfect or comprehensive outcome measure, recidivism rates offer valuable information about how youth fare after release from a committed residential placement. Historically, Maryland's recidivism rates have been high – 51% of youth are re-arrested within one year of discharge from a residential program, and 72% of youth are re-arrested within three years of discharge. The Department of Juvenile Services publicly releases recidivism rates for some committed care programs but not others, complicating efforts to evaluate the success of any single program in reducing re-offending.

Since Victor Cullen's opening in July 2007, 24 youth have successfully completed the program. Eight of the 24 had been re-arrested by the end of June, 2008.[1]

Many variables may affect recidivism of Victor Cullen youth, including inconsistent implementation of the rehabilitative model during startup, uneven aftercare services, or generally high recidivism among the type of youth sent to a medium-secure facility. But the State should immediately examine recidivism and other outcome measures among those completing the Victor Cullen program and make program adjustments as needed. Before expanding the Victor Cullen model to additional treatment facilities, its effectiveness must be demonstrated.

In the past year, eight girls successfully completed the Waxter Program. Three girls continue to be successful in the community, primarily living with their parents. Three of the eight have been re-arrested (one of the three is now AWOL); two girls have run away from home and are listed as AWOL.

All three girls successfully completing the Waxter Program during the 2nd Quarter have run away and are officially listed as AWOL. The examination of Waxter's program model and aftercare services for girls must be an immediate priority.

Of 329 youth successfully completing the Youth Center programs in FY2006, 58% were re-arrested (in the juvenile or adult system) within 1 year of discharge.[2] The Youth Centers have used the Positive Peer Culture (PPC) rehabilitative model (also implemented at Victor Cullen) for over five years, and outcome data should be studied to determine how well PPC works when fully and consistently implemented.

No recidivism data is publicly available for the William Donald Schaefer House (WDSH) drug treatment program.

THERAPEUTIC AND REHABILITATIVE PROGRAMMING

Today substantial research exists showing what works to rehabilitate delinquent youth. Programs that have been evaluated in controlled trials and show large sustained benefits to participants and/or society are referred to as "evidence-based practices."

The primary therapeutic and rehabilitative model at the Youth Centers and Victor Cullen Center is Positive Peer Culture and EQUIP (a skills-based supplement to PPC) with individual mental health counseling and substance abuse treatment when warranted. PPC is a group-based model premised on the theory that youth have the ability to help others, and by doing so, develop self-esteem, responsibility and positive social values.

Studies on the effectiveness of Positive Peer Culture have been mixed. It is not included in evidence-based model guides developed by the U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention (OJJDP), the U.S. Surgeon General, or others. In June, however, the California Evidenced-Based Clearinghouse for Child Welfare gave the model a 60-day provisional

[1] *Victor Cullen successfully discharged its first youth in October, 2007.*

[2] *Department of Juvenile Services Annual Statistical Report for FY2007, p. 75.*

approval as an evidence-based practice, based on the strength of research supporting it.

Some studies have found PPC improves youth behavior in facilities but does not yield long-term positive benefits. More study of PPC is needed, particularly in settings with highly-trained staff in which the program is implemented with complete fidelity to the model. PPC in Maryland facilities should be examined more fully before expanding it to additional juvenile offender programs.

There appears to be no coherent and consistent treatment model at The Waxter Center for Girls. While DJS Headquarters Staff describe a treatment model that is being implemented at Waxter, "Growing Great Girls," Waxter facility staff and youth could not describe the rehabilitative process followed in the program. Each girl has a file with detailed progress notes, but staff do not adhere to a set schedule of daily treatment group meetings. DJS should immediately focus on fully implementing a comprehensive program model at Waxter.

Staff at William Donald Schaefer House (WDSH) use a 12-Step model, based on Alcoholics Anonymous. No evidence supports the effectiveness of the program although youth commented that the WDSH staff care about them and try to help them. Programming should also be reevaluated at WDSH.

VOCATIONAL PROGRAMMING

Research shows that most vocational training programs for delinquent youth yield little long-term benefit. Factors affecting the success of these programs include whether they are tied to real jobs and continuing education opportunities in the community and whether youth are assisted over the long-term after release by mentoring, academic, and other supportive services.

Victor Cullen launched a promising pre-apprenticeship program this summer. Most youth involved gave the program high praise. Those youth completing the program should be given extra supports after release and tracked to gather more data on long-term benefits of the program.

Unfortunately, the Pre-Apprenticeship Program will not be repeated again until 2009, and may or may not be offered again at Victor Cullen. The Department has not publicly discussed the reasons for the delay in repeating the program.

No vocational programming exists at either Waxter or Schaefer House.

The Youth Centers operate a number of vocational programs, including carpentry, aquaculture, and auto mechanics. None of these programs are connected to ongoing job opportunities in the community, but youth generally enjoy them and gave particularly high marks to the Backbone Mountain carpentry program.

AFTERCARE

Youth returning home after residential placement need major support to succeed. OJJDP recommends research-based aftercare programs that seamlessly connect the residential placement and reentry. No matter how strong the treatment program, without substantial aftercare support, most youth will be unable to fully integrate their newly-gained knowledge and skills.

Maryland law requires that aftercare planning begin as soon as a youth arrives at a residential placement. Facility and community-based staff must develop a comprehensive step-down plan of services to be provided to the youth after discharge.

Evidence of aftercare planning in facilities was mixed. Staff complained that involvement of youth's Community Case Managers varies considerably – some Community Case Managers interact often with the youth and treatment team, and others rarely visit. The Youth Centers and WDSH develop detailed aftercare programs for their youth, and youth interviewed expressed satisfaction with the aftercare support they were receiving.

Youth files at Victor Cullen showed little evidence of aftercare planning, and youth interviewed said post-discharge assistance was limited. Waxter staff said that aftercare planning is handled by the Community Case

Manager rather than the facility. Girls interviewed at Waxter had little idea about what they would do post-release.

Evidence-based practices, including Multi-Systemic Therapy, Functional Family Therapy, and Family Integrated Transitions, should be expanded to aftercare youth as funds become available. The Department might consider beginning with a pilot group consisting of Victor Cullen or Waxter youth.

RECOMMENDATIONS

The report includes both short- and long-term recommendations to improve programming at committed care programs, ultimately leading to enhanced outcomes for youth. We believe the Administration's first-year focus on safety and basic living conditions was critical and appropriate. Evidence-based residential programming, well-trained staff, and strong aftercare must be the next steps in the State's continuing reform agenda.

SECTION I

RECIDIVISM

Juvenile recidivism is the repetition of delinquent behavior. Recidivism rates may be defined, analyzed or measured in a variety of ways - repeat offending at intake, re-arrest, court referral, adjudication and/or commitment. Recidivism rates may be measured over weeks, months, or years.

"The most useful recidivism analyses include the widest possible range of system events that correspond with actual re-offending and include sufficient detail to differentiate offenders by offense severity in addition to other characteristics." To be fully understood recidivism rates should be "calculated…for more than one time frame (6 months, 1 year, 2 years, etc.)."[3]

"There are no national recidivism rates for juveniles,"[4] and comparing recidivism rates among States can be difficult due to the variety of ways recidivism data is collected and measured.

In 2006 Virginia's Department of Juvenile Justice reported that 43% of post-committed youth were re-arrested within 1 year of their release, and 26% were re-incarcerated within 1 year of their release. The writers of the Virginia report also expressed frustration with the criteria and methods used to track recidivism due to variations in how recidivism is defined and measured.

Recidivism research also demonstrates that there is enormous variability in the effectiveness of different types of programs for seriously delinquent youth. The most effective programs, on average, reduce the rate of subsequent offending by nearly half (46%) compared to controls, whereas the least effective programs actually increase the rate of subsequent offending by 18% compared to controls. So, while some kinds of interventions substantially reduce youth violence and delinquency, others appear to be harmful (iatrogenic), actually increasing involvement in these behaviors.[5]

Juvenile justice professionals use many other outcome measures to determine how well programs work to rehabilitate delinquent youth,[6] but recidivism rates continue to be one of the most commonly used measures of successful youth rehabilitation. Despite the challenges, recidivism data provides us with useful information about how well youth fare after release from treatment.

"Staying active; doing things that will impact me in a positive way and learning to make better decisions. These are the most important things for me to do to succeed. The program gave me a lot of insight into how to see things and how to handle things."

- R.R., Youth recently discharged from Savage Mountain Youth Center

Note: All youth quoted in the report are identified using pseudonyms to protect their anonymity.

[3] *U.S. Dept. of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP), "National Report on Juvenile Offenders and Victims, 2006.*

[4] *Ibid.*

[5] *U.S. Department of Health and Human Services, Office of the Surgeon General, Youth Violence: A Report of the Surgeon General (2001),* http://www.surgeongeneral.gov/library/youthviolence/chapter5/sec1.html

[6] *See Greenwood, P. Changing Lives: Delinquency Prevention as Crime Control Policy, 2006, discussing self-reported crime and drug use, academic performance, graduation and employment rates.*

RECIDIVISM IN MARYLAND

While the DJS 2007 Strategic Plan emphasizes that "the juvenile justice community has not reached a consensus on how best to define recidivism with one measure,"[7] DJS still measures recidivism, using a variety of metrics. The Office of the Governor's StateStat Program[8] captures data from both the juvenile and adult systems for youth who recidivate from DJS residential placements. Youth are tracked at one, two and three years after discharge, and they are tracked for re-arrest, re-adjudication (court finding of guilt) and re-commitment (incarceration).

"Follow up and mentoring are needed to check up on youth at school and at the job site to encourage youth in their attempts to better themselves.

-- Facility Case Manager

Department of Juvenile Services
Governor's StateStat Report
Volume 12, Number 19 – May, 2008[7]

	FY2003	FY2004	FY2005	FY2006
After One Year				
Re-Arrest Juvenile/Adult	51%	52%	52%	51%
Re-Adjudication or Conviction	25%	19%	20%	19%
Re-Commitment or Incarceration	45.9%	46.9%	45%	43.9%
After Three Years				
Re-Arrest Juvenile/Adult	73%	72%		
Re-Adjudication or Conviction	59%	48%		
Re-Commitment or Incarceration	43%	37%		

[7] *Md. Department of Juvenile Services Strategic Plan, FY2007.* www.djs.state.md.us

[8] *A performance management tool used by Maryland State Government to measure progress and improve governmental functioning. This and other StateStat reports may be found at* http://www.statestat.maryland.gov/

Although one year recidivism rates for FY2007 have not been reported yet, in the previous 4 fiscal years, one-year recidivism remained fairly stable except for a 6% decrease in re-adjudications/convictions between FY2003 and FY2004. Three year recidivism rates have not been reported to include FY2005 yet, but three-year re-adjudication and re-commitment percentages declined between FY2003 and FY2004. Nevertheless by three years after discharge, nearly three-quarters (72%) of DJS committed youth are re-arrested.

RECIDIVSM BY INDIVIDUAL FACILITY

Recidivism data is not publicly available for all committed care facilities but aggregate data for the four Youth Centers is published. Of 329 youth successfully completing the Youth Center programs in FY2006, 58% were re-arrested (in the juvenile or adult system) within 1 year of discharge.[9] The Positive Peer Culture model has been implemented at the Youth Centers for over five years, and outcome data should be studied to determine how well PPC works when fully and consistently implemented

With a 72% total re-arrest rate at 3 years following discharge, it is safe to say that historically Maryland's committed care and aftercare programs have not worked very well to rehabilitate youth. Decision makers need data showing which programs are succeeding and which are failing to make reasoned judgments about implementation of rehabilitative program models in Maryland.

VICTOR CULLEN CENTER

Victor Cullen opened in July, 2007. By the end of June, 2008, 24 youth had successfully completed the program and been discharged. Eight of the 24 had been re-arrested by the end of June, 2008.

[9] *Department of Juvenile Services Annual Statistical Report for FY2007, p. 75.*

Victor Cullen Center Recidivism – FY2008

Category	Total Number	Percentage
Youth Discharged (July, 2007 – June, 2008)	34	100%
Youth Discharged before Program Completion (July, 2007 – June, 2008)[10]	10	29%
Youth Successfully Discharged (October, 2007 – June, 2008)[11]	24	71%
Youth Successfully Discharged but Re-Arrested (October, 2007 – June, 2008)	8	33%

The sixteen youth who have been successful post-discharge from Victor Cullen are involved in a variety of aftercare structures including Intensive Probation Supervision. Most are living with their parents, and at least one has begun attending college classes.

Thirty-three percent of the youth released from Victor Cullen since October have been re-arrested. This is a relatively small sample and can not be compared to system-wide recidivism rates which measure larger numbers of youth at 1, 2, and 3 years following discharge.

Nevertheless, the high number of youth re-arrested soon after their discharge from Victor Cullen is an extremely important indicator of how well the program or its aftercare components are working. Many factors may affect recidivism, but these numbers are not encouraging, particularly for a program intended to be the model replicated in DJS residential programs around the state.

One youth was re-arrested within one month of his release from Victor Cullen, but most were arrested at between 4 and 6 months following release. They were arrested on charges ranging from motor vehicle theft to controlled substance possession/distribution to robbery.

Several possible reasons for Victor Cullen's high recidivism should be explored:

1. *Lack of an evidence-based treatment model* – The Victor Cullen treatment model, PPC/EQUIP, has not been proven by rigorous scientific research to significantly improve youth outcomes, so a new evidence-based treatment model may be needed. (See Section II of the report – Therapeutic and Rehabilitative Programming.)

2. *Need to more successfully implement the treatment model* – Victor Cullen has experienced a number of start-up challenges, and it may be that as the program is more consistently and fully implemented, recidivism will drop.

3. *Lack of aftercare* – Comprehensive aftercare is essential to successful transition back into the community. As discussed in Section V of the report, since its opening, aftercare planning at Victor Cullen has been inconsistent.

[10] *Youth may be released early because the program does not have the services they need, because they escape, etc.*

[11] *Youth completing the entire program and released to the community*

4. *Youth placed at Victor Cullen* – Victor Cullen is considered a "medium secure" facility. It is possible that youth needing a medium security placement have more difficulty with rehabilitation and recidivate at higher rates than other groups of committed youth. In fact, the DJS FY2007 Annual Statistical Report showed that among all committed youth, youth committed to "medium secure" facilities did recidivate at higher than average rates.

FY2004 Recidivism at One and Three Years
Re-Arrest Juvenile/Adult[12]

After One Year	67%
After Three Years	88%

Nevertheless, historical recidivism does not justify tolerating poor outcomes for youth going through the Victor Cullen program. Enormous tax dollars and effort have been focused on the program, and program adjustments up to and including changing the entire therapeutic program model should be tried until repeat offending rates improve for youth completing the Victor Cullen program. Certainly, this model should not be replicated in additional DJS residential programs until its efficacy has been proven.

We interviewed nine Victor Cullen youth – six who were still at the facility and three who had successfully completed the program. Most said a job was very important to keep from re-offending, and two of the youth said they needed more skills training or follow-up in the community to obtain a job. Three youth said the program at Victor Cullen provided them with everything they needed to keep from re-offending. Three youth said the program failed to provide them with what they needed, two youth said the program was partially helpful and one youth had already been arrested as an adult on a handgun charge.

WAXTER CENTER FOR GIRLS

In the past year, eight girls successfully completed the Waxter Program. Three girls continue to be successful in the community, primarily living with their parents. The other five have not been successful post-release. Three of the eight have been re-arrested (and one of these three is now AWOL); two additional girls have run away from home and are listed as AWOL.

All three girls successfully completing the Waxter Program during the 2nd Quarter have run away and are officially listed as AWOL.

While a very small sample, again this finding is a leading indicator of how well the rehabilitative program at Waxter (and/or its aftercare components) has been achieving its goal of stabilizing these girls' lives. The next section of the report discusses the lack of any coherent program model at Waxter – this issue must be addressed immediately and aftercare services for girls must be substantially strengthened to improve outcomes.

WILLIAM DONALD SCHAEFER HOUSE

DJS does not publicly release recidivism data for the William Donald Schaefer House. The program director said that an in-house program was in place in 2005 in which the Facility Case Manager called Community Case Managers[13] for youth who had been released to determine if they had "gotten in trouble" again (apparently this included not only re-offending, but also truancy and incorrigibility). This practice ended in 2006 when the program moved temporarily to MYRC and has not been reinstated.

[12] *DJS Annual Statistical Report for FY2007, http://djs.state.md.us/pdf/2007stat_report-section2.pdf*

[13] *Throughout this report, Probation Officers are referred to as "Community Case Managers," the official DJS title for professionals working with youth in the community.*

Two youth who successfully left the program were interviewed. One of the youth from Schaeffer House's program was in juvenile detention for a new offense and the other said the best thing that happened to him was that his family moved when he got out of commitment and his old "friends" were not negatively influencing him.

YOUTH CENTERS

Recidivism data on each individual Youth Centers is not publicly available, but DJS publishes aggregate data. Of 329 youth successfully completing the Youth Center programs in FY2006, 58% were re-arrested (in the juvenile or adult system) within 1 year of discharge.[14]

Because the PPC program model is well-established at the facilities and staff are experienced in the use of the model, recidivism data on these individual programs over the past few years should be collected and examined.

Even though research on PPC has not shown to substantially improve youth outcomes (see Section II of this report), many variables such as consistent program implementation and fidelity to a therapeutic model can affect research outcomes. An examination of recidivism rates for individual Youth Center programs would provide important information about how well PPC is working when fully and consistently implemented.

"What do I need not to re-offend? I just need determination and a lot of support – attend meetings and be very honest with my family."

- G. J.,Youth discharged from Meadow Mountain Youth Center

Three youth were interviewed from the Green Ridge Youth Facility. Two of the three youth felt self control and discipline were most important to keep from re-offending. One felt a good job was needed and all three Green Ridge youth said they received what they needed to keep them from re-offending. Two said they learned self-respect and one said he was going back to college.

Three youth from Backbone Mountain were interviewed. Two said they needed self control and one said he needed a job. All of the Backbone youth said they learned to make the right decisions and two said they could always count on the program for support.

"What I need most to keep from re-offending is a job. I need more job training and help finding jobs once I'm ready to go home."

-- M.J.,Youth at Victor Cullen Center

[14] *Department of Juvenile Services Annual Statistical Report for FY2007, p. 75.*

SECTION II

THERAPEUTIC AND REHABILITATIVE PROGRAMMING

The measure of effectiveness in juvenile treatment programming lies in the ultimate long-term outcome for youth and families. This section of the report reviews current rehabilitative models and programming in DJS committed care programs.

In the past fifteen years, researchers have studied numerous programs that treat serious juvenile offenders to determine what approaches work best to rehabilitate them. The most cited meta-analyses of programs that prevent violent youth behavior are those conducted by Lipsey and Andrews.[15] This research concluded that:

"effective treatment can divert a significant proportion of delinquent and violent youths from future…crime….contradicting the conclusions of scientists two decades ago who declared that nothing had been shown to prevent youth violence." [16]

Programs that are most effective are generally referred to as "evidence-based practices." The Council for Excellence in Government defines evidence-based practices (EBP's) as "treatments that have been evaluated in well-designed randomized controlled trials, in community settings, and shown to have sizeable, sustained benefits to participants and/or society."

Excellent resources for discussion of evidence-based, model, and promising programs include:

- Youth Violence: A Report of the Surgeon General (2001) http://www.surgeongeneral.gov/library/youthviolence/chapter5/sec1.html
- U.S. Dept. of Justice, Office of Juvenile Justice and Delinquency (OJJDP) Prevention Model Programs Guide, Version 2.5 http://www.dsgonline.com/mpg2.5/mpg_index.htm
- University of Colorado, Blueprints for Violence Prevention http://www.colorado.edu/cspv/blueprints/
- Washington State Institute for Public Policy http://www.wsipp.wa.gov/topic.asp?cat=10&subcat=54&dteSlct=0

This section of the report evaluates DJS therapeutic program models based on the following factors:

1. Whether the program model is evidence-based;

2. How fully and consistently the program model is implemented in the facility.

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[15] *Lipsey, 1992a, 1992b; Lipsey & Wilson, 1998; Andrews, 1994; Andrews et al., 1990*

[16] *U.S. Department of Health and Human Services, Office of the Surgeon General, Youth Violence: A Report of the Surgeon General (2001), http://www.surgeongeneral.gov/library/youthviolence/chapter5/sec1.html*

THE MISSOURI MODEL

One treatment model that has received national attention is the Missouri Model, implemented at committed care programs operated by the state of Missouri.

"Research has shown that the most effective secure corrections programs serve only a small number of participants and provide individualized services (Howell, 1998). Missouri, for example, has achieved 'exceptional' reductions in juvenile recidivism by abolishing its State reform school and replacing it with a network of small group homes emphasizing personal attention and therapeutic treatment (Mendel, 2003)."[17]

Several years ago, because of Maryland's historically high recidivism rates, state officials and lawmakers looked to other states, especially Missouri, in an effort to develop and implement more effective treatment programs in Maryland.

The Missouri Model for residential programming is built around community-based therapy and uniform practices and incorporates interaction among youth, families, treatment center staff and community staff. The model's elements include:

1. **Small, home-like facilities** – youth facilities hold no more than 35 residents. Juvenile "cottages" use an open design and furnishings to create a home-like environment. Missouri operates a total of 32 facilities with 726 beds, approximately 22 beds per program.

2. **Structure and safety** – Three different levels of facilities are available – group home models for non-violent offenders, medium secure programs in state parks who need more structure and supervision, and seven hardware secure programs. Even the hardware secure facilities are very small.

3. **Strong link to family and community** - To the extent possible, juvenile facilities are located in the middle of communities and built to look like normal houses on the outside.

Youth live in facilities no more than 50 miles from home, and families are fully involved in their treatment. Therapists drive family members to facilities to participate in family therapy sessions.

4. **Highly trained staff; social services philosophy.** Approximately two-thirds of staff have bachelor degrees or higher. They receive intensive ongoing training in addressing underlying causes of youth's behavior. Credentialed therapists run daily group sessions, and case managers have no more than 15-20 youth on their caseloads.

Missouri's philosophy and treatment approach has a social services rather than punitive orientation. It considers accreditation by the American Correctional Association antithetical to its philosophy.

5. **Intensive aftercare** - Day treatment centers assist youth recently discharged from a residential program with their transition back into the community. Community members and college students mentor youth by keeping in regular contact, helping with school, and involving them in community activities. Aftercare services last six months on average.[18]

According to the Annie E. Casey Foundation, Missouri's recidivism rates are "far better than most states, even though its costs are low."[19]

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[17] *U.S. Dept. of Justice, Office of Juvenile Justice and Delinquency (OJJDP)Prevention Model Programs Guide, Version 2.5* http://www.dsgonline.com/mpg2.5/mpg_index.htm

[18] *The "Missouri Model" refers only to youth committed to the Division of Youth Services and does not take into account locally operated detention facilities where Missouri houses the majority of juvenile offenders.*

[19] *Annie E. Casey Foundation, A Roadmap for Juvenile Justice Reform, KIDS COUNT, 2008.*

THE MARYLAND MODEL

The Maryland Model focuses on increasing public safety through the rehabilitation of youth. It is a work in progress and based on the concept of regionalization. The plan calls for the utilization of small 36-48 bed facilities and the development of evidenced-based treatment services in youth's communities. Ultimately, each of the six designated regions is designed to have full continuum of care capability, including detention, residential committed care, and community services.[20]

The Western Region has served as a pilot in the development of regionalization. The opening of the Victor Cullen Center in July, 2007 with an ultimate 48-bed capacity is intended to complete the continuum of care capability for the Western Region.

In addition to regionalization and small facilities, the new Maryland Model incorporates many of the same principles as the Missouri Model:

1. Evidence-based programs;

2. Services provided in youth's communities;

3. Individualized treatment;

4. Strong aftercare programs.

However, Maryland has not yet embraced many aspects of the Missouri Model – including its social services orientation and raising required credentials and education of staff. The only small home-like facility operated by the State is the William Donald Schaefer House which is located in a grand old refurbished home near Druid Hill Park in Baltimore.

The Department has begun many efforts to more fully develop the Maryland Model in recent years, including increasing the number of slots for family-focused evidence-based interventions, opening the 48-bed Victor Cullen facility, and beginning work on a comprehensive assessment and service planning instrument. There should be no doubt that DJS staff is focusing intensively on development of the Maryland Model. And it is too early in the process to make long-term predictions about the effectiveness of this model.

However, at this early point in the process, two universal themes emerged from our study:

1. While new approaches and treatment models are discussed at Headquarters, many front line staff do not understand them and are not implementing them consistently;

2. This conclusion is supported by data showing that so far, youth continue to fare poorly after release from residential placements in Maryland, including youth released from the new Victor Cullen program.

POSITIVE PEER CULTURE AND EQUIP

The primary therapeutic model employed at the Youth Centers and at the Victor Cullen Center is Positive Peer Culture (PPC) and EQUIP with individual mental health counseling and substance abuse treatment when warranted. Missouri incorporates some peer group work into its therapeutic programs but does not use Positive Peer Culture.

The fundamental premise of Positive Peer culture is that youth have the ability to help others, and by doing so develop self esteem, responsibility, empowerment, and positive social values.[21] Youth are placed in groups of between nine and twelve members. The group holds five 60-90 minute weekly meetings, and under adult guidance, youth learn to take responsibility for identifying their own and others' problem areas, and assist in helping address those problems in an atmosphere of mutual care.

[20] *Md. Human Services Code Ann. §9-238.1.*

[21] *Positive Peer Culture developed from the work of Harry Vorrath and Larry K. Brendtro. See Positive Peer Culture (2nd Ed.), 1985. See California Evidence-Based Clearinghouse for Child Welfare for more description of Positive Peer Culture.* http://www.cachildwelfareclearinghouse.org/

Studies on the effectiveness of Positive Peer Culture have been mixed. It is not included as an evidence-based, model, or promising program in the OJJDP Model Program Guide, the Surgeon General's Report on Youth Violence, or Blueprints Model/Promising Programs.

This summer, the California Evidenced-Based Clearinghouse for Child Welfare (CEBC) gave PPC a 60-day provisional approval based on the strength of research evidence supporting the practice.[22] In 1998, The University of Colorado's Center for the Study and Prevention of Violence issued a position summary on PPC which stated:

"Overall, the empirical evaluations of…(PPC)…are inconsistent; some evaluations yield no effect, others yield beneficial effects, and still others yield adverse effects.

There is some evidence that these types of programs help maintain or restore institutional order….

Overall, however, the adverse effect of some peer-based interventions is a serious warning sign for this type of intervention. When implemented, these interventions should be applied only in an experimental context because their beneficial nature and efficacy has not been consistently demonstrated."[23]

More research on PPC is needed, particularly studies in which the program is implemented with fidelity to the model, staff are fully credentialed and trained, and the youth in the program are the youth the program was designed to reach. (See Program Implementation, below.)

EQUIP is a psycho-educational skills-based treatment intervention. EQUIP consists of teaching youth the skills needed to help one another, and how to make responsible social/moral decisions. EQUIP includes moral education, social skills training, anger management, correction of thinking errors, and role-play.[24]

Little research on the effectiveness of EQUIP exists. A 1993 study found that youth receiving EQUIP training showed significant improvements in conduct and lower recidivism over 12 months than youth in control groups,[25] but more research on its effectiveness is needed.

Although EQUIP covers life skills in a number of areas, it incorporates an anger management module called Aggression Replacement Training, or ART.®. ART has been designated an Evidence-Based Practice and has been shown to significantly reduce aggressive behavior in youth. ART sessions are conducted 3 hours each week over a period of 10 weeks. In comprehensive studies of incarcerated youth, ART was shown to improve institutional behavior as well as post-release functioning in the community.

While studies show ART to be effective when delivered individually, to date no studies have evaluated whether outcomes improve when PPC/EQUIP is are added to the treatment protocol.

PROGRAM IMPLEMENTATION

A major difficulty in gauging the success of any treatment model is whether the program is implemented consistent with the program's principles and whether it is serving the population it was designed to serve. Positive treatment outcomes are completely

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[22] *Ibid.*

[23] *University of Colorado, Blueprints for Violence Prevention, Position Summary on Positive Peer Culture* http://www.colorado.edu/cspv/publications/factsheets/positions/pdf/PS-003.pdf

[24] *The EQUIP model had its beginnings in 1986 as John C. Gibbs and Granville Bud Potter collaborated to combine their work on motivating and equipping youth to help one another. Subsequently, the work of Arnold P. Goldstein in Aggression Replacement Training® (ART) was incorporated in the EQUIP intervention process.*

[25] *Leeman, L.W., Gibbs, J.C., & Fuller, D. (1993). Evaluation of a Multi-component Group Treatment Program for Juvenile Delinquents. Aggressive Behavior, 19, 281-292.*

dependent on effective implementation of any given treatment model on a day-to-day basis.

For example, the CEBC report says that direct care PPC staff should hold a minimum of a bachelor's degree in the helping professions, and group leaders should hold a master's degree in social work or a related field. Supervisors should have five or more years experience in positive youth development, and staff should have a working understanding of Situational Leadership, stages of group development, and developmental psychology. Maryland does not require these credentials for juvenile direct care workers, and few direct care staff have them.

In a recent newsletter, Larry Brentro, one of the developers of PPC, discussed the long-term implementation problems:

"Many organizations ran effective PPC programs for a time but faltered with changes in leadership. Some programs called 'Positive Peer Culture' were pale imitations of the real thing. The lack of formal PPC certification and training systems contributed to this instability." [26]

Despite the mixed research on PPC, its effectiveness in any given setting may ultimately lie in the training and skills of those implementing it and their fidelity to the model. Although the four Youth Centers have used PPC for over five years no recidivism or other outcome data has been collected on youth going through individual Youth Center programs. That data is needed to study how PPC has been working for Maryland youth.

VICTOR CULLEN CENTER

For its first nine months of operation, Victor Cullen Center purported to use Positive Peer Culture, EQUIP, and Aggression Replacement Training® (ART) but no elements of the programs were actually implemented, except group meetings. Staff had not been trained in the PPC model, and no ART® or EQUIP curriculum was purchased or used with the youth.

With the help of DJS Youth Center staff, where PPC/EQUIP has been implemented for a number of years, Victor Cullen Center staff and youth underwent intensive training in the spring of 2008 in order to begin to implement the treatment model.

Victor Cullen Center now holds PPC three times a week though the developers of PPC recommend that staff hold meetings 5 times a week. It also holds two EQUIP training meetings each week and 3 hours of ART over 10 weeks of the youth's stay. Catoctin Summit Addictions Counselors provide Substance Abuse group one time a week, for each group, with additional intensive counseling provided as needed up to nine hours a week.

Assessment tools utilized at Victor Cullen include the Massachusetts Youth Screening Instrument (MAYSI), the Problem Oriented Screening Instrument for Teenagers (POSIT), and the Substance Abuse Subtle Screening Inventory (SASSI).

Victor Cullen employs two LCSW-C therapists and one counselor holding a Masters in Social Work. These staff members hold two Special Group sessions with their assigned group each week in addition to overseeing the EQUIP meetings. Each youth is also seen a minimum of one time a week by his group therapist, and depending on need, may be seen for up to five hours per week.

Victor Cullen has four Case Managers, all required to have a bachelor's degree and two years of experience working with juveniles.

In addition to PPC, EQUIP, substance abuse and mental health counseling, the youth at Victor Cullen are required to progress through three Focus Areas: Skill Development, Accountability, and Community Safety. The Focus Area process includes youth completing assignments and making presentations in each area. In addition to progressing in each aspect of treatment on campus, youth must have completed three successful home visits before being considered for release. The

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[26] *Brentro, Larry K. et al, "Positive Peer Culture: Antidote to Peer Deviance Training," Reclaiming Children and Youth, Vol. 15 No. 4 (2007).*

first visit is for 24 hours; the second visit is for 48 hours; and the third visit is for 72 hours.

WAXTER CENTER FOR GIRLS

Initially, the Superintendent reported that Positive Peer Culture/ EQUIP is the treatment model in Waxter's Enhanced Maximum Security committed program for girls, but later interviews with staff made it clear that this treatment model has not been implemented at Waxter. There was no consensus among those interviewed, staff and youth, as to the treatment model or rehabilitative process employed at Waxter. There was some discussion that Waxter may utilize Dialectical Behavioral Therapy (DBT) in the future.

DJS Headquarters reports that Waxter uses elements of PPC/EQUIP and "Growing Great Girls," a treatment approach developed by Denise Bray, former Director of the PACE Center for Girls in Florida. While this model is not evidence-based, it incorporates many of the elements experts believe are essential to successful treatment of delinquent girls – gender, trauma, and strengths-based foci. The Department has worked with Ms. Bray to develop and implement the "Growing Great Girls" program for approximately 15 months. The fact that no Waxter staff members interviewed could name or discuss the treatment model at this point is cause for serious concern about the implementation of of the "Growing Great Girls" program.

Waxter has a licensed clinical psychologist who works two days each week, supervises the other clinicians and offers individual therapy. Currently there are two other clinicians and Waxter is in the process of hiring a third who will focus on delivery of services to the committed girl's program. A psychiatrist reportedly comes to Waxter one evening per week.

Each youth in the committed care program receives a bio-social interview at intake, and assessments administered include the Minnesota Multiphasic Personality Inventory (MMPI), the Massachusetts Youth Screening Instrument (MAYSI), and the Substance Abuse Subtle Screening Inventory (SASSI).
Youth and staff report that a morning goals group occurs daily and consists of setting goals and talking about concerns. Youth, direct care staff, or sometimes the Case Manager may lead this group. Youth report, however that therapeutic programming, led by staff, does not occur every day. Youth receive weekly individual therapy and addictions counseling/education. Each Case Manager may hold different group sessions during the week, but there is no set curriculum. Case Managers may also meet one-on-one with the girls. In one observed group session, the Case Manager passed out a packet about family history, but then the group just talked about issues they were having in the group.

Waxter works with several community groups including the Junior League, YMCA (self-esteem projects), and the MICA film project.

Beyond the morning goals group, Waxter staff members do not follow a consistent treatment group schedule, and apparently, each day is scheduled as it goes. The printed schedule does not reflect the reality of daily life at Waxter. Youth report that "No one looks at that schedule anymore, and it's confusing here." Staff commented that "Staff need to be more connected. No one knows what anyone else is doing." There is no Master Schedule posted on the Committed Care Unit although a Master Schedule was recently developed for the Detention Unit.

Overall, there appeared to be a lack of communication and collaboration among staff. Additionally several staff commented that the quality of contact between staff and youth needs to be improved, and that staff should invest in more meaningful therapeutic connection and interaction with the youth.

Staff and youth interviewed made a number of recommendations to improve the treatment program, summarized as follows:

1. More clinicians must be hired for staff to consistently implement an effective therapeutic model.

2. Staff should follow a reliable schedule of treatment and rehabilitative programming.

3. Staff members should demonstrate interest in programming and engage in more meaningful contact with the girls.

4. More music and art activities should be added.

5. More and enhanced community-based programs should be developed to help youth transition home after leaving Waxter.

6. Community Case Managers' involvement should be strengthened. It is inconsistent, depending on the individual Case Manager.

7. Youth and their families need to maintain contact, and more therapeutic services for families should be offered.

8. Youth need enhanced educational opportunities, parenting classes, and job training.

WILLIAM DONALD SCHAEFER HOUSE

The clinical staff at the William Donald Schaefer House have essentially created their own treatment model based on the 12-Step Alcoholics Anonymous program. None of the counselors, the social worker, or the director identified a model for the drug treatment program at this facility.

There is no Clinical Director and there are no clinical team meetings for each youth. There is however, a regular meeting every Wednesday for all the staff members. Each staff member is encouraged to bring up two youth for discussion by the entire group, and recommendations are made. Youth are usually discussed if they are having behavior problems, if they are about to be released, or if there is a possibility their time in the program may be extended.

There are three drug treatment counselors. Two of the counselors have the designation "CAC", Certified Associate Counselor. One holds a BS degree in psychology with emphasis on drug abuse. Another holds both a BS and an MA in Counseling. One counselor has a high school diploma. He is working on an AA degree, was "grandfathered" in, and has the designation "CSC" (Certified Supervised Counselor"). All three have similar duties and workloads. According to the Director, these counselors get 40 hours of refresher training each year, and they are up to date on their training. The Director of Schaefer House also is a Certified Associate Counselor.

The Social Worker at Schaefer House is a Licensed Clinical Social Worker. She does one-on-one counseling with youth as needed, and handles all of the mental health issues that arise. Schaefer House administers the Massachusetts Youth Screening Instrument (MAYSI), the Substance Abuse Subtle Screening Inventory (SASSI), and the Problem Oriented Screening Instrument for Teenagers (POSIT) to youth as part of their assessment procedure.

The Case Manager does not participate in the therapeutic program, but handles administrative matters for the youth, such as contact with their Community Case Managers.

All three counselors agreed that release from the program is primarily based on behavior rather than recovery. Extension in the program is most often the result of excessive SBR's (behavior reports). Youth must participate in a behavior program called "Youth Competency Training." Staff report that the program is more appropriately classified as a group home than a drug treatment program.

There is no evidence available to support the effectiveness of the treatment program.

Most youth stay for approximately 90 days, and the counselors hold group meeting each weekday night. On Mondays and Fridays, group is educational. The counselors take turns conducting the group educational meeting. On Tuesday, Wednesday and Thursday, the three counselors meet separately with their assigned groups of 6-8 youth. In these sessions, they address more personal problems and issues. These meetings take place every weekday. Counselors do not keep notes of the group meetings, but do make individual progress notes in each youth's file.

Speakers come to the program from AA on Mondays and Thursdays. After a youth has completed 45 days of his program, he is allowed to go to outside NA meetings on Thursday evenings.

Youth must complete three workbooks during the program. The workbooks appear to be homemade, and no author is acknowledged. The workbooks seem to be based on the AA 12 step program.

There are 30, 60, and 90 day reviews of progress for youth in the program. Parents are invited, and Community Case Managers are invited. At a minimum, staff said Community Case Managers should attend the 60 day review to begin preparing for the youth's release. They said that often the Community Case Managers are not able to make it, and sometimes the reviews are held over the phone so they can participate.

Parents are allowed to visit on Sunday afternoons from 1 to 4 – during this time, parents can only visit for one hour. The Social Worker sometimes takes this opportunity to work with the youth and his parents.

One WDSH youth was interviewed post-release. He had been re-arrested and was in detention at Hickey. D.H. said the program at WDSH was good, the youth were cooperative and engaged, and they took the program seriously. The employees really made an effort to help the youth. But the program did not help him. D.H. said, "I'm going to do me regardless; I don't need anyone's help." He says that he only cooperated so that he could be released to go home and smoke marijuana again.

D.H. was assigned to Intensive Aftercare, he had two caseworkers who visited him, and he was assigned to go to NA meetings. His caseworkers visited him unannounced and would come at all times of the day or night to check on him. He was required to give random urine samples, attend substance abuse and family counseling. He felt the aftercare program was a good one, but he was not willing to give up smoking.

The Department plans to adopt of the "Seven Challenges" treatment model and curriculum for all residential substance abuse programs operated by the State, beginning in 2009. Currently the "Seven Challenges" model is under review for designation as an Evidence-Based Practice by the National Registry of Evidence-Based Practices (NREBP) of the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Early studies have shown "Seven Challenges" to significantly reduce continuing substance abuse by youth, particularly those with co-occurring mental health diagnoses. WDSH staff were aware of potential changes in the treatment model but did not know specifics.

YOUTH CENTERS

The Youth Centers use Positive Peer Culture/EQUIP and substance abuse counseling/education. Through an arrangement with the Allegany County Health Department, the Centers provide individual mental health therapy to youth as needed. Psychiatric services and medication monitoring are also provided through the Allegany County Health Department. Youth are administered screening assessment tools including the MAYSI, The POSIT, and the SASSI.

The exception to the above is the adventure impact program, Mountain Quest, located at Green Ridge Youth Center. Mountain Quest uses a somewhat different group process. Youth assigned to Mountain Quest are administered the MAYSI, but do not receive the SASSI or the POSIT.

All of the Youth Centers have developed Interdisciplinary Teams (IDT). The Teams consists of the Case Managers, Teachers, Substance Abuse Counselors, and Mental Health Counselors. The IDT meets on a weekly basis and reviews each resident on a monthly basis.

Each Youth Center has now incorporated the possibility for youth to earn home passes, and each Center has increased family involvement overall.

Though the basic elements of programming are the same, each Youth Center has its own culture and unique program elements.

GREEN RIDGE

Green Ridge primarily serves Region III youth and operates three separate programs on one campus. "Mountain Quest" is an intensive adventure based treatment program. "Revelations" is a 120-day (minimum) substance abuse program, and Green Ridge has two therapeutic groups, "Odyssey" and "Team Unity," averaging six to eight months. Each treatment group has its own name to help youth form identification with the group.

Mountain Quest is an adventure-based impact program that uses group process as a primary treatment modality. Youth or staff can call group meetings whenever there is an issue that needs to be worked through. The group holds a scheduled group meeting every evening.

With the leadership of the staff, youth confront behaviors, express feelings, and develop relationships as they tackle the adventure-based tasks and daily living responsibilities. In addition to the treatment group, Mountain Quest offers competency training in such areas as victim awareness, character building, conflict resolution, and social decision-making. Therapeutic visits on campus with family members, and 3-day home visits are also arranged. Youth are expected to keep a daily journal record of problems and progress.

The group takes adventure trips such as hiking, bicycling and camping. Mountain Quest has also made use of the Reflections ropes course at Meadow Mountain. Youth are involved in helping to develop their aftercare plan. The Mountain Quest group attends school, and teachers have occasionally accompanied them on trips. Each youth is expected to help with the daily details, work projects, and kitchen assignments. Finally, each youth participates in a bi-weekly progress review process. Though Mountain Quest is housed in a dorm with the other groups, it has its own section that is separated by a wall from the open dormitory.

Youth in the Mountain Quest program are not receiving any substance abuse assessment or treatment services. Green Ridge does not have the clinical staff capability needed to provide this crucial aspect of treatment.

Revelations is the Intensive Outpatient Program (IOP) serving youth needing a higher level of substance abuse treatment programming. In addition to PPC and EQUIP meetings, youth in Revelations receive - at a minimum - a total of 9 additional hours of addictions treatment services, and often receive more. The minimum required program is 3 hours weekly in Recovery Group, learning specific coping and social skills, 2 hours weekly in Special Treatment Groups, learning to have fun without using drugs or alcohol, 2 hours weekly in Drug Education, 1 hour of Individual Counseling, and 1 on-campus NA (Narcotics Anonymous) meeting each week.

Odyssey and Team Unity use PPC/EQUIP along with substance abuse counseling/education and individual therapy as needed. PPC groups meet 5 nights a week, and "focus" meetings are held at any time needed. EQUIP sessions are scheduled 2 evenings each week. Case Managers meet individually with youth on a weekly basis as do the Addiction Counselors and the Mental Health Therapists. Youth earn home visits toward the end of the treatment program, and family meetings take place on the Green Ridge campus on a regular basis. Youth are assessed to determine their risk for substance abuse, and either are given Early Intervention Services, a minimum of 4 hours of services weekly, or Outpatient Services, a minimum of 6 hours of service on a weekly basis.

"The program is really helping me. You can't 'front' your way through the program. Staff and youth in my group are helpful, and that makes me feel an obligation to help others in my group."

-- S.U., Youth at Green Ridge

SAVAGE MOUNTAIN

Savage Mountain primarily accepts youth from outside Region III, and currently has three groups of 12 youth, all in the 6-9 month therapeutic program. The treatment program utilizes PPC, EQUIP, and Substance Abuse education/counseling along with individual therapy for those needing that treatment intervention. Savage Mountain has recently begun to incorporate youth home visits when youth near the end of their treatment program. Thus far, this aspect of treatment has been a success, but staff reported some Courts or Counties do not permit youth to make home visits.

Savage Mountain has plans to reduce group size and go to 4 groups of 9 youth. Having smaller groups will enhance the effectiveness of the group process and the capability of staff to provide individualized attention to group members.

Unlike the other Centers, Savage Mountain is able to separate the groups in the separate wings of the dorm, whereas the other Centers have open dorms.

> *"Some youth just do their time and move along. Some try to put you down instead of helping you. I don't feel that youth should put you down in the program."*
>
> *--R.J., Youth at Savage Mountain*

Four currently-enrolled youth were interviewed about the program, and their assessment was mixed. Two youth said the program was helping them, with one remarking, "We have the opportunity to discuss our problems and learn how to deal with issues. The Case Managers tell us what to work on, and we get to take leadership of the group."

Two other youth said the program only works if youth decide to invest in it. "Some youth bring attitude."

One EQUIP session was observed – the topic was "Suicide and Depression". Youth were fully engaged, asked each other questions, and provided examples that expressed their feelings about a particular situation.

MEADOW MOUNTAIN

Meadow Mountain operates as an Intensive Outpatient Drug Treatment Program. The Maryland Department of Health and Mental Hygiene Alcohol and Drug Abuse Administration certifies the treatment program for operation.

There are 4 groups at Meadow Mountain, including a Relapse Prevention group for youth nearing completion of the program. This group focuses on exercises designed more specifically to enable youth to avoid controlled substances after release.

Each group participates in Drug Education classes, Recovery Group, Life Skills Group, AA/NA Group, EQUIP exercises, PPC Mutual Help Group, and Recreational Therapy. Each youth receives one hour of one-on-one substance abuse counseling each week, and mental health therapy is provided by the Allegany County Health Department for youth needing that additional service. On average, approximately two thirds of the youth are scheduled to receive weekly individual therapy. Because of the other substance abuse programming requirements, Meadow Mountain youth participate in PPC (Mutual Help) groups three times a week instead of five times a week.

Meadow Mountain has incorporated more family involvement into the program. Family conferences are held on site and over the phone. In addition home passes are earned by the youth as they near the end of the treatment program. The intensified family participation has reportedly been a positive addition to the overall program.

Two PPC group sessions were observed. In the first, youth debated who had the most difficult time recently, socially and

emotionally – the chosen youth would be the subject of the day's session. They could not come to an agreement. Youth did not appear to be motivated in the group; rather a little disgruntled because they could not come to an agreement.

In the second session, youth were much more engaged, holding each other responsible for their own actions and being tough on peers in their assessments and judgments. At the same time, youth offered each other practical advice, focusing on individual responsibility and connecting individual responsibility to responsibility for others in the groups.

The consensus of youth interviewed is that the treatment program is helpful. One youth stated that, "I believe it helps, especially the knowledge and the common sense approach – when you get out on the streets and you stay committed to change yourself." Two youth indicated that they felt that the EQUIP Groups helped them the most because they could practice handling situations. Two other youth cited the PPC Mutual Help Groups as helping the most because of learning how to deal with conflict appropriately.

"Has the program given you what you need to keep from re-offending?"

"Yes, absolutely. The program gave me great focus. Staff gave me honest feedback and advice."

--L.P., Youth recently discharged from Meadow Mountain

BACKBONE MOUNTAIN

Backbone Mountain Youth Center is the only Center offering the Honor Academy, a Learning Opportunities Partnership between Garrett County Community College and the DJS Youth Center. The Honors Academy College Program had 13 youth enrolled in the Summer Session. All 13 passed the college courses and were honored on August 8th at Garrett Community College.

Backbone Mountain has 3 other groups of 12 youth each. Like the other Centers, Backbone Mountain uses PPC/EQUIP, substance abuse intervention and mental health counseling as primary treatment components in the 6 to 9 month treatment program. An Allegany County Health Department counselor provides individualized mental health counseling to youth on an as needed basis. Approximately

50% to 75% of the youth require mental health counseling at any given time.

The Honor Academy enrolls youth who have either completed high school, have passed the GED, or are close to being ready to pass the GED. The Honor Academy youth live in a separate cabin. In addition to taking core subjects, these youth take 2 college classes. The Honor Academy youth are also enrolled as AmeriCorps volunteers. Upon completion of 450 hours of community service and successful completion of their college classes, the youth are eligible for a $1,167 voucher to be sent toward their next college placement.

The Monitor interviewed five youth**.** All agreed that the program had helpful aspects but gave mixed reviews overall. Although they felt EQUIP was helpful, they thought many of the scenarios were "silly." One youth commented, "It feels good to help. I don't want to let group members down." Another said, "The major goal here is doing the time, getting out, and going home. This program makes you not want to come back."

One youth interviewed was in the Honors College program, and expressed gratitude for the opportunity to participate, saying, "It prepares us specifically for a plan afterwards."

Youth said some staff really cared about them and others only came for the paycheck. They did say they can talk with some staff and especially acknowledged the Substance Abuse Counselor and Mental Health Counselor as adults they could confide in.

STAFF INTERVIEWS

Staff feedback was essentially the same from center to center:

1. Youth need intensive aftercare support.

2. They often need more involvement from their Community Case Managers.

> *"The program helped because it kept me out of trouble. The EQUIP classes involving social skills were most helpful. It showed me how to make the right decisions and not get mad."*
>
> *-- D.C., Youth recently discharged from Backbone Mountain*

3. Families often need intensive treatment intervention.

4. Youth need alternative post placement options to going back into the same environment.

5. Youth need to go directly to school or into work without having down time at home.

6. Youth leaving the centers and going into the work world need to leave with a specific job skill and a job opportunity secured before being discharged.

7. The centers should offer vocational trade skill programs in a variety of areas, and connect youth directly with unions and trade organizations upon graduation as well as certification from job training.

> *"PPC doesn't work. The youth themselves are not together. You can't expect them to help someone else with their problems when they have their own stuff."*
>
> *- Youth at Backbone Mountain Youth Center*

SECTION III

TREATMENT SERVICE PLANS

In addition to operating under a coherent treatment model, rehabilitative programs must develop service delivery plans that take into account the individual needs of youth in their care. State law requires that all adjudicated youth receive a Treatment Service Plan detailing services to be provided to them and their families.[27] The Treatment Service Plan (TSP) must be presented to the judge at the disposition hearing and must be implemented within 25 days of the date of the disposition hearing.

At a minimum the TSP must include:

(a) The recommended level of supervision for the child,
(b) Specific goals for the child and family to meet, along with timelines for meeting those goals,
(c) A statement of any condition that the child's parent, guardian, or legal custodian must change in order to alleviate any risks to the child,
(d) A statement of the services to be provided to the child and child's family; and
(e) Any other information that may be necessary to make a disposition consistent with the child's needs.

The TSP is to be created with input from the youth and parents/guardians and signed by the youth (and parents/guardians if possible). The TSP must set goals and define services to be provided in the following areas: physical health, mental health, substance abuse, education, cognitive awareness programming, and family services. It must also detail transition services provided in each of these areas and post-discharge supervision.

[27] *Md. Courts and Judicial Proceedings Ann. §3-8A-20.1*

TSP's are developed before residential placement, but they must be forwarded to the youth's residential placement for filing in the residential case file.[28] While a youth is in placement, the Community Case Manager (who supervised the youth before placement and will likely supervise the youth after discharge) is required to visit youth monthly, and the residential Treatment Team must update the TSP at least every 90 days.[29]

There was wide variation in the use of Treatment Service Plans among the residential facilities. Most youth had a Treatment Service Plan (both a paper copy and a copy in the ASSIST Database) that had been created before the youth's disposition hearing. But each treatment facility appeared to have developed a *second* treatment service plan, referred to by a number of names (hereinafter, "Facility-Developed Treatment Service Plans"), that may or may not have taken into account the initial TSP (hereinafter, "State-Mandated Treatment Service Plan").

Staff at all facilities complained that they have very little information about youth arriving at their facilities, including incomplete treatment and placement history.

VICTOR CULLEN CENTER

Eleven randomly chosen files of currently enrolled youth were examined. All eleven files included the State-Mandated Treatment Service Plan, but 8 of the 11 State-Mandated TSP's contained very little detail. Two youth's TSP's still showed them in detention or another treatment program even though

[28] *DJS Policy CJ-2-03, Treatment Service Plans, 2003, COMAR 16.03.01.01.*

[29] *DJS Policy CJ-2-03, Treatment Service Plans, 2003, COMAR 16.03.01.01.*

they had been at Victor Cullen for several months.

Victor Cullen creates its own Facility-Developed Treatment Service Plan for each youth (called an "ITSP"). The plan is not based on the goals and services prescribed in the DJS Treatment Service Plan Policy, but rather on completion of exercises in the three Focus Areas: Skill Development, Accountability, and Community Safety. Ten of the eleven files included a Facility-Developed Treatment Service Plan. Six plans were very comprehensive; three included only partial information, and one included very little detail.

Only two of the Facility-Developed Treatment Service Plans had been signed by youth so it was difficult to determine how aware youth were of their treatment goals. No Treatment Plans had been signed by parents/guardians.

WAXTER CENTER FOR GIRLS

The files of all six youth currently enrolled at Waxter were examined.

Three of the six did not have copies of the State-Mandated Treatment Service Plan in their files. Of the three plans in youth files, none were signed and all were only partially completed. On the other hand, each girl had a comprehensive treatment plan developed by Waxter staff. All of these Facility-Based Treatment Service Plans were both signed by all relevant parties and up to date.

WILLIAM DONALD SCHAEFER HOUSE

Eight randomly chosen files of currently enrolled youth were examined. William Donald Schaefer House staff said they do not use the State-Mandated Treatment Service Plans. No files included copies of them. In addition, WDSM staff reported that they only learned how to use the ASSIST database within the past two months, so historically the staff has had no access to the electronic files for youth entering their program. Information about youth has been primarily gathered informally from others.

All youth had a Facility-Based Treatment Service Plan developed by WDSH staff. Four of the plans were signed by all relevant personnel, the youth, and his parents/guardians. Three contained some signatures, and one had not been signed. Four of the Facility-Based Treatment Plans were very incomplete and four were partially completed.

YOUTH CENTERS

GREEN RIDGE

The files of eight currently enrolled youth were randomly chosen for review. Each youth's file had a copy of the State-Mandated Treatment Service Plan although there was no indication they had been updated every 90 days as required. Two files included Facility-Developed Treatment Service Plans but the other six did not. Only one of the Facility-Developed Plans was signed, and none had been updated.

Nevertheless, all files included frequent progress notes and other reviews.

BACKBONE MOUNTAIN

Ten files were randomly chosen for review. All included the State-Mandated Treatment Service Plan. Four Plans were signed as required; the other six were either not signed or only signed by one person. Only one Plan was complete and current. The other nine included minimal information and/or had not been updated.

Five of the youth files included Facility-Developed Treatment Service Plans. The other five either did not include a plan or included only a signature page.

SAVAGE MOUNTAIN

Savage Mountain also keeps duplicate Treatment Service Plans – the State-Mandated and a Facility-Developed Plan. Staff said that many youth arrive at Savage Mountain, particularly youth from Baltimore City, with incomplete or virtually blank State-Mandated Treatment Services Plans.

Seven files of currently enrolled youth were chosen for review. Each youth's file had both a State-Mandated and a Facility-Developed Treatment Service Plan. Five out of the seven plans were partially signed; one was

signed by the Case Manager, and one included no signatures.

Five files of discharged youth were also chosen for review. Each file contained Treatment Service Plans as required. Four plans were partially signed, and one was signed only by the Case Manager Supervisor. Three of the five files included progress notes.

MEADOW MOUNTAIN

Eight youth files were reviewed. Although no files included paper copies of the State-Mandated Treatment Services Plan, staff regularly access the plans via the ASSIST database. In addition, staff develop a Facility-Based Treatment Plan within 3-5 days of each youth's admission. This plan, updated every 30 days, focuses on and tracks progress in the substance abuse treatment program. At the time of each youth's discharge, Meadow Mountain staff amend the State-Mandated Treatment Service Plan to reflect treatment, goals, and recommendations from the program. All plans were reasonably well-developed, but none included signatures by youth, parents/guardians, or Treatment Team members.

SECTION IV

VOCATIONAL PROGRAMMING

Juvenile justice professionals and advocates have long promoted youth training and employment as an alternative to incarceration and as a component of rehabilitative treatment within juvenile justice systems. "The notion of work as a way to prevent delinquency and reform juvenile offenders is close to universal."[30] In 1998, Congress passed the Workforce Investment Act that provides federal funds to the states to encourage year round jobs programming and strengthen links between workforce development and juvenile justice systems. In general, the numerous youth vocational programs around the country are designed to increase earning potential, raise self-esteem, instill a positive work ethic, bind juveniles to conventional norms, and to occupy idle time to decrease opportunities for delinquency.[31]

There is evidence of a connection among poverty, unemployment and delinquency.[32] Two of the most prominent theoretical explanations that link employment and crime are economic choice theory and control theory:

- *"Economic Choice Theory implies that individuals choose work that is more rewarding and attractive, even if that work is illegal or criminal (Ehrlich, 1973). However, education attainment plays a mitigating factor in framing that choice. In other words, if the legal labor market opportunities appear weak, a youth is less likely to make adequate investment in acquiring the human capital necessary for success in the legal labor market. Subsequently, low educational attainment puts youths at risk of frequent periods of unemployment and of achieving only low paying jobs. Consequently, bolstering vocational skills and employability theoretically provides a buffer to the draw of the illegal labor market.*

- *Control Theory posits that employment exerts social control over an individual (Gottfredson and Hirschi, 1990). On an individual level, the absence of employment leads to a breakdown of positive social bonds and increased criminal or delinquent activity. Thus, reduced future offending is not a product of an increase in employability but rather stems from an increase in opportunities for social control."*[33]

And so it seems to make sense to provide youth, especially incarcerated youth, with opportunities to learn job skills and prepare for legal employment. During the period of incarceration the youth is a captive audience and may be highly motivated to participate in such training in order to secure his release. But research on outcomes of vocational programming for delinquent youth, both inside and outside the institution, has not supported this intuition to date.

"There have been several evaluations of major youth

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[30] *Brown, D., DeJesus, E. and Schiraldi, V., Barriers and Promising Approaches to Workforce and Youth Development for Young Offenders Tool Kit, Annie E. Casey Foundation, Baltimore, Maryland, 2002.*

[31] *U.S. Dept. of Justice, OJJDP Model Programs Guide, Version 2.5, http://www.dsgonline.com/mpg2.5/mpg_index.htm*

[32] *Currie, Elliott. Crime and Punishment in America. Henry Holt, New York (1998).*

[33] *U.S. Dept. of Justice OJJDP Model Programs Guide, Version 2.5, http://www.dsgonline.com/mpg2.5/mpg_index.htm*

employment and training programs in the last decade. Bushway and Reuter (1998) reviewed the findings of 19 job training programs specifically connected to the criminal justice system. Unfortunately, most of the programs had negligible or only very modest success, suggesting that the impact of employment and vocational skills training on delinquency and protective factors is mixed."[34]

In describing programs for youth that do not work, Peter W. Greenwood notes: "[T]he largest category of ineffective strategies and programs contains those developed to work with more serious delinquent youth. It includes residential programs, boot camps, individual counseling, milieu therapy…(and) *vocational programs.* (Emphasis added).[35]

A U. S. Department of Labor report found that, "[T]he limited evaluation evidence that is available suggests that temporary employment programs without additional services bring little or no post-program benefits to disadvantaged youth."[36]

Additional services that enhance outcomes include:

- Tutoring, study skills training, dropout prevention, alternative secondary school services, activities that promote positive social behavior outside of school hours;
- Occupational skills training, summer employment opportunities linked to academic and occupational learning, paid and unpaid work, internships, job shadowing;
- Leadership development, community service, peer-centered activities;
- Supportive services; adult mentoring for at least a year; follow-up services for at least a year; comprehensive guidance counseling and drug and alcohol abuse counseling.[37]

In sum, those vocational programs that work best for seriously delinquent youth are tied to real jobs in the community, include long-term mentoring and follow-up, and focus on continuing education and skills development.

Interestingly, research supports the benefits of vocational instruction for formerly incarcerated youth once they are released into the community as long as the additional services described above are attached to the training.[38] (See Section V – Aftercare.)

DJS VOCATIONAL PROGRAMS

VICTOR CULLEN CENTER

From May 24 to July 24, a pilot Pre-Apprenticeship Program in the Skilled Construction Trades was offered to 12 Victor Cullen students. Eleven youth graduated from the program and received CPR/First Aid and OSHA Awareness certificates. The program resulted from a partnership among the Governor's Office, DJS, and the Maryland Department of Labor, Licensing and Regulation.

Youth attended three 3-hour classes per week during the 10 week program and participated in field trips to union halls and apprenticeship programs. Classes were conducted by volunteers from the Insulators Union Local 24. DJS also provided classes in

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[34] *U.S. Dept. of Justice OJJDP Model Programs Guide, Version 2.5, http://www.dsgonline.com/mpg2.5/mpg_index.htm*

[35] *Greenwood, Peter W. Changing Lives: Delinquency Prevention as Crime-Control Policy,University of Chicago Press, 2006.*

[36] *Stanley, Marcus. What's Working (And What's Not): A Summary of Research on the Economic Impacts of Employment and Training Programs. U. S. Department of Labor, Washington D.C. (1995).*

[37] *Brown, DeJesus and Schiraldi., supra.*

[38] *Bullis, M. and Yovanoff, P. "Those Who Do Not Return: Correlates of the Work and School Engagement of Formerly Incarcerated Youth Who Remain in the Community, Journal of Emotional and Behavioral Disorders, v. 10 (2), pp. 66-78 (2002)*

resume writing, work ethics and application and interviewing skills. Youth were chosen from the Victor Cullen population through an application process.

Most youth had high praise for the program, and at least one already had a job after discharge. Several youth said they would have liked more hands-on work experiences, and one staff member complained that youth were frequently observed sleeping during the vocational classes.

Unfortunately, DJS does not intend to repeat the Pre-Apprenticeship Program until 2009. The reasons for the delay have not been clearly articulated, but many youth will move through the Victor Cullen and Youth Centers programs in the coming months without having an opportunity to participate in this promising program.

WAXTER CENTER FOR GIRLS

No vocational programs are available to girls in the committed program at Waxter.

WILLIAM DONALD SCHAEFER HOUSE

No vocational programs are available to youth in the WDSH drug treatment program.

YOUTH CENTERS

BACKBONE MOUNTAIN

Backbone Mountain Youth Center has a carpentry vocational program. All 48 youth participate in the program 4-6 hours per week. The carpentry program has a defined description and curriculum. Youth receive one-half school credit for successful completion. The instructor is accredited by MSDE as an Instructional Arts teacher, and holds an Advanced Professional Certification (APC).

The carpentry program is not approved by any trade group or business association, and no vocational trade certification is awarded. There is no mechanism to assess whether learned skills transition into employment when youth leave the facility, but Aftercare Case Managers sometimes make contacts with trade schools or Job Corps.

The program and its instructor, John Martin, have become well-known throughout the system for high quality woodcraft and special projects, such as the specially designed and constructed cherry desk for Secretary DeVore, Judge Welsh's conference table and deacon benches for BCJJC. The program also provided six oak library tables and bookcases for Noyes detention center and trestle tables, chairs, and dressers for DNR cabins at New Germany State Park.

Five youth interviewed (four in the program, one discharged to the community) expressed satisfaction with the program. "It was fun" and "Mr. Martin is great" were unanimous opinions. All youth interviewed expressed a desire to learn more skills and to receive certification that could lead to employment upon release. Staff also expressed a desire to expand the program so youth can receive broader skills training and obtain skills certification.

GREEN RIDGE

Green Ridge has a carpentry vocational program. All 40 youth in the program attend carpentry 2 hours per day, 5 days per week as part of the school curriculum. Youth receive one school credit for the course. There is no defined description or curriculum for the program. The Instructor explained that he "develops projects as (he) goes." The instructor has 23 years of experience as a tradesman, but is not a certified vocational teacher.

The carpentry program is not approved by any trade group or business association, and no vocational trade certification is awarded. There is no mechanism to assess whether learned skills transition into employment when youth leave the facility. Youth indicate that they do use their experience at Green Ridge as a reference when they apply for employment.

Youth indicated a positive experience in the carpentry program. The Assistant DJS Regional Administrator stated, "[T]he vocational curriculum needs to be refined."

MEADOW MOUNTAIN

Meadow Mountain has an aquaculture vocational program. All youth at Meadow Mountain participate in the program, and each youth spends about 16 hours per month in various classroom and field activities. The program utilizes up-to-date textbooks and scientific equipment, provided in part by DNR. The instructor was a high school biology teacher for 13 years. Instruction is also provided by DNR personnel who visit 2-3 times per week. The class takes place in a large, well equipped classroom and greenhouse. Opportunities for field work are hampered by staff shortages and lack of vehicles for transportation.

The program is a research center for the Department of Natural Resources. The Instructor and students gather data for DNR, test water and assist in re-stocking streams. They are raising hybrid sunfish, rainbow trout, tilapia and brown trout. They are working to achieve a mini-fishery certificate. Certification is not yet part of the program, but the instructor is negotiating with DNR to facilitate certification. Youth have also been able to participate in river and stream clean-ups.

There is no mechanism to transition learning to employment, but the Instructor provides help with references and resumes.

Youth interviewed said they enjoy the program, but doubt it will be useful to them when they are released. One youth said,"[I]t is only useful if you have a pet; it teaches you how to take care of your pet, but will not prepare you for a job."

SAVAGE MOUNTAIN

Savage Mountain offers an Automotive Tecnology vocational program. Youth attend the Auto Tech program approximately three hours per week and receive one-half school credit. All 36 youth at Savage participate in the program. The program takes place in a building on the facility grounds, and there are two donated cars. There is no defined description or curriculum for the program. The Instructor holds an Advanced Professional Certificate in the automotive field.

The program is not approved by any trade group or business association, but youth do receive an informal certificate of completion of the program. There is no mechanism in place to assess transition of learned skills to employment.

Youth interviewed were positive about their experiences in Auto Tech but did not relate the experience to future employment. One youth found value in learning to maintain a vehicle.

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SECTION V

AFTERCARE PLANNING

Aftercare for youth in the juvenile justice system should "prepare out-of-home placed juveniles for reentry into the community by establishing the necessary collaborative arrangements with the community to ensure the delivery of prescribed services and supervision."[39]

Aftercare planning should begin when a youth is sentenced to out-of-home placement; continue during placement; and for a period after release in the youth's home community. Youth designated as at high risk of re-offending should have intensive aftercare services including family therapy and mentoring in addition to the traditional supervisory form of aftercare associated with parole officers and courts.[40]

One study found that successful aftercare programs included "trained personnel" with a "strictly adhered to" plan; frequent contact between staff and youth; cognitive and behavioral treatment in the community; and a concentration on youth at high risk of re-offending. [41]

Juvenile justice practitioners and researchers have recognized that housing youth at facilities and sending them back to their communities without "a comprehensive aftercare system … does little to correct delinquent behavior." The OJJDP supports "research-based programs" incorporating "a seamless set of systems" and "the creation of a continuum of community services" with "public-private partnerships to expand the overall capacity of youth services."[42]

The OJJDP also endorses an Intensive Aftercare Program (IAP) Model for high-risk youth based on "data-driven research," with an "overarching case management system" and "highly structured and enhanced transition from confinement to the community" encompassing "family and peer relations, education, jobs, substance abuse, mental health, and recidivism" and a focus on youth thinking, behavior, and relationships."[43]

The agency details "five elements" of a case management system geared to deliver the IAP model:

1. A focus on high-risk youth through the utilization of a validated tool to assess youth risk of re-offense;

2. Individualized case management incorporating family and community perspectives;

3. A mix of intensive surveillance and services;

4. A balance of graduated incentives and consequences; and

5. Links with community resources and social networks.[44]

AFTERCARE THAT WORKS

In an effort to cut down on the percentage of youth re-offending in Washington State and finding no established pre-existing aftercare program incorporating evidence-based practices, the Washington State Legislature

[39] *U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP),Juvenile Justice Bulletin, September, 2003.*

[40] *Ibid.*

[41] *Andrews et al, Criminology, 28(3): 369-404 (1990); Sherman et al, Preventing Crime, Report to U.S. Congress (1997).*

[42] *OJJDP, supra.*

[43] *Ibid.*

[44] *Ibid.*

underwrote a pilot program called Family Integrated Transitions (FIT) in 2000. FIT aimed to rehabilitate youth at high risk of re-offending after release because of co-existing addiction and mental health conditions. The program begins during the last two months youth are in a facility and continues from 4 to 6 months after release into the community while youth are on parole.

In December 2004, independent program evaluators at the Washington State Institute for Public Policy (WSIPP) found that FIT works to reduce youth involvement in felony offenses by one-third during the 18-month period following release. The WSIPP program evaluators described FIT as an "intensive family-based and community based treatment targeted at the multiple determinants of serious anti-social behavior." The WSIPP study of FIT included a cost/benefit calculation estimating the program saves taxpayers over 3 dollars for each dollar spent on youth by cutting costs associated with incarceration and victimization.[45]

FIT combines family involvement in youth treatment with elements of evidence-based programs within a core framework derived from Multi-Systemic Therapy, "an empirically validated, cost-effective, and intensive family preservation model of community-based treatment that addresses anti-social behavior in juvenile offenders." [46]

After prioritizing the engagement of families to help in treating youth, FIT works with youth and family to "promote behavioral change in the youth's home environment, emphasizing the systemic strengths of family, peers, school, and neighborhoods to facilitate change." FIT therapists are available at all times and answerable to youth families who report on their performance – the therapists carry small caseloads of four to six families and work with case managers in both the community and facility. As reported in 2007, the FIT program continues to serve Washington State youth at a rate of approximately 80 youths each year.[47]

AFTERCARE THAT DOES NOT WORK

According to OJJDP, the traditional approach to aftercare, which involves supervision after release, and where youth are "sometimes provided with services," has not proved effective. OJJDP promotes aftercare programs incorporating:

- Both supervision and services;
- Planning and service delivery while youth are institutionalized, during transition and after release.

A study of a Pennsylvania aftercare program which combined treatment and supervision found that that youth in the program had "significantly fewer re-arrests" than those in a control group.[48]

The provision of intensive aftercare services and supervision can be well designed in theory but delivery of services must be assured by those charged with putting a promising model into practice. The risk of failure is illustrated by the provision of a grant-funded aftercare program designed to help Baltimore City youth in the mid-1990s. Evaluators found serious shortcomings in the delivery of the family therapy, psychological assessments and individual counseling that were part of the design of the program. Youth had far fewer contacts than planned with program staff, seeing staff an average of once-a-week instead of on a daily basis. By the end of the program, 36 youth remained of the 162 youths who started the program. The researchers evaluating the program concluded that "aftercare services of the quality and intensity delivered in the (Baltimore) program were not beneficial."[49]

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[45] *Washington State's Family Integrated Transitions Program for Juvenile Offenders: Outcome Evaluation and Benefit–Cost Analysis. Washington State Institute for Public Policy, 2004.*

[46] *Ibid.*

[47] *Overview: Family Integrated Transitions Program, Washington State Juvenile Rehabilitation Administration, 2007.*

[48] *OJJDP Bulletin, supra.*

[49] *OJJDP Bulletin, supra.*

MARYLAND AFTERCARE POLICIES

Legislation enacted in 2004 requires that all Maryland youth discharged from residential placement receive an aftercare plan designed to help reintegration in the home community and to help prevent youth from re-offending.[50] Step-down aftercare plans must incorporate programming that provides education and rehabilitation and services and treatment to ease the transition of children from…custody…to their homes and communities.[51]

In 2003, DJS adopted a formal strategy on aftercare. The policy requires that each youth's Treatment Service Plan include specific aftercare planning and that aftercare planning should begin upon admission to a residential facility, if not before.

Once discharged, the policy requires youth to have daily contact with the Community Case Manager for the first month and to be referred to services and programs in the community, including tutoring, substance abuse or mental health programs, family therapy, and educational or community service opportunities. In the second phase of aftercare, Community Case Manager contacts decrease to five per week, but youth must be in school, working, or in vocational training.

The policy includes a comprehensive list of graduated sanctions and rewards for behavior during aftercare. Maryland policy also includes specific Intensive Aftercare requirements for youth considered to be at high risk of re-offending.[52]

[50] *Md. Human Services Code Ann. §9-240.*

[51] *Ibid*

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[52] Md. Dept. of Juvenile Services, Aftercare Strategy, 2003. http://www.djs.state.md.us/pdf/aftercareplan09-01-03.pdf. Also see DJS Policy CJ-1-03, Aftercare Policy, 2003.

MARYLAND AFTERCARE PLANNING

Maryland's aftercare policies and procedures are comprehensive, clear, and robust. The problem appears to be in the implementation of the programs. Although not a scientific sampling, our interviews with youth both pre- and post-discharge indicated that frequency and quality of Community Case Manager contact with the youth and family differs markedly depending on the individual Community Case Manager.

It also appeared that quality of aftercare planning during a youth's residential placement differed markedly – with some programs doing little aftercare planning and others beginning aftercare planning immediately upon admission.

In addition, the paucity of strong programs in the community make directing youth to aftercare programs almost impossible. One recommendation would be to expand either Multi-Systemic Therapy (MST) or Functional Family Therapy (FFT), both evidence-based practices, to youth and families during reentry. DJS has already expanded the number of MST and FFT slots – currently over 550 FFT and MST slots exist statewide. Although limited additional slots may be available through other agencies, all of DJS' MST and FFT funding is directed to adjudicated youth who might be diverted from residential placement with these therapeutic interventions.

It may take some time to implement, but we strongly recommend that the Department begin offering MST and FFT to youth during reentry to decrease their risk for re-offending. Particularly for discharged Victor Cullen youth, a small number, it would be helpful to see whether evidence-based practices during aftercare would improve current recidivism rates.

Alternatively, Maryland could begin implementing the Washington State Family Integrated Transitions (FIT) program, another evidence-based program designed specifically for youth in aftercare.

Baltimore-based Advocates for Children and Youth published a fact sheet in May 2008, quoting youth about to be released from out-

of-home placements in Maryland "who had no indication of their aftercare plans." The writers also claimed that evidence-based practices are in critically short supply in Maryland.[53] Even if implementation of these services requires an increase in funding, multiple studies have shown they are worth the investment. MST and FFT can reduce recidivism between 25-70% and 25-60% respectively.[54] And as mentioned above, Washington State's FIT program is saving taxpayers over 3 dollars for each dollar spent on aftercare youth by reducing crime and future incarceration.[55]

AFTERCARE PLANNING IN INDIVIDUAL FACILITIES

"Some kids hardly ever see their Community Case Managers – it's 'out of sight, out of mind' …But some Community Case Managers are very good. One Case Manager comes all the way from the Eastern Shore and regularly sees his kids. If he can do it, why can't they make it from Baltimore City and other places much closer to here?"

- Residential Facility Staff

We examined the files of discharged youth to determine how much aftercare planning occurred during their residential placement and how fully they were prepared for release. Unfortunately, most files contained little aftercare planning information. It may be that most, if not all, aftercare planning information is kept in the Community Case Manager's file (in the community rather than in the facility), but the Monitor's office was not granted access to paper files of Community Case Managers so we were not able to draw a conclusion.

Although not a scientific sampling, we interviewed youth who had been discharged about aftercare planning and follow-up, and their comments were illuminating. And the fact that facility records include few, if any, notes on aftercare planning raises questions about how much serious planning for the future occurs while youth are in placement

VICTOR CULLEN CENTER

Ten randomly-chosen files of discharged youth at Victor Cullen were examined. Five included some evidence of aftercare or transition planning. The remaining 5 files showed no evidence of aftercare or transition planning prior to the youth's release or transfer.

None of the files included notations on youth's medical needs post-release, particularly drug prescriptions, and no files revealed the planned frequency of contact with Community Case Managers.

One file did show that one youth was assigned a family intervention specialist to provide assistance following his release.

Two youth interviewed at the facility indicated that staff was helping them to prepare for release, but they were not aware of what their Community Case Managers were doing and whether any community transition plan was being prepared.

Three youth already discharged were interviewed regarding aftercare subsequent to their release. These youth indicated that some staff assisted them to make community connections before they were released, but the efforts were inconsistent. One youth who is working as a baker found a job on his own. He said, "It would be nice if DJS set up guys for jobs when they leave." Another youth, who found his own job as a dishwasher by applying for jobs when he was on home passes, said "My last couple of weeks were

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[53] *Advocates for Children and Youth report "12 spots for MST in Frederick County" and "12 spots for FFT in Montgomery County," a "pattern [which] holds across the other regions [of Maryland]." (Maryland Deviates from Best Practice in Juvenile Justice Reform, Issue Brief, Vol.5, No. 19)*

[54] *Md. Dept. of Juvenile Services, Press Release, June 12, 2008.*

[55] *Washington State's Family Integrated Transitions Program for Juvenile Offenders: Outcome Evaluation and Benefit–Cost Analysis. Washington State Institute for Public Policy, 2004.*

confusing. I didn't know when I was getting out."

Youth M.D. and his mother stated that they were not satisfied with the aftercare program because the youth was never connected to any GED programs or jobs in the community. M.D.'s mother stated that she attempted to talk to staff about aftercare planning on numerous occasions but could not get a response. This youth calls his Community Case Manager almost every day, but she does not initiate contact with him, and does not visit regularly. His mother added, "DJS did not do anything; it seems like they want him to fail."

The program sold me dreams; but they never set me up with any GED classes or jobs."

-- K.R., Youth recently discharged from Victor Cullen Center

W.R.'s mother was interviewed. W.R. is in adult jail on a handgun charge. She stated that R.W. obtained his diploma and was accepted at Baltimore City Community College prior to his release from Victor Cullen. But when he came home wrap-around services were not set up as promised. Three different Community Case Managers were assigned, and it was difficult to determine what he was supposed to be doing. By the time services were implemented, W.R. had been re-arrested.

WAXTER CENTER FOR GIRLS

A review of 11 randomly selected files of discharged youth at Waxter revealed some aftercare planning in the Facility-Based Treatment plans of all discharged youth. No files were complete, and none included medical or prescription transition plans. No files indicated planned frequency of contact with Community Case Managers, but all 11 files included progress notes added during the youth's stay at Waxter.

Waxter staff members indicate that aftercare planning begins when girls enter the program. A Treatment Team meets for each girl every thirty days, and aftercare planning is a part of the responsibility of the treatment team. Each girl has a discharge summary. The Treatment Team makes recommendations to the Community Case Manager who then makes appointments and other arrangements for the youth.

Six of the seven youth interviewed at the facility indicated that although they planned to go to work or school or both, they had not applied for work and did not know where they would be going to school. They indicated they needed more assistance to prepare for their transition to the community.

WILLIAM DONALD SCHAEFER HOUSE

A discharge summary is prepared for each youth before release. These summaries are very complete, and include recommendations for the Community Case Manager. There is a separate educational discharge summary, a medical/dental discharge summary, and a mental health discharge summary.

Review of 5 randomly-selected files of discharged youth revealed extensive discharge planning and recommendations in all 5 files. All the files appeared to be quite complete and included medical and education transition planning. No files indicated the planned frequency of contact with Community Case Managers. All five files contained extensive progress notes.

Interviews of 4 youth at the facility indicated that all were in contact with the individual who would be their Community Case Manager upon release, and all could describe what the Community Case Manager was doing to prepare for the transition. Such activities include setting up job interviews, making arrangements for school re-entry, and making arrangements for GED testing.

One youth (H.D.) who had been released from WDSH was interviewed. He had been re-arrested and was in detention at Hickey. H.D. said the program at WDSH was good, the youth were cooperative and engaged, and they took the program seriously. The employees really made an effort to help the youth. But the program did not help him. H.D. was assigned to intensive aftercare, he had two caseworkers who visited him, and he was assigned to go to NA meetings. His

caseworkers visited him unannounced and would come at all times of the day or night to check on him. He was required to give random urine samples, attend substance abuse and family counseling. He felt the aftercare program was a good one but he was not willing to give up smoking marijuana.

The WDSH Director said that expanded community services would be necessary for youth to be more successful upon release. He recommended supportive mentoring services and vocational placement and training, facilitated by Community Case Managers.

> *"The staff spend a lot of time providing structure for the youth, but no one follows up on them once they are released back into the communities."*
>
> *-- DJS Facility Case Manager*

YOUTH CENTERS

BACKBONE MOUNTAIN YOUTH CENTER

Review of 5 randomly-selected files indicated discharge and transition planning in all 5 files. The files appeared to be very complete, even though none indicated transition plans for medical prescriptions or appointments. No files contained notations on frequency of planned contact with Community Case Managers. All 5 files contained progress notes.

Two youths were interviewed after their release from Backbone Mountain. Both youngsters were very satisfied with the aftercare planning and follow-up services they received. Both are visited regularly by their Community Case Managers. Both also participated in planning their transition after completing the program. One youth interviewed is attending college

GREEN RIDGE YOUTH CENTER

Of 5 randomly-selected files of discharged youth reviewed, 4 files indicated aftercare or transition planning. Four files appeared to be fairly complete, but only 1 file revealed evidence of medical transition planning, including prescriptions. One file included evidence of frequency of planned contact with Community Case Managers. All five files contained progress notes.

Two youths who had been released from Green Ridge were interviewed. Both youth were satisfied with the aftercare services provided to them. One youth said he met with staff three times before he left the facility to discuss future plans. Another youth said. "They try to set up too much stuff." This youth has a full time job that was set up by his drug and alcohol counselor and coordinated by his mother. His Community Case Manager sees him once per week.

> *"My Community Case Manager calls every other day and visits me four times a week. He helped set up my GED exam and is helping me with college applications."*
>
> *-- C.V., Youth recently discharged from Green Ridge Youth Center*

MEADOW MOUNTAIN YOUTH CENTER

Meadow Mountain counselors indicate that there is an aftercare plan for each youth, and that the plan is part of the Treatment Services Plan. Aftercare planning begins when youth enter group 4, which is around 6 months after they enter the program. Youth are connected to mental health and substance abuse services in the community. Sometimes arrangements are made by facilities counselors, sometimes by community case managers and sometimes they work hand in hand.

Administrators indicated they believe youth need more follow-up and support when they are released to the community. Youth indicated that they are satisfied with aftercare planning and that they know who their

community case managers will be when they are released.

SAVAGE MOUNTAIN YOUTH CENTER

An aftercare plan is prepared for each youth at Savage Mountain after the youth has been in the program about 5 weeks. The aftercare planning team includes the youth, the Facility Case Manager, the Substance Abuse Counselor, the Community Case Manager, and the family. The Community Case Manager connects youth to recommended services in the community. All appointments are made for youth before they leave the facility. The Community Case Manager is expected to undertake follow-up communication and verification.

Youth interviewed at the facility indicated they were aware of their aftercare plans. One youth was concerned that he had not heard from his Community Case Manager even though he was very close to release. Another youth indicated that he had been in contact with his Community Case Manager, and was receiving assistance from staff at the facility.

Three youths were interviewed after their release from Savage Mountain. Two of the three were satisfied with after care services. S.M. said, "Each youth must spend time formulating their own aftercare plans, and then bring it to their counselors for approval." He added that, "Ms. F. said my plan was the best she had seen in a long time. I made sure my answers were detailed." S.M. is currently employed as a busboy and dishwasher, and he will be returning to high school in the fall. R.A. had no complaints, but said he was self-sufficient – he has valuable skills as a cook and knew he would have a job when he left Savage Mountain. He felt he needed very little aftercare planning.

However, J.M. says his mother has done virtually all of his aftercare planning. He has not had a consistent Community Case Manager with whom to develop a relationship. He is in GED classes, and said he wished DJS would help youth find a job faster.

"We should hold parents accountable. The kids often come from nothing and we send them back to nothing. Maybe as part of aftercare, have the parents be involved in treatment. Make them part of what the kid does. Get them all in here, get them all talking, and work on the problems with the parents and the kids together."

-- Youth Center Staff Member

FINAL THOUGHTS

Simply put, Maryland does not have the number of effective programs, either residential or community-based, to meet youth needs. The State needs a full continuum of effective evidence-based services to meet the needs of youth at every level and every stage who make contact with the juvenile system. Evidence-based programs are being expanded for youth in their community. Now serious thought must be given to implementing research-proven strategies to rehabilitate youth in residential placements and during aftercare.

As the State begins implementing evidence-based treatment models, sufficient numbers of qualified staff will be critical to the consistent and skillful implementation of the programs. While the Department has increased pay scales for facility staff, ultimately the youth services workforce must be professionalized. Over time, college degrees should be required, or at least strongly preferred, for direct care staff, and tuition reimbursement programs and other incentives offered to enable staff to continue their educations. All States that have made large strides recently in improving youth outcomes now employ substantial percentages of direct care staff with college degrees.

Family involvement is also crucial to helping youth make positive changes. Families often need significant intervention and cannot be left out of the equation. Family therapy is always a part of recovery, regardless of the setting. As a youth sits in therapeutic group, his family sits beside him unseen. Failure to grasp this truth and make therapeutic use of it leads to missed opportunities.

Finally, creative community-based alternatives to traditional post-release probation supervision need to be offered.

Checking in with a probation officer, even on a daily basis, does little to integrate learning that occurred in the residential program and does nothing to connect youth to jobs, schooling, and other supports they need in the community. As we prepared this report, youth and staff told us over and over again that youth need to return to their communities with detailed aftercare plans and multiple supports in place.

This Administration has worked with great dedication to turn around a situation that was many years in the making. It is a gargantuan task. While more beds are needed to treat Maryland's delinquent youth in-state, development of new facilities should be a thoughtful, deliberate process, based on existing research.

We do youth and their families no favor by treating them in-state with treatment programs or aftercare with little record of improving youth outcomes. We do the public no favor by returning youth to their communities to re-offend. Models to improve youth outcomes exist, and they should be at the center of the Maryland Model.

Recommendations relating to this report appear in the next section. Some of these recommendations (such as implementation of basic evidence-based treatment models) should be implemented immediately, and others will take longer. More ambitious programming improvements such as enhanced aftercare could begin as pilot programs for specific youth (e.g., Region III or youth released from Victor Cullen) and be expanded from there.

RECOMMENDATIONS

Short-Term

1. Publicly release recidivism data by individual facility/program to determine which programs are working to improve youth outcomes.

2. Begin immediate investigation of the high repeat offending rates for youth completing the Victor Cullen program.

3. Make appropriate adjustments to the therapeutic program or aftercare for Victor Cullen youth to improve outcomes. These adjustments should include consideration of a new evidence-based treatment model.

4. Fully implement an evidence-based treatment program specifically designed for girls at the Waxter Center.

5. Ensure that Waxter staff adheres to a regular treatment program schedule.

6. Provide additional staff training and/or hire additional credentialed staff at Waxter to ensure that group and program meetings are meaningful and that the treatment model is fully and appropriately implemented.

7. Implement an evidence-based substance abuse treatment model at William Donald Schaefer House.

8. Fully involve Community Case Managers in all phases of residential treatment to begin developing aftercare strategies. Require Community Case Managers to attend all Residential Team Meetings.

9. Ensure that no youth leave residential placement without a clear aftercare plan, including scheduled medical and therapeutic visits, school transition plans, and jobs, where appropriate.

10. Begin offering MST, FFT, or FIT as part of aftercare to enhance both youth and families' ability to navigate transition and community reintegration. Start with a pilot project for Victor Cullen youth to provide more data on program outcomes.

Long-Term

1. Track other outcomes and indicators of youth success such as high school graduation and employment rates post-release.

2. Systematize the development and implementation of Treatment Service Plans among all treatment facilities.

3. Devise a method of integrating the best parts of the State-Mandated and Facility-Developed Treatment Plans to reduce confusion and duplication of effort.

4. Develop a method of updating and storing Treatment Service Plans electronically so that treatment professionals at all points of youth contact with the system have access to full information on the youth's history and past treatment.

5. Significantly increase family involvement in residential treatment and aftercare. Community Case Managers should drive families to Treatment Team or family therapy sessions, or some meetings should

be scheduled in the community, possibly during youth home visits.

6. Expand aftercare programming options – open Day Treatment Centers, intensive vocational or apprenticeship programs, and the like.

7. Provide transitional quasi-independent living opportunities for youth who cannot return to their homes after discharge.

8. Measure the success of the Victor Cullen Pre-Apprenticeship Program, make appropriate adjustments, and expand to other residential programs. Ensure that all vocational training is tied to youth certification, real jobs and ongoing job support in the community.

9. Develop vocational programs at William Donald Schaefer House and the Waxter Center.

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Department of Juvenile Services (DJS)
Response to Juvenile Justice Monitoring Unit (JJMU)
Second Quarter Report 2008 Sections I - V

DJS welcomes the opportunity for dialogue concerning effective youth rehabilitation systems and strategies, and appreciates the Juvenile Justice Monitoring Unit's recognition of the success of the Department's many reform initiatives under Secretary DeVore's leadership. The JJMU Second Quarter 2008 Report ("JJMU Report") outlines concepts that have been widely recognized and reported in the national research literature on effective approaches to treatment services for delinquent youth.

However, the JJMU Report misstates and misses important aspects of the bigger picture of system reform in which the Department has been actively engaged. While the JJMU is correct that the Department focused intensively on improving conditions and services in its residential detention facilities during the past year, the JJMU Report falls significantly short of its stated goal "to enhance knowledge among decision makers about what works to rehabilitate youth in residential programs and what services Maryland programs offer today" (JJMU Report, p. 4) because it does not identify the Department's *simultaneous* implementation of substantial reforms of treatment services that are the subject of the Report. Many conclusions in the JJMU Report are also unfounded because they are based on incomplete, inaccurate and unreliable information.

To inform dialogue about what works in youth rehabilitation and juvenile justice, the Department's response clarifies and more completely and accurately describes the Maryland Model, including the implementation of Evidence-Based Programs for youth in residential treatment programs and in the community during the past year. Moreover, to an unprecedented degree, the Department has partnered with other child-serving agencies in local and State government, law enforcement, the judiciary and community stakeholders in advancing these reforms.

DJS Response to Section I – Recidivism

The JJMU Report does not accurately interpret and compare Maryland recidivism rates:

Maryland has a lower rate of recidivism if defined according to Missouri's more restrictive definition

The JJMU Report identifies the complexities involved in defining, comparing and interpreting juvenile recidivism rates – but then utilizes the same "apples-to-oranges" reasoning that the research literature cautions against to reach conclusions about recidivism rates in Maryland.

Recidivism is defined and measured differently across states. The broadest definition of recidivism is re-arrest, which also generally yields the highest rates. Even the definition of re-arrest varies along a continuum from least to most restrictive: DJS defines re-arrest very broadly to include any arrest, juvenile or adult, regardless of whether the charges were sustained or a new placement occurred as a result. To provide the most complete picture, DJS also reports a wide range of outcomes at one, two, and three year follow up periods, into the juvenile and adult systems and at the three standard levels of re-arrest, re-adjudication or adult conviction, and re-commitment or adult incarceration.

While the JJMU characterize Maryland's recidivism as "high" and suggest that Missouri's recidivism is lower, Maryland certainly has at least a comparable recidivism rate and it could very well be that Maryland has a *lower* rate of recidivism if defined according to Missouri's more restrictive definition. Missouri reports a 7 percent recidivism rate that includes only juvenile-level re-commitment; when "revocations" (youth re-committed while on aftercare with no additional court action) are factored in, the recidivism rate increases to 15 percent. Recalculating the Maryland recidivism rate according to the Missouri definition of recidivism, the comparable rate for Maryland youth was only 7.7 % after one year and 12% after two years.

Like Maryland, Virginia uses a broad definition of recidivism. The Virginia combined juvenile and adult re-arrest rate after three years was 79.1% for youth released in FY 2004. The comparable Maryland rate is 71.8%.[1] Both states follow youth released from juvenile committed out-of-home placements for three years, tracking juvenile and adult arrests.[2]

[1] Maryland Annual Statistical Report, available at www.djs.state.md.us/Publications.
[2] Virginia Department of Juvenile Justice Data Resource Guide, 2007: http://www.djj.virginia.gov/About_Us/Administrative_Units/Research_and_Evaluation_Unit/pdf/Reoffense.pdf, and Virginia Department of Juvenile Justice, Juvenile Recidivism in Virginia, DJJ Research Quarterly, April, 2005.

In summary, the JJMU Report presents an incomplete picture of recidivism and its utility for determining program efficacy. More troubling, the JJMU Report bases sweeping conclusions about the effectiveness of treatment models on re-arrest rates for a very small number of youth (e.g., eight girls released from Waxter in all of FY 08). This is far outside any standard and reliable research protocol.

The JJMU Report is misleading with respect to recidivism rates for Victor Cullen and the Waxter Center:

The JJMU utilizes its calculation of the Victor Cullen recidivism rate - although it represents only one aspect of a broader and more complex issue, and is at present available for only a very small number of youth over a limited period of time - to make a sweeping conclusion that the Victor Cullen program has not been effective and that its "entire therapeutic program model" (JJMU Report, p. 13) may need to be changed. Basing conclusions about the efficacy of juvenile treatment programs in this way is totally unsupported by accepted research methodologies and by expert practitioners in the field.

The JJMU Report utilizes re-arrest as the only measure of recidivism for Victor Cullen and calculates that 29 percent of youth were re-arrested post-release – but because the JJMU uses a small sample, this percentage actually represents four youth.

In line with its emphasis on transparency and accountability, DJS publicly reports a wide range of recidivism measures.

Using Missouri's calculation method, Victor Cullen's recidivism rate would be just 4 percent. In other words, of 28 youth who completed the program and were released in the 13-month period from July 1, 2008, when Victor Cullen opened, to August 27, 2008, one youth has been re-committed to a juvenile facility.

Of a total of seven youth released from Waxter in FY 08, the JJMU report that three youth were re-referred, but they do not indicate that only one youth has been re-adjudicated and none has been re-committed.

The JJMU Report incorrectly identifies the type of recidivism data that DJS regularly measures, tracks and reports:

DJS is a data-driven and transparent agency. In line with its emphasis on transparency and public accountability, DJS publicly reports a wide range of recidivism measures in *Annual Statistical Reports*.[3] Similarly, the current and

[3] See www.djs.state.md.us/Publications.

previous JJMU Reports have relied nearly exclusively on data collected and provided by DJS.

DJS publishes recidivism rates by program type including Group Home, Residential Treatment Center, and Youth Centers, in our Annual Statistical Report. DJS does not publish recidivism rates for each program due to methodological limitations – for many programs the number of youth is statistically small, and youth are sometimes served by multiple programs - but contrary to the JJMU's assertion, data for all the programs are used internally for program evaluation and shared with the individual programs.

DJS has collected and analyzed preliminary recidivism data for Victor Cullen, and Victor Cullen youth that have been out of the program for at least a year will be represented in the standard annual recidivism study for FY 2007 which will be completed at the end of this calendar year.

DJS Response – Section II Therapeutic and Rehabilitative Programming

***The JJMU Report does not accurately describe the Maryland Model*:**

The Maryland Model focuses on increasing public safety through the rehabilitation of youth. At its core, the Maryland Model provides services to youth in the least restrictive settings closer to their home. The Maryland Model promotes objective decision-making based on scientific and validated assessment instruments to prevent re-offending and to match youth with appropriate services in order to create an effective and responsive service delivery system. In order to articulate and implement the Maryland Model, the Department is focused on the development of professional staff, the utilization of best practices and quality assurance processes, and the reliance on strong collaboration with law enforcement, courts, service providers, child serving agencies and community stakeholders.

The Maryland Model is a regionalized service delivery model, with an emphasis on evidence-based practices and community collaboration, validated assessment and treatment tools, treatment, and successful reentry for youth requiring residential care.

To ensure the implementation of the Maryland Model, DJS has taken steps to build in-state treatment capacity, increase community-based services, strengthen interagency collaboration, recruit and train professional staff, implement national best practices, and increase agency accountability through a quality assurance process.

The following overarching goals are associated with achieving the objectives of the Maryland Model:

- **Treating Maryland's Youth in Maryland;**

- **Improving Conditions of Confinement at all DJS Facilities;**
- **Achieving Better Outcomes for Youth and Families by Becoming a More Data and Results Driven Agency;**
- **Reducing the Number of Homicides and Non-Fatal Shootings of Youth under DJS Supervision; and**
- **Aligning Organizational Development with Strategic Planning.**

The Department has reorganized its previous five service areas into six new regions to better coordinate with local public safety, city and county agencies, as well as community-based providers, including those who will be providing expanded evidence-based services and programs. Currently, detention centers predominantly serve youth by geographic area. Regional reconfiguration will not change the areas served by the existing and proposed replacement detention centers. The newly configured regions are as follows:

Baltimore Region:	**Baltimore City**
Central Region:	**Baltimore, Carroll, Harford & Howard Counties**
Western Region:	**Allegany, Frederick, Garrett & Washington Counties**
Eastern Region:	**Eastern Shore & Cecil County**
Southern Region:	**Anne Arundel, Calvert, Charles & St. Mary's Counties**
Metro Region:	**Montgomery & Prince George's Counties**

DJS is structuring a cooperative, unified and efficient service delivery and administrative infrastructure. To integrate the facilities into the regional structure, Superintendents will report to Regional Directors. Program services (Behavioral Health, Medical and Education), as well as support services (Finance, Human Resources, IT, Procurement, and Maintenance and Training) will be decentralized with key support staff embedded in the regions, but reporting centrally to Headquarters. The Regional Directors will maintain oversight of intake, probation and aftercare, and will assume oversight of community detention. The DJS Headquarters in Baltimore will continue to provide oversight to ensure compliance to policy, procedure and law, and ensure quality services.

One of the overarching goals of the Department is to serve Maryland youth in Maryland. This means that youth who have been served historically in the out-of-state programs would be served in new in-state programs. With the construction of two new secure treatment centers to house male youth, one 48-bed center at Cheltenham and one 48-bed center in Baltimore City, and the existing 48 beds at Victor Cullen, the Department will have a capacity of 144 beds for the most challenging segment of its population and improve its ability to serve Maryland's youth in Maryland and to further reduce the Pending Placement average length of stay.

DJS uses a continuum of community-based services, treatment, and placements for delinquent youth in their communities or out-of-home. Traditional community-based programs include probation, home detention and monitoring, court-ordered

community services, victim restitution and counseling. These options are now augmented with the use of innovative Evidenced-Based Programs (EBP), to include Functional Family Therapy (FFT), Multi-Systemic Therapy (MST), and Multi-Dimensional Treatment Foster Care (MTFC).

DJS has nearly tripled our funded slots for Evidence-Based Practices

Secretary DeVore committed to the significant expansion and utilization of Evidence Based Practices (EBP) throughout the State, an essential underpinning to the full implementation of the Maryland Model. Under Secretary DeVore's leadership, DJS has nearly tripled our funded slots for EBP – increasing from 107 slots when he arrived to 297 funded MST and FFT slots. In 2009, Maryland will have its first funded Multi Dimensional Treatment Foster Care beds. In addition to dramatically improving access to EBP, the Children's Cabinet approved funding for the Maryland Child and Adolescent Mental Health Institute to monitor the State's creation, implementation and utilization of EBP. DJS is working with the University of Maryland to ensure fidelity to the EBP models.

In addition, Maryland became the first State to become a member to the Association of the Advancement of Evidence Based Practices (see www.aaebp.org).[4] In September 2008, Secretary DeVore will be a featured speaker at the Association's national conference that will focus on the implementation and utilization of EBP. In recognition of the important work he has undertaken in this area, the Association will present a Leadership Award to the Secretary at the conference.

The Department is completing development of the Maryland Comprehensive Assessment and Service Planning (MCASP) process. This is an innovative objective risk and needs assessment process that will be conducted throughout a youth's involvement with DJS and includes ongoing assessment to guide treatment and placement decisions and services. MCASP will produce a score that places the youth into a risk level. The risk levels vary from low- to high-risk. The risk level will primarily be used for placement into the different levels of care that include community services, foster care, residential programs, or secure care.

The MCASP will include the ten major domains known through research and practice to be related to juvenile delinquency and continued re-offending: 1) Criminal History; 2) School; 3) Use of Free Time; 4) Employment; 5) Relationships; 6) Family; 7) Alcohol and Drugs; 8) Mental Health; 9) Attitudes/Behaviors and 10) Skills. The new classification model begins with nonresidential placement alternatives and ends with secure residential programs.

As a result of standardized and accurate risk assessments and an emphasis on placing youth in appropriate settings, a treatment plan will be generated that

[4] The Executive Director of the Association for the Advancement of Evidence Based Practices is Dr. Peter Greenwood, whose seminal work in this field is cited in the JJMU Report.

targets risk and criminogenic need areas so that youth will be matched to placements within the State based on public safety considerations and their treatment needs.

The MCASP model of integrated assessment and client case planning uses an evidence-based approach to service planning and management. The model is based on current research about the causes of and effective treatments for delinquency and recidivism. The Department has engaged national experts on integrated assessment systems in juvenile justice for consultation and technical assistance in this major undertaking. The Department is fully automating the MCASP process to support seamless electronic data exchange, communication, and production of treatment service plans throughout youths' residential placement and aftercare.

DJS also is implementing enhancements to its core programming for youth. Youth admitted to DJS treatment facilities will participate in the core programming while receiving individualized services based upon needs identified through assessment and service planning. All new treatment facilities will include the capacity to provide programming that will address the needs of the youth at any given point in the continuum. The program model is as follows:

- **EQUIP**
- **Seven Challenges**
- **Cognitive Behavioral Therapy**
- **Individual and Family Counseling**
- **Specialized Clinical Groups**
- **Educational Services**
- **Vocational/Career Preparation and Training**
- **Restorative Justice Activities**
- **Structured Recreation**
- **Transition Planning and Services**
- **Outcome Measures**

***The JJMU Report does not accurately describe the similarities between the Maryland and Missouri models*:**

The Maryland Model is similar to Missouri's framework in that we utilize small group homes in residential neighborhoods to serve moderate-risk offenders. We have four Youth Centers that provide structure and supervision in a wilderness setting. In addition, we currently have one 48-bed hardware secure program (Victor Cullen) and we have engaged very actively in planning to build additional treatment facilities. Missouri incorporates a variety of practices in its residential treatment model including peer group approaches, and the Maryland Model incorporates the use of EQUIP, which has a Positive Peer Culture component.[5]

[5] The Department consults with the former Director of the Missouri Department of Youth Services who spearheaded many of the well-regarded reform initiatives.

***<u>The JJMU Report does not accurately describe EQUIP, the treatment model used at the Victor Cullen Center, Waxter Center, the Youth Centers and Schaefer House</u>*:**

The JJMU Report reflects a lack of understanding of the EQUIP treatment model. EQUIP assimilates the social skills training, anger management, and moral education components of Aggression Replacement Training (ART) into a modified Positive Peer Culture program.[6] In other words, EQUIP is PPC plus ART.[7] ART is identified as an effective practice by the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Washington State Institute for Public Policy. EQUIP is also included in the Handbook of Adolescent Behavioral Problems: Evidence-based Approaches to Prevention and Treatment (2005). All facilities that have been trained in the EQUP model are currently using ART. The EQUIP approach includes training in moral judgment, anger management, correction of thinking errors and pro-social skills.

Youth involved in the EQUIP training program participate in two types of group sessions - Equipment Meetings (in which the leader teaches specific skills) and Mutual Help Meetings (in which the leader coaches students as they use the skills they've learned to help each other). Contrary to the JJMU's assertion that only three weekly treatment group meetings are held, Victor Cullen conducts five treatment group meetings weekly in accordance with the requirements of the EQUIP model and the recommendations of its developers to hold a mix of mutual self-help meetings (PPC/Positive Peer Culture) and skills-based meetings (ART/Anger Replacement Therapy). A mix of three PPC and two ART meetings weekly is fully in line with the model.

Victor Cullen phased in and strengthened implementation of the EQUIP treatment model in its first months of operation, while continuing to hire and train direct care staff and clinicians and to increase the youth population served in the facility. The treatment model has been fully implemented.

The JJMU Report also inaccurately characterizes the status of the treatment model and services provided for youth at Waxter. Waxter currently uses elements of Positive Peer Culture, EQUIP and Growing Girls for Greatness models while transitioning fully to use of Growing Girls for Greatness. This period of transition may account for the JJMU's conclusion that the program lacks a coherent treatment model and the variability of responses by some staff to the JJMU's questions about the treatment model.

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[6] The Department has consulted with Larry Brendtro, one of the developers of Positive Peer Culture, about the model and related staff training.

[7] *The EQUIP program: Teaching youth to think and act responsibly through a peer helping approach*, Gibbs, J., Potter, G., & Goldstein, A. P. (1995).

The Department has engaged a national expert to assist implementation of Growing Girls for Greatness, a specialized model focused on effective gender responsive practices in juvenile facilities. Gender responsive services provided at Waxter also currently include trauma screening; individual, group and family therapy; Girl Talk psycho-educational life skills groups; and individualized behavior management plans.

Contrary to the JJMU's assertions, Waxter's Master Schedule is followed unless there is a need for modification such as special programming and educational field trips, or adjustments for individual youth for court, medical appointments or illness.

The JJMU cite their observations of a PPC group at Meadow Mountain in which they observed youth to be "little disgruntled because they could not come to agreement" (JJMU Report, p. 25). Interestingly, this observation may be consistent with an expected aspect of group process. The developers of PPC explain that, "The struggle to reach a decision can be animated and at times frustrating… There may be honest differences of opinion on who most needs the meeting but differences can also cause a power struggle among individuals not really interested in deciding whose need is greatest… The conflict need not be solved for them… Occasionally, a leader may even let the group spend a whole meeting in trying to decide who should be helped, which may be a trying experience for a group but also may stimulate members to try to 'get it together'."[8]

The William Donald Schaefer House utilizes a 12-step recovery model and is certified by the Maryland Department of Health and Mental Hygiene, Alcohol and Drug Abuse Administration, as a Substance Abuse program. Note that the JJMU Report incorrectly identifies that parents can visit youth at Schaefer House for one hour per week. Visitation for parents/families is available for three hours per week.

Within the Department's regionalization structure, Green Ridge was established as a Regional Center supporting a continuum of services. The JJMU Report implies that Mountain Quest should have greater capacity for provision of substance abuse services. However Mountain Quest was not designed as a Substance Abuse Program. Green Ridge has Out Patient Substance Abuse Treatment and Intensive Out Patient Treatment Programs. Mountain Quest is not intended for youth who need these substance abuse programs; it is only 90 days in duration and is a wilderness adventure program.

Moreover, during the first half of FY 2009, the Department has contracted for specialized training for all addictions, mental health and case management staff statewide, including at the Schaeffer House, to implement the evidence-based Seven Challenges Program. Behavioral Health Services is considering options to enhance mental health treatment, including trauma-informed cognitive behavioral treatment

[8] Vorrath, H. & Brendtro, L. (1985). Positive Peer Culture, (2nd Edition). New York: Aldine, pp. 91-92.

and dialectical behavioral treatment. Once the model is selected all behavioral health staff in the committed facilities will receive training.

Studies have shown substantial reduction in substance abuse and improvement in mental health status as measured by the GAIN (Global Appraisal of Individual Needs) inventory with use of the Seven Challenges Program. Some research also indicated significant mental health benefits as measured by the POSIT inventory (Problem Oriented Screening Instrument for Teenagers), a standardized screening method of assessing the severity of an adolescent's addiction and need for treatment and the screening tool that COMAR requires Maryland Adolescent Substance Abuse Treatment programs to use.

Seven Challenges is a counseling program for adolescents with substance abuse and co-occurring mental health and trauma issues. It incorporates motivational, cognitive behavioral and problem solving. Counseling sessions are supplemented by cooperative journaling in nine interactive journals and storytelling.

Through a series of trainings and ongoing fidelity monitoring, DJS will become licensed to provide the Seven Challenges Program. The Seven Challenges is projected to begin implementation in November of 2008. The program includes Leader Training for DJS designated staff. Each facility and program will select at least one Leader (generally the clinical director and clinical supervisor) to attend clinical training and learn how to monitor for fidelity to the model. The Leaders are also taught and qualified to deliver the Initial Training to new counselors and staff joining their facility.

DJS Response - Section III Treatment Service Plans

The Department is establishing the Maryland Comprehensive Assessment and Service Planning (MCASP) process, a major re-structuring of the approach to the development and implementation of treatment service planning that is described in more detail in the DJS Response to Section II of this JJMU Report.

The MCASP is designed as a seamless assessment and planning process that is modified to reflect the progress and needs of each youth throughout their involvement with DJS. For example, similar to recommendations in the JJMU Report, community case managers and facility case managers (within a multidisciplinary team including the youth and parents/guardians) will work jointly to identify priority needs and coordinate services for youth during placement.

With implementation of the MCASP, requirements of State Mandated and facility-specific treatment service plans will be closely aligned. Training for community case managers will be provided to enhance coordination, collection and analysis of information for completion of assessments, and accurate identification of youth needs and associated interventions. Regionalization of the Department's operational

functions will also foster integration of the focus and work of community and facility case managers for treatment service planning.

Initial facility treatment service plans are completed for youth on admission to committed facilities. The Treatment Service Plan process is ongoing and the planning becomes more detailed over time. This may explain the observation in the JJMU Report that treatment services plans contain a range of information from basic to very detailed.

Finally, the JJMU is incorrect that Schaefer House staff only received training to utilize ASSIST two months ago. ASSIST access has always been available in the facility, and staff receive training when they initially become ASSIST users and subsequently as needed. All Schaefer House staff who require access to ASSIST to perform their responsibilities for treatment service planning have been using ASSIST regularly. Most recently, DJS technology staff provided refresher training to ASSIST users at the Schaefer House about one month ago.

DJS Response – Section IV Vocational Programming

DJS is expanding workforce development opportunities for youth in the residential treatment facilities. By design, vocational programs should be differentiated to accommodate various program features such as length of stay. The content and focus of vocational curricula for youth at Schaefer House, where the length of stay is about 90 days, will differ from that at longer-term facilities. Schaefer House currently integrates career exploration and employability skills in the academic curriculum, and DJS will enhance this focus while emphasizing opportunities for linkage to career training and meaningful employment on release. DJS also provides and is expanding post-secondary educational opportunities for youth in the residential programs through distance learning and partnerships with community colleges.

The JJMU allege that DJS may not continue the Pre-Apprenticeship Program in the construction trades at Victor Cullen due to "difficulties" in scheduling. The JJMU is insinuating difficulties where none exist. Rather than experiencing difficulties, the Department continues to experience complete and enthusiastic cooperation from union officials and Department of Labor, Licensing and Regulations staff. The Department has discussed the Victor Cullen Pre-Apprenticeship Program in a variety of public forums and has responded to many inquiries. To our knowledge this is the first program of its kind in the country, and we welcome the very positive attention that the program has generated.

The Victor Cullen Pre-Apprenticeship prepares youth for high-growth jobs in the construction trades

A fall program was not possible for the Union Training Directors and Facilitators that conducted the 80-hour core curriculum, and the program is being offered in March 2009 to accommodate their schedule.

Eleven youth completed the inaugural Pre-Apprenticeship program with participation of 25 instructors from 18 Unions or Union Affiliated organizations who together delivered 84 hours of industry-recognized instruction in Building Trades, and hosted three half-day Trade Center Visits to Baltimore and Washington DC area apprenticeship programs. Additionally, youth received 12 hours of jobs skills training, including resume preparation and interviewing skills and Victor Cullen staff provided an additional 27 hours of math review and related activities in support of the program.

Participating youth received three college credit hours from the National Labor College, and eligibility for direct entry into many Union Apprenticeship Programs, and certificates for completion of CPR /First Aid and Occupational Safety and Health Administration (OSHA) training. Each youth also earned a $150 stipend.

A celebration was hosted by the National Labor College and attended by Secretary DeVore and Secretary Tom Perez of the Department of Labor, Licensing and Regulation (DLLR), who read the positive testimonials of youth to the assembled youth, families and staff. Follow up with youth includes communication with field case managers, mentoring, and further educational and work opportunities. Plans are underway by DJS, the Maryland Department of Labor, Licensing and Regulation (DLLR), and the unions to begin a second program session.

DJS Response – Section V Aftercare Planning

The JJMU introduce this section of their report by summarizing selected best practices for aftercare planning, including initiating planning at entry to treatment facilities and continuing throughout the term of commitment, individualized case management, use of a validated assessment, and adjusting intensity of services to youth risks and needs.

The JJMU identify evidence of the use of many best practices for aftercare planning in their review of documentation in the residential facilities including:

At Waxter –

- **All files reviewed included progress notes**
- **Staff consistently identify that aftercare planning begins at entry**
- **Treatment Team meets for each girl, every 30 days**
- **Extensive discharge planning**

At Schaefer House –

- **Discharge summaries are "very complete" and are prepared for each youth**
- **Extensive progress notes in all files**
- **All youth were in contact with their community case manager**

- **The example of aftercare services provided to one youth included assignment of two caseworkers who "visited him at all times of the day or night," and NA, substance abuse and family counseling**

At Backbone Mountain-

- **Discharge and transition planning evident in all files reviewed**
- **All files contained progress notes**
- **Both youth interviewed were involved in their aftercare planning**

At Green Ridge –

- **All files reviewed contained progress notes**
- **4/5 files reviewed contained detailed transition plans**
- **Both youth interviewed were satisfied with and could identify their aftercare plans**

At Meadow Mountain –

- **Aftercare plan established for each youth**
- **Aftercare planning begins on entry**

At Savage Mountain –

- **A multidisciplinary team including the youth and parent prepare an aftercare plan for each youth**
- **Community case managers connect youth to services in the community**
- **Community case managers follow-up to ensure youth are connected to services on discharge**
- **All youth interviewed knew their transition plans**
- **Two of three youth interviewed were satisfied with their aftercare services**

To further strengthen aftercare planning, the Department is establishing Transition Specialist positions to maintain consistent contact with youth before their admission and following discharge from treatment facilities. Transition Specialists will ensure that youth are linked to appropriate community services.

The Department has focused MST and FFT services on diversion from residential placement but already offers and will continue to expand these evidence-based practices as part of aftercare to facilitate successful community re-entry.

Note that the JJMU Report discusses aftercare planning for two youth identified as M. D. and K. R. and as having been discharged from Victor Cullen, but a thorough search of our records failed to locate youth with those initials. While we certainly understand that the JJMU use pseudonyms in the report, in order to respond and address the identified issues, please contact us with information about specific youth..