DEPARTMENT OF JUVENILE SERVICES, ALCOHOL AND DRUGADDICTION ADMINISTRATION ANDTHE OFFICE OF THE PROBLEM SOLVING COURTS

2011 JCR RESPONSE
SUBSTANCE ABUSE OPTIONS FOR COURT-INVOLVED YOUTH

INTRODUCTION

In the *Report on the State Operating Budget (SB 140) and the State Capital Budget (SB 142) and Related Recommendations – Joint Chairmen's Report, 2010 Session,* the Maryland General Assembly requested that the Department of Juvenile Services (DJS), the Alcohol and Drug Addiction Administration (ADAA), and the Office of the Problem-Solving Courts (OPSC) of the Administrative Office of the Courts, in consultation with adolescent substance abuse providers, jointly prepare a report that addresses the concerns expressed by the General Assembly. This request was extended in the *Report on the State Operating Budget (HB 70) and the State Capital Budget (HB 71) and Related Recommendations – Joint Chairmen's Report, 2011 Session*. Accordingly, DJS convened a Task Force comprised of representatives from the two agencies and the judiciary, as well as the State's Attorney's Office, the Office of the Public Defender, Mental Hygiene Administration and Governor's Office for Children (see Appendix I for list of Task Force members).

The Task Force gathered substantial information concerning the identified need for substance abuse treatment for court involved youth, and the array of services presently available. Juvenile drug courts are one alternative in the continuum of services available for youth; however, the enrollment data reflects underutilization of treatment slots in many of the drug courts throughout the State.

The Task Force spent significant time gathering information, on a regional basis, concerning the operation of the existing juvenile drug courts through a series of listening sessions. (See Appendix II for list of participants at each regional meeting). These sessions while broadly focused provided information beneficial in the analysis of the strengths and benefits associated with these programs, and the gaps or deficits in substance abuse treatment services. This report outlines the following based on the Task Force's findings:

I. Identifies the demand for substance abuse services within the juvenile justice system at both the State and local levels;
II. Assesses what the range of treatment options should be available to court-involved youth;

III. Reviews the evidence-based program options available for the different levels of substance abuse treatment considered appropriate; and
IV. Provides recommendations for moving forward.

I. IDENTIFYING THE DEMAND FOR SUBSTANCE ABUSE SERVICES FOR COURT-INVOLVED YOUTH

Research has shown that a strong link exists between substance abuse and juvenile delinquency. Arrest, adjudication, commitment/probation and referral for treatment by the juvenile justice system are the consequences for many youth who engage in alcohol and other drug use. Researchers have identified substance use as a risk factor for delinquent behavior. In addition, both substance abuse and delinquent behavior are correlated with other problems: family dysfunction; involvement with negative peers, experience academic difficulties and gang involvement.

Youth who are involved with the juvenile justice system have substantially higher rates of mental health and substance abuse disorders than youth in the general population. National studies show that the prevalence of mental health disorders among youth in the juvenile justice system is as high as 70 percent[1]. Of those, an estimated 79 percent met criteria for two or more diagnoses. Among youth with mental health diagnoses, 61% also met criteria for a substance abuse disorder.

The recovery process is complex. It is a process that focuses on increasing a person's ability to sustain abstinence and achieve a drug-free lifestyle. Recovery is almost never a clear and straight process of sustaining abstinence. Relapse rates among youth are high. Habits associated with drug use are difficult to change and often continue to be reinforced within the individual's environment. Drug use by youth may be enmeshed with other issues such as histories of physical and/or sexual abuse, delinquency, homelessness, and co-occurring psychological disorders. The depth of these problems calls for a more holistic approach. To be treated, the problem must be found, therefore emphasizing the importance of identifying the demand for substance abuse services for court-involved youth.

The Task Force also assessed the demand for substance abuse services among court-involved youth using two *indicators* of need: (1) official records of CDS charges among a cohort of youth referred to DJS during fiscal year 2010; and (2) self-report data on current alcohol and/or drug use collected at intake and post-adjudication. Both measures serve as proxies for substance abuse treatment need as neither a CDS charge nor a self-report of alcohol or drug use may be considered conclusive in determining whether a child needs substance abuse services. Substance abuse treatment screening is required to determine whether a child needs substance abuse services. The Task Force also examined substance abuse screening data collected at DJS' detention, committed and contractual facilities.

CDS involvement as measured by CDS charges among youth referred to DJS during fiscal year 2010 is shown in the chart below.

[1] Shufelt, J.L., and Cocozza, J.J. Research and Program Brief: Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study. National Center for Mental Health and Juvenile Justice, June, 2006.

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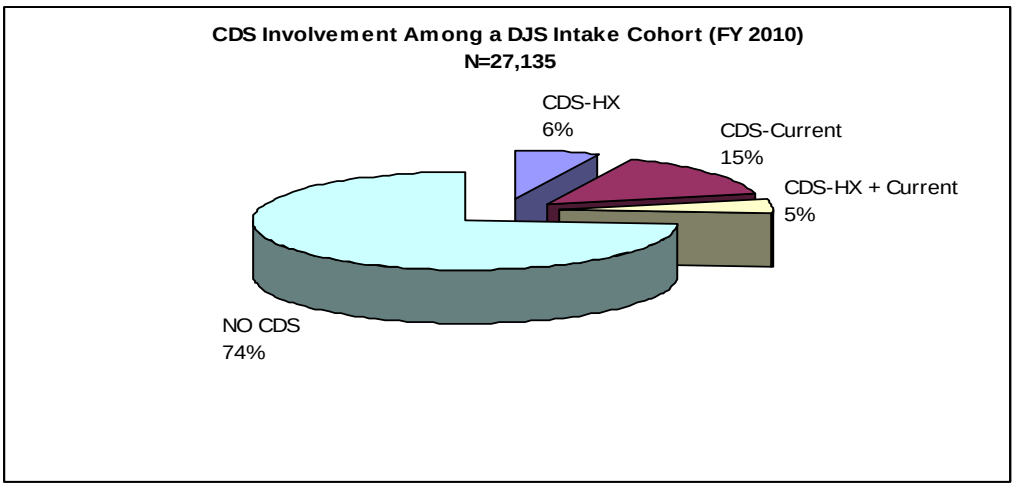

The chart shows the following:

- N=4,087 (15.1%) of these youth were charged with at least one CDS offense during fiscal year 2010;
- N=1,709 (6.3%) of these youth had a history of a CDS offense charge *only* (that is, prior to fiscal year 2010); and
- N=1,315 (4.9%) of these youth had both a history of a CDS offense charge AND a current CDS offense charge.

Self-report data on recent drug and alcohol use are collected as part of the Maryland Comprehensive Assessment and Service Planning (MCASP)-Risk Screen completed at DJS intake and the MCASP-Needs Assessment collected post-adjudication. Examination of these data revealed the following:

- One in five youth (20.8%) referred to DJS intake during fiscal year 2010 reported using drugs within the last 3 months.
- Youth who were charged with a CDS offense during fiscal year 2010 were much more likely to report drug use (greater than 50%).
- One in three youth (32.8%) who started a term of probation during fiscal year 2010 reported alcohol or drug use within the last three months.
- More than one in three (43.0%) youth committed to DJS and placed on aftercare during fiscal year 2010 reported alcohol or drug use (within the last 3 months). Youth with one or more CDS charge were more likely to have used alcohol or drugs within the last three months.

Substance abuse screening data collected at DJS' detention, committed and contractual facilities in past years indicates that approximately 60% or more of youth screened in these programs have a substance abuse problem. In fiscal year 2010, the combined total of admissions of youth to DJS detention and committed facilities was 8,623 and 6541 youth (75%) received substance abuse screening. Therefore at least 3,925 youth were identified as needing substance abuse treatment.

After reviewing the DJS data and the national incidence estimates, several conclusions were drawn. First, an estimated 4,650 to 6,000[2] youth coming into contact with DJS each year are likely to have some level of substance abuse problems. Second, the deeper a youth goes into the DJS system, the more likely they are to have used drugs or alcohol and to have problems as a result of that use.

Current best practices identifying juvenile offenders with such disorders require screening (including drug testing) and then a diagnostic comprehensive assessment following a positive screening for a substance use disorder. Screening identifies that a youth may have a significant substance use problem. The comprehensive assessment confirms the existence of a problem and helps confirm other problems connected with the adolescent's substance use disorder.

Comprehensive information can be used to develop appropriate interventions inclusive of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders and to ensure referrals to the least intensive level of care that will keep them safe.

Best practices indicate court-involved youth should be screened and assessed at the earliest possible point in a youth's contact with the juvenile justice system and at all points of entry and re-entry into the juvenile justice system.

The Department owns and operates an adolescent substance abuse assessment unit in the Central Region. The assessment unit receives referrals for substance abuse assessments from every field office in Central Region, and serves youth on all levels of probation. The unit also conducts full assessments on youth who are pending placement or detained at the Charles H. Hickey, Jr. School.

II. EVIDENCE-BASED SUBSTANCE ABUSE PROGRAM OPTIONS FOR COURT-INVOLVED YOUTH

Best or evidence-based practice refers to a prevention or treatment intervention that is rigorously applied and requires training and fidelity to the model. It should produce positive or improved outcomes, in contrast to treatment or prevention as usual, or none at all. The carrying out of best practices for youth in a juvenile justice setting does not imply, however, that those practices alone will lead to better outcomes. NREPP, SAMHSA's National Registry of Evidenced-Based Practices and Programs (http://www.nrepp.samhsa.gov/Search.aspx) is the federally recognized source of approved prevention and treatment practices.

With regard to treatment, psychotherapy research has pointed to the primary factor of an effective therapist-patient alliance more than the type of therapy practiced. In other words, the interactional skills of the therapist, the formation of a treatment alliance and rapport, and the positive and welcoming nature of the institution, clinic or office appear to lead to positive outcomes regardless of the specific practice. In this light, the Alcohol and Drug Abuse

[2] This estimate was arrived at in the following manner: the high number was based on the percent (20.8%) of youth referred to intake who reported using drugs within the last three months. The low number was based on national prevalence data which indicated that 70% of youth coming into contact with DJS (10,873 youth in detention, detention alternatives, community supervision and in committed placements) have a mental health disorder and 61% of those have a co-occurring substance abuse disorder.

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Administration requires each program to choose best practices that are resonant with its mission and institutional personality as long as it produces specific positive measured outcomes.

Review of Best Practices
To identify what programs/interventions have been identified as evidenced-based for court-involved youth, DJS asked the Innovations Institute to conduct a review of the literature. This review was submitted to ADAA for review and comment.

ADAA Best Practices Recommendations

- Uniform screening and assessment practice.
- Uniform screening and assessment instruments with proper training for screeners and assessors.
- Electronic Health Record that monitors treatment progress, provides outcome data, enables timely referrals, and ensures secure information exchange.
- Uniform criteria for placing a patient at a specific level of care- in Maryland, for substance abusing and dependent youth, the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for Adolescents is required by ADAA through COMAR.

ADAA recommends the following three approaches for adolescents and families based upon their practicality, outcome studies, cost-effectiveness, utility for professionals from all disciplines, and usefulness in milieu treatment:

- Motivational Interviewing and Enhancement Therapy
- Adolescent Community Reinforcement Approach
- Brief Strategic Family Therapy for Substance Abusing Adolescents.

Innovations Institute Literature Review
Key Factors that Constitute Best Practice in Adolescent Substance

Assessment and treatment matching
Standardized assessment is key to effectively screening for the presence of substance abuse or related mental health problems as well as understanding the kinds of risks that are present and level of treatment required in order to make an appropriate referral (match).

A comprehensive, integrated treatment approach
To address the complex needs of youth and families involved with the juvenile justice system, a comprehensive and integrated approach, working in collaboration with multiple youth service agencies to meet individualized needs.

Family involvement in treatment (also supported by Chassin, Knight, Vargas-Chanes, Losoya, & Naranjo, 2009)
Family involvement is key to the youth's long-term success, yet many face barriers that preclude them from participating in treatment efforts. It is critical to provide outreach, support, and information to the family, and to give them every opportunity to be fully-involved with the treatment program.

Developmentally appropriate programming
The youth's engagement in the treatment program, including goal setting, is essential to their success. Services/programs need to be developmentally- or "age"-appropriate", so youth can effectively participate; strengths-based programming has also been found to be very effective in gaining active youth participation.

Engagement and retention of adolescents in treatment
The most innovative programs serving court-involved youth encourage leadership and ownership of the process, are strengths-based, and invite youth ideas about how to improve their own lives and the lives of their families and community members.

Qualified staff
Qualified staff demonstrates an adequate knowledge of best practices. An effective infrastructure that can provide staff with on-going professional development and training is ideal to ensure that all staff is trained in the latest and most effective approaches.

Aftercare/Relapse Prevention
Substance abuse treatment is most effective when adequate supports are planned following the initial intervention/treatment (aftercare).

Gender and cultural competence
Culturally responsive service options and capacity is essential. Culturally relevant best practices need to be infused in to substance abuse programming for youth. Gender appropriateness is also vital to successful programming.

Well-Established Programs
The following interventions are well-established and commonly used programs to treat substance abuse among youth with disruptive behavior disorders/juvenile delinquents. All four programs are evidence-based practices that have also been validated among minority youth (Cunningham, Foster & Warner, 2010).

- Functional Family therapy (FFT)
- Multidimensional Family Therapy (MFT)
- Multisystemic Therapy (MST)
- Brief Strategic Family Therapy (BSFT)

III. TREATMENT OPTIONS AVAILABLE FOR COURT-INVOLVED YOUTH

Treatment should be seen as a continuum of care that seeks to initiate recovery by establishing a period of abstinence and sustains the recovery process. This continuum of care includes identifying adolescents with substance abuse problems, facilitating their admission into treatment, providing primary treatment to initiate the recovery process, helping them to build a support network, and continuing aftercare services to maintain recovery.

The Department continues to concentrate on developing substance abuse services and initiatives that address the changing needs of Maryland youth and have significantly expanded and enhanced the availability of treatment options for court-involved youth in the following areas.

A. ADAA Services

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Court-involved youth are enrolled in a variety of ADAA-certified[3] substance abuse programs. These providers are certified to deliver a specific level of care, as defined by the American Society of Addiction Medicine Patient Placement Criteria, the most widely used and comprehensive national guidelines for placement, continued stay, and discharge of patients with alcohol and other drug problems. The ASAM PPC-2R provides two sets of guidelines, one for adults and one for adolescents, and five broad levels of care for each group. (The main difference is that there are no separate detoxification services for Adolescents in the ASAM PPC-2R) The levels of care are: Level 0.5, Early Intervention; Level I, Outpatient Treatment; Level II, Intensive Outpatient/Partial Hospitalization; Level III, Residential/Inpatient Treatment; and Level IV, Medically-Managed Intensive Inpatient Treatment.

CODES	ASAM LEVELS OF CARE	DEFINITIONS	EXAMPLES
0	Early Intervention	Patients in early stages of alcohol and drug abuse	Counseling with at-risk individuals and DUI programs
I	Outpatient Treatment	Patients who require services for less than 9 hours weekly	Office practice, health clinics, primary care clinics, mental health clinics, "Step down" programs
I OMT	Opioid Maintenance Therapy	Patients receive pharmacological interventions such as methadone, LAMM	Methadone Maintenance Programs
II	Intensive Outpatient Treatment	Patients who receive 9 or more hours weekly	Day or evening outpatient programs
II.5	Partial Hospitalization	Day treatment 9 or more hours weekly	
III.1	Clinically Managed Low-Intensity Residential treatment	Residential care and at least 4 hours a week of treatment	Day treatment programs, Halfway Houses with 'Recovery" Services or "Discovery" Services; Sober Houses, boarding houses, or group homes with in-house Level I intensity services and a structured recovery environment
III.3	Clinically Managed Medium -Intensity Residential treatment	Residential care for long term care with structured environment and treatment	Therapeutic Rehabilitation Facility for extended or long-term care
III.5	Clinically Managed High -Intensity Residential treatment	Residential care with highly structured with high intensity treatment and services	Therapeutic Community or Residential Treatment Center and Step-down from Level III.7

[3] ADAA certifies all substance abuse programs in the state but does not fund all certified programs.

III.7	Medically Monitored Intensive Inpatient Services	Medically monitored inpatient treatment program	Inpatient treatment center, ICF
IV	Medically Managed Intensive Inpatient Services	Acute Hospitals, Acute psychiatric Hospitals.	Acute Care General Hospital, Acute Psychiatric Hospital or Unit within a general hospital, Licensed Chemical Dependence Specialty Hospital with Acute care Medical and Nursing Staff

In fiscal year 2010, youth were enrolled in ADAA certified substance abuse programs in all counties across the state but but not every county has each level of care available locally. Every county had one provider who offered out-patient or early intervention substance abuse programs, but not every county had in-patient treatment services available. In fiscal year 2010, ADAA funded programs served 4,023 youth. Of those, approximately 50% (2,033) of the youth were referred by DJS or Drug Court.

The vast majority of youth enrolled in ADAA-funded treatment programs (referred by DJS and juvenile Drug Court) were between the ages of fifteen and seventeen (90%.) Most youth enrolled in ADAA-funded treatment were male (85%) and roughly one-half of those youth were African-American (49%), followed by White youth (43%), Hispanic youth (6%) and youth classified as "other" race/ethnicity (3%).

In fiscal year 2010, the vast majority of DJS youth enrolled in treatment received either: (a) ASAM-Level I services (71.4%), *i.e.*, outpatient treatment; or (b) ASAM-Level II.1 services or intensive outpatient treatment (9.8%). Enrollment in any type of inpatient treatment by DJS youth was less common. Approximately eleven percent (11.4%) of DJS youth enrolled in substance abuse treatment during fiscal year 2010 received some form of inpatient treatment. The most common form of inpatient treatment was ASAM-Level III.7 or Intermediate Care. An additional seven percent (7%) of youth enrolled in substance abuse treatment during fiscal year 2010 received ASAM-Level 0.5 or early intervention treatment.

In total, thirty-nine (39) providers enrolled DJS youth across the State in ASAM-Level I treatment (1,773 youth were served). Nineteen (19) ADAA certified providers across the state offered intensive outpatient services to DJS youth (ASAM-Level II.1) to 243 youth. Nineteen (19) ADAA certified providers across the state offered early intervention treatment to 184 youth. Two hundred and eighty two (282) DJS youth were enrolled in inpatient treatment received services from the following six providers: (a) Jackson Unit-Allegany County Addiction Services; (b) Pathways; (c) Sabillasville Residential; (d) Mountain Manor; (e) William Donald Schaefer House; and (f) Peninsula Addiction Services.

B. DJS Community Services[4]

[4] Community Services are defined as substance abuse treatment services for court-involved youth who are on probation and living in the community.

In addition to referring youth to ADAA certified substance abuse treatment programs, the Department has implemented two evidence-based programs that provide treatment in the community to youth and their families. These programs include Functional Family Therapy (FFT) and Multisystemic Therapy (MST). DJS is generally using both programs as alternatives to out-of-home placement, specifically group homes.

The youth referred to these programs have a moderate- or high-risk level for re-offending and have family issues that need to be addressed in order to prevent re-offending behavior. They may have displayed antisocial behavior, poor judgment, and a lack of self-discipline. Additionally, they may have socially inappropriate value systems, experimented with alcohol and drugs, come from dysfunctional and/or inadequate family systems, and have a negative response to authority. Both evidence-based programs are community-based and services are provided in a family setting. The length of treatment is normally three to four months for FFT and three to five months for MST. These programs are designed to reduce recidivism, out-of-home placements, and treatment costs for DJS. Currently DJS has 392 evidence-based program slots and served approximately 940 youth and families in fiscal year 2010.

C. DJS Residential Services

DJS operates eight (8) detention facilities that provide temporary care of youth who, pending court disposition, require secure custody for the protection of themselves or the community. Substance abuse clinicians provide screening, assessment, psycho-education, brief treatment and referral services for youth in detention.

DJS operates six (6) committed residential programs for adjudicated youth. Each of the six committed residential programs and one vendor on the Eastern Shore are certified by the Maryland Department of Health and Mental Hygiene to provide substance abuse treatment. The DJS programs have 14 substance abuse counselors and the capacity to treat 268 youth at any given time. Every youth admitted receives a complete assessment, including drug testing. All programs including the one vendor became licensed in 2009 to provide the Seven Challenges® adolescent substance abuse treatment model.

DJS conducted a review of adolescent substance abused evidence-based treatment models and selected the Seven Challenges to implement in its facilities. The Seven Challenges® LLC is designed for adolescents who have alcohol and other drug problems and co-occurring mental health disorders. It is a promising program and has been successfully used as a treatment approach with youth across the country.

Seven Challenges starts where the youth is in terms of perception of substance use and harm, and not where counselors wish they might be and not where the youth might pretend to be. This program avoids the pitfalls of engaging in a power struggle with youth resorting to high intensity confrontational techniques, or of eliciting dishonest responses. It considers the stage of change of each youth being served and helps them through a decision making process. This program helps youth master developmental tasks to define their own identity, to learn systematic logical thinking and to prepare for adult roles as they think about and examine their lives, their drug use, and the potential impact of their drug use upon their future.

This program is appealing to those who work in the juvenile justice system because it steps away from the aggressive approaches that breed defiance. This program is relationship-based and

particularly well-suited for engaging resistant youth, including youth with a trauma history, and helping them learn how to make safe relationships.

The program and materials were developed working with a culturally diverse group of youth such as those served by DJS. The program is an empowerment model as opposed to a deficit model. Youth are encouraged to believe in themselves and to take power over their own decisions and own life which is developmentally appropriate.

Listed in the table below are the fiscal year 2010 utilization rates for DJS operated residential facilities.

FACILITY	ADP	CAPACITY[1]	RATE
Youth Centers (total)	**149**	**164**	**91%**
Backbone	47	48	98%
Greenridge	39	40	98%
Meadow Mountain	40	40	100%
Savage Mountain	23	36	64%
Wm. Donald Schaefer House	**9**	**20[2]**	**45%**
Victor Cullen	**39**	**48**	**81%**
TOTAL	**197**	**232**	**85%**
[1]Per DJS ADP and State Stat data *[2]Current capacity reduced to 6 due to funding constraints.*			

D. Juvenile Drug Courts

The first drug treatment court in Maryland began in 1994 in Baltimore City. While the early Maryland initiatives were adult programs, the first juvenile drug court was planned and implemented in Baltimore City in 1997. As local jurisdictions explored the efficacy of the treatment court model, use expanded throughout the State. As of October 2010, there were 40 drug courts in operation in Maryland, including adult programs in district and circuit courts, family dependency courts, DUI courts, and juvenile drug courts. Overall, 14 juvenile drug courts have been instituted, although the programs in both Dorchester and Calvert Counties were eventually terminated based in part to chronic low program referrals and admissions.

Juvenile drug courts are designed to provide intensive, collaborative programs within the juvenile courts for drug involved youth and their families. The program model ensures intensive judicial supervision over delinquency cases that involve substance abusing youth, with a coordinated and supervised delivery of an array of support services to address the problems that contribute to juvenile involvement in the justice system. Service areas include substance abuse treatment, mental health treatment, primary care, family counseling, education, and employment services. DJS provides intensive probation supervision and case management by partnering with other stakeholders to link youth and their families to treatment and other services. The drug court model has demonstrated successful results by combining intensive case management and service delivery with consistent judicial supervision, including a system of sanctions and incentives to enhance compliance.

Drug courts are best viewed as one approach in a continuum of intensive supervision options which include ancillary and substance abuse treatment services. Youth must choose to voluntarily enter and should be admitted to juvenile drug courts based upon an assessment of

their treatment needs, so that the intensity of services and supervision is appropriate for their level of care. Ideally, appropriate placement in drug courts will reduce utilization of longer term DJS residential placements.

Recent evaluations of several Maryland juvenile drug court programs provide unequivocal evidence of improved outcomes for participating youth[5]. Youth who graduate from drug court programs demonstrate significant reductions in both substance use and recidivism when compared to similar youth who did not participate in the program. Even youth who participate in the program for a period of time without graduating evidence improved outcomes. The recent Maryland evaluation data demonstrates that Maryland's juvenile drug court graduates demonstrated a 23% reduction in arrest rates over an 18 month period from entry in the program. The average graduation rate for program participants was 53%. During the period of program participation, positive urinalysis tests were reduced by 69%.

Each operational Maryland juvenile drug courts grew out of a local, collaborative planning initiative. These planning committees included representatives of the juvenile court, DJS, the Office of the Public Defender, the State's Attorney's Office, the local treatment community, and other stakeholders as appropriate to the jurisdiction. Significant effort and commitment of these stakeholders was required before the drug court could commence operation. Despite these efforts and the demonstrated positive outcomes for participants, enrollment in these courts throughout the State has lagged well below their capacity.

REGION	COUNTY	CAPACITY	UTILIZATION (As of 12/31/09)	UTILIZATION (As of 3/31/11)
SOUTHERN	Anne Arundel	30	9 (30%)	30 (100%)
	Charles	25	14 (56%)	18 (72%)
	St. Mary's	25	19 (76%)	724 (96%)
	Calvert	Closed	-	-
BALTIMORE CITY	Baltimore City	78	39 (52%)	54 (69%)
CENTRAL	Baltimore Co.	80	45 (56%)	57 (71%)
	Harford	30	17 (57%)	46 (153%)
	Caroline	20	12 (60%)	8 (40%)
EASTERN SHORE	Somerset	10	9 (90%)	10 (100%)
	Talbot	25	5 (20%)	7 (28%)
	Worcester	17	6 (35%)	7 (41%)
	Dorchester	Closed	-	-
	Prince George's	60	22 (37%)	55 (92%)
METRO	Montgomery	20	18 (90%)	13 (65%)
WESTERN	Washington	20	5 (25%)	17 (85%)
TOTAL		437	220 (50%)	346 (79%)

[5] The analysis of Maryland's juvenile drug courts is contained in the *Maryland Problem-Solving Courts Evaluation, Phase III Integration of Results from Process, Outcome and Cost studies Conducted 2007-2009* prepared by NPC Research in December 2009 for the Office of Problem Solving Courts for submission to the General Assembly.

IV. INTERIM EFFORTS TO IMPROVE REFERRALS

Representatives of DJS, the judiciary and OPSC met to review and evaluate the data gathered by the Task Force, as it pertains to continued underutilization of treatment slots available in drug courts throughout the State. In recent years, DJS has implemented several changes in the screening and risk assessment process at intake. The standardization that now exists in that initial assessment process provides a basis for consistent, early identification of potential drug court participants.

The MCASP Risk Assessment completed at intake, and the MCASP Needs Assessment completed post-adjudication provide data concerning substance abuse treatment needs. In an effort to identify youth under supervision who may benefit from drug court services, DJS directed its regional directors to complete a review of the MCASP Needs Assessment domain that focuses on substance abuse treatment needs for all active probation and aftercare cases. Any youth determined to demonstrate a moderate or high need for substance abuse treatment is identified for possible referral to the local drug court. In addition, on an ongoing basis, youth under supervision are to be referred to drug court when an indicator of the need for substance abuse treatment becomes known to the Case Management Specialist, to include positive drug testing, self-report, parent report, or reports from school or providers.

Effective June 22, 2011, DJS has implemented a policy designed to highlight treatment needs and potential drug court candidates in the juvenile intake process. Intake personnel will now submit a referral to drug court for all youth who self-report drug use in the MCASP Intake Risk Screen whose cases are not resolved at intake or through pre-court supervision. Similarly, youth already under supervision who present with a new drug related offense will be referred to drug court, regardless of whether they self-report drug use.

The certified substance abuse provider or assessor will then conduct a more intensive substance abuse treatment assessment to determine the appropriate ASAM level of care. Appropriate candidates for admission to the local drug court will then be identified based upon the parameters of the local program, including such factors as the ASAM level of treatment services provided, supervision needs, and program criteria.

Both DJS and the local juvenile drug courts will track the drug court referrals and the actions taken on each matter. DJS Regional Directors are required to report monthly, to include the number of youth currently enrolled in the drug court program, the number of youth referred, the action taken on each referral, and the reason for rejection from the drug court program.

V. ONGOING REFERRAL ANALYSIS

The Office of Problem Solving Courts will create a standing Juvenile Drug Court Work Group to review the monthly referral data generated by DJS. This group will meet quarterly to discuss and refine the referral policies until enrollment in the juvenile drug courts stabilizes at or near capacity. The Work Group will be staffed by the Office of Problem Solving Courts, and will include representatives of the judiciary, DJS, the Office of the Public Defender, the State's Attorney's Office, drug court coordinators, and ADAA.

In refining the referral process, the Work Group will continue to review and discuss the screening process. The interim measures taken by DJS will provide a comprehensive assessment of youth currently under supervision, with identification of any youth who may benefit from drug court

services. The Work Group will make recommendations to ensure pre-disposition identification of possible candidates. In addition, the Work Group will develop recommendations to ensure youth under supervision who demonstrate a need for more intensive substance abuse treatment are returned to Court for referral to a different level of care, to include drug court if appropriate.

VI. CONCLUSION

DJS is committed to increasing the number of referrals to Drug Court. With the implementation of the Maryland Comprehensive Assessment Service Planning (MCASP) DJS is able to determine youth in need of substance abuse treatment and intense supervision at intake and will now refer youth who meet this criteria to Drug Court. Current DJS youth are also being reviewed and will be referred at any point if a need is recognized. The Department believes this will significantly increase the number of DJS referrals to Drug Court.

APPENDICES

I. Task Force members

II. Regional Listening Session Attendees

APPENDIX I

Maryland State Department of Juvenile Services
JCR Task Force Membership List

Name	Agency	Address
Arleen Rogan, Co-Chair	DJS/HQ	120 W. Fayette Street Baltimore, MD 21201
Ed King, Co-Chair	DJS/Western Region	1 James Day Drive Cumberland, MD 21502
Judge Kathleen Cox	Baltimore County Judiciary	401 Bosley Ave Towson, MD 21204
Gray Barton	OPC	2011 D Commerce Park Dr Annapolis, MD 21401
Tom Cargiulo	ADAA	55 Wade Ave Catonsville, MD 21228
Rosemary King-Johnston	GOC	301 W. Preston Street Baltimore, MD 21201
Judge Edward Hargadon	Baltimore City Judiciary	3451 Courthouse Dr. Ellicott City, MD 21043
Paul DeWolfe	OPD	6 Saint Paul Street Suite 1400 Baltimore, MD 21202
Master Douglas Cooley	Charles County Judiciary	200 Charles Street LaPlata, MD 20646
Alberta Brier	DJS/HQ	120 W. Fayette Street Baltimore, MD 21201
Jill Farrell	CJJ-Innovations	737 W Lombard Street 4th fl Baltimore, MD 21201
Al Zachik	MHA	55 Wade Ave Catonsville, MD 21228
Patricia Flanigan	DJS Baltimore City	300 N. Gay Street Baltimore, MD 21202
Pat Jessamy	Baltimore City SAO	110 N. Calvert Street Baltimore, MD 21202
Frank Weathersbee	AA Co. SAO	7 Church Circle Annapolis, MD 21401
Sheila Peksenak	JDC Coordinator, Baltimore City	300 N. Gay Street Suite B3800 Baltimore, MD 21202
Glen Plutschak	JCD Coordinator, Talbot County	Talbot County Circuit Court 11 North Washington St. Easton, MD 21601

APPENDIX II
REGIONAL LISTENING MEMBERS

SOUTHERN REGIONAL MEETING PARTICIPANTS:
8/11/10

Donald DeVore-DJS Secretary
Sheila Sullivan-OPD
William Stevens-DJS
Paul Thompson-DJS
Dan Schaidt-DJS
Dina Beasley-Walden
Cyntrice Bellamy-DHMH/MHA
Seri Wilpone-Legal Aid
Ghia Ridley-Pearson-DJS
Quanetta West-DJS
Barbara Smith-DJS
John Streifeli-DJS
Jennifer Moore-OPSC
Gray Barton-OPSC
Michael Hawkins-GOC
Kimberly Short-Drug Court, PG County
Charmian Crawford-DJS
Donna Millar-DJS
Vincent Taylor-DJS
Mary Ann Kellstrom-DJS
Gary Ruble-DJS
Vanessa Tyler-DJS
Virgil Walker-DJS
Julisa Robinson-Drug Court PG County
James Schropp-DJS
Paula Fish-Drug Court AA County
Karla Donaldson-OPD
Robin Walters-DJS
Kathleen Cox-Baltimore County Circuit Court Judge
Edward Mayo-DJS
Douglas Cooley-Master, Charles County Circuit Court
William Square-Center for Children
Edward King-DJS
Arleen Rogan-DJS
Lauren Gordon-DJS
Claire Souryal-Shriver - DJS

BALTIMORE REGIONAL MEETING PARTICIPANTS:
AUGUST 25, 2010

Donald DeVore – Secretary, DJS
Michael Hawkins - GOC
Kathleen Cox - Judge, Baltimore County
Claire Souryal-Shriver- Researcher, DJS
Althea Handy – Judge, Baltimore City
Patti Flanigan – Assistant Regional Director, Baltimore City, DJS
Pam Kemmerer – Baltimore County Bureau of Behavioral Health
Shannon Bowles – DJS
Janet Harking – Office of State's Attorney
Albert Zachik – MHA, DHMH
Delmonica Hawkins – Baltimore City Regional Director, DJS
Delmas Wood – Baltimore City Regional Administration, DJS
Sheri Meisel – Assistant Secretary for Operations, DJS
Carolyn Ross – Office of Public Defender
Gray Barton – Office or Problem Solving Courts – MD Judiciary
Tom Cargiulo – Alcohol and Drug Abuse Administration
Stephanie Veach – DJS
Tim Wrightson – Baltimore County, DJS
Lauren Gordon – Planning, DJS
Arleen Rogan – Director of Professional Services, DJS
Lynn Jones – DJS
Edward King – Assistant Regional Director, Western Region, DJS
Wardell Barksdale, Jr. – Harumbee Treatment Center
Edward Hargadon – Judge – Baltimore City

APPENDIX II
REGIONAL LISTENING MEMBERS

EASTERN SHORE REGIONAL MEETING PARTICIPANTS: SEPTEMBER 8, 2010

Donald DeVore-Secretary DJS
Glen Plutschak-Talbot County Drug Court
Lynne Duncan-Talbot Co. Public Schools
Samantha Parker-Caroline Co. Drug Court
Alberta Brier-DJS
Ghia Ridley-Pearson-DJS
Elizabeth Cook-DJS
Tashica Hilliard-Worchester Drug Court
Spencer Tracy-DJS
Robin Slechter-DJS
Taneishe DeShields-DJS
Ann Simpers-Health Department
Lynn Robinson-DJS
Sheila Warner-DJS
Tom Carguilo-ADAA
Arleen Rogan-DJS
Madeline Moore-DYS
Tamara Stofa-OPD
Mark Carpenter-Addictions
John Winslow-Addictions
Frank Weathersbee
Mike Hawkins-GOC
Jennifer Moore-OPSC
John Gadsby-DJS
Tim Haynes-DJS
Gray Barton-OPSC
Cory Fink-DJS
Lauren Gordon-DJS
Claire Souryal-Shriver - DJS

MONTGOMERY COUNTY/WASHINGTON COUNTY MEETING PARTICIPANTS: SEPTEMBER 22, 2010

Donald DeVore-DJS
Scott Beal-DJS
Ed King-DJS
Ken Long-Washington Co. Circuit Court Judge
Steven Kessell-State Attorney's Office-Washington County
Doug Powell-DJS
Samantha Lyons-Montgomery County Circuit Court-Drug Court Coordinator
Jennifer Bricker-Washington County Drug Court
Jennifer McLucas-Washington County Health Department
Helen Mency-DJS
Angela Talley-Montgomery County Government-Juvenile Justice Services
Darryl Norwood-Montgomery County Public Schools
David Thompson-DJS
Sheri Meisel-DJS
Tom Carguilo-ADAA
Robert McElvie-DJS
Dennis Nial-DJS
Arleen Rogan-DJS
Albert Zachik-DHMH/MHA
Michael Hawkins-GOC
Rick Growden-DJS
Nancy Schrock-DJS
Alberta Brier-DJS
Mary Siegfried-OPD
Lauren Gordon-DJS
Claire Souryal-Shriver - DJS