



Maryland Department of
Juvenile Services
Treating • Supporting • Protecting



Gap Analysis Addendum 2009 To 2004 Phase I: Gap Analysis

March 9, 2009



Anthony G. Brown
Lt. Governor

Martin O'Malley
Governor

Donald W. DeVore
Secretary



Maryland Department of
Juvenile Services
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Gap Analysis Addendum 2009

To

2004 Phase I: Gap Analysis

MARYLAND DEPARTMENT OF JUVENILE SERVICES
GAP ANALYSIS ADDENDUM 2009



MARTIN O'MALLEY
Governor
ANTHONY BROWN
Lieutenant Governor

T. ELOISE FOSTER
Secretary
DAVID C. ROMANS
Deputy Secretary

March 9, 2009

The Honorable Donald W. DeVore
Secretary
Maryland Department of Juvenile Services
One Center Plaza
120 West Fayette St.
Baltimore, MD 21201

RE: Juvenile Services Gap Analysis, March 9, 2009 Revision

Dear Secretary DeVore:

The Department of Budget and Management (DBM) has completed its review of the revised gap analysis, dated March 9, 2009, entitled "Maryland Department of Juvenile Services Gap Analysis."

I am pleased to inform you that the gap analysis has been approved. The approved gap analysis addresses the service demand and capacity for the four types of youth services that comprise the juvenile justice system: Secure Detention, Alternatives to Detention, Residential Placements, and Community-Based Services.

The document provides an overview of the Department's service delivery system, a description of the recent history of the system, and a discussion of the reform initiatives being undertaken by the Department. These reforms will:

- Divert youth from secure detention facilities to Alternatives to Detention
- Expedite the placement process for committed youth
- Reduce the number of inappropriate treatment placements
- Expand Community-Based Services, Treatment, and Placements

As you know, this analysis was initiated at the request of the Maryland General Assembly. The budget committees requested "a gap analysis of currently available State and community-based service capacity compared to the ideal service delivery system." This analysis will serve as the basis for a Facilities Master Plan (FMP), a plan for how to improve the Department's facilities to reflect the need identified in the gap analysis. Once the revised FMP has been submitted to DBM, we will conduct an expedited review of it and the approved FMP will then be submitted to the budget committees.

~Effective Resource Management~

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The Honorable Donald W. DeVore
March 9, 2009
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Please provide a copy of the approved gap analysis to the budget committees for their review. If you require any further information, please contact me or Chad Clapsaddle of my staff.

Sincerely,



T. Eloise Foster
Secretary

cc: Mr. Matthew Gallagher, Deputy Chief of Staff, Office of the Governor
Mr. Chad Clapsaddle, Executive Director, Office of Capital Budgeting, DBM
Mr. David Treasure, Executive Director, Office of Budget Analysis, DBM
Mr. Francis Mendez, Deputy Secretary, Support Services, DJS
Dr. Ronald Lippincott, Budget Analyst, Office of Capital Budgeting, DBM
Mr. Christopher McCully, Budget Analyst, Office of Budget Analysis, DBM
Dr. Simon Powell, Policy Analyst, Maryland General Assembly

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KEY TERMS:

ADP - Average Daily Population, a head count, typically annual, for a certain population type
Admissions - The number of youth admitted to a program or facility, a turnstile count typically annually.

ALOS - The Average Length of Stay, in days, for each youth admitted to a program or facility

ATD - Alternatives to Detention, community based, short-term programs that serve youth whose cases are pending in juvenile court and who would otherwise be placed in secure detention.

CY - Calendar Year, *e.g.*, CY 2007 is January 1 2007 - December 31, 2007.

FY - Fiscal Year, *e.g.*, FY 2007 is July 1, 2006 - June 30, 2007.

Pending Placement - Youth who have received a judicial disposition of delinquency and a program assignment, but have not been admitted to the assigned program. For the purposes of this analysis, post-dispositional youth in a detention status are referred to as Pending Placement. The term post-dispositional will not be used.

Post-Reform - Data showing the expected population of the system once reforms currently being implemented are achieved.

Pre-Disposition - Youth who are charged with delinquency but who have not had their case heard by a judge. These youth are awaiting a judicial hearing.

Pre-Reform - Data from CY 2007, prior to the impact of reforms initiated in 2007.

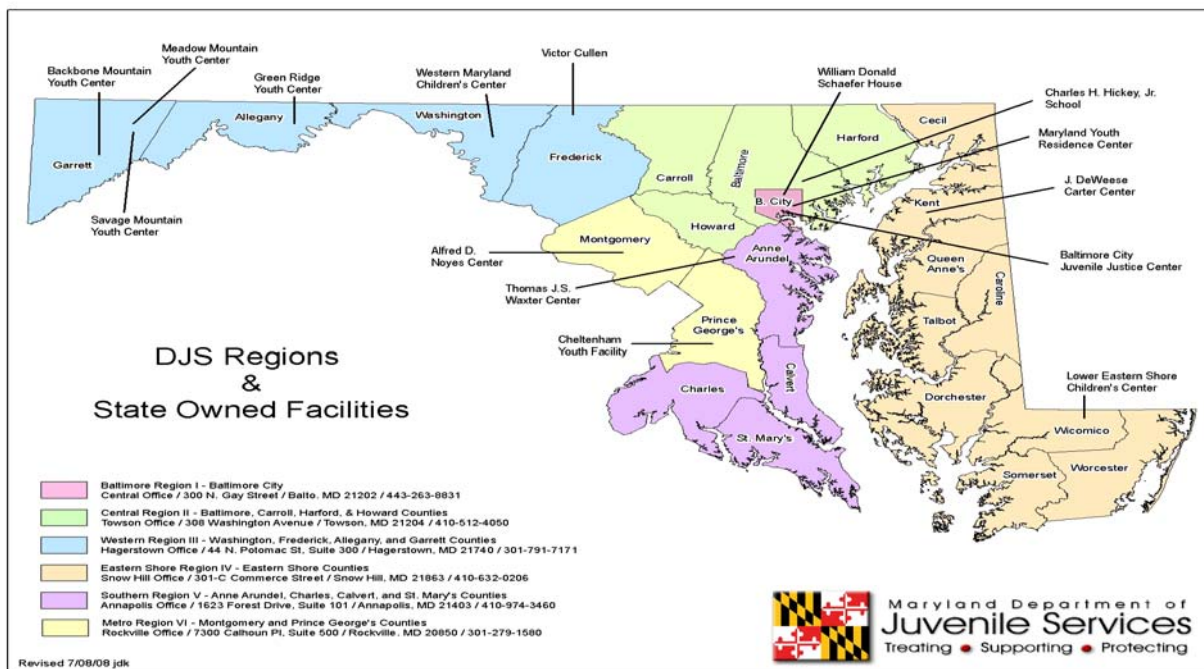
INTRODUCTION

SECTION 1: OVERVIEW OF THE JUVENILE SERVICES SYSTEM

The Department of Juvenile Services (DJS) seeks to ensure public safety, hold juvenile offenders accountable to victims, and provide youth with the services needed to assist them in becoming responsible and productive members of society. DJS operates a system of juvenile justice services delivered in communities and facilities to meet the specific needs of youth and their families without compromising public safety.

In 2008, the Department transitioned from a system comprised of five service areas to a six-region model to better coordinate with local public safety, city and county agencies, as well as community-based providers. Regionalization will result in more efficient administration of facilities and resources, and will ensure that youth under DJS supervision stay connected to their families, service providers, and communities. The newly configured regions are as follows:

Region I	Baltimore Region:	Baltimore City
Region II	Central Region:	Baltimore, Carroll, Harford, and Howard Counties
Region III	Western Region:	Allegany, Frederick, Garrett, and Washington Counties
Region IV	Eastern Region:	Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties
Region V	Southern Region:	Anne Arundel, Calvert, Charles, and St. Mary's Counties
Region VI	Metro Region:	Montgomery and Prince George's Counties



Juvenile Services Delivery Types

The Department serves youth who meet one of the following two definitions:

- **Pre-Treatment** youth are not yet receiving individualized treatment services
- **In-Treatment** youth receive services matched to their specific needs

Pre-Treatment youth are in the Department's care for one of two reasons:

- The youth is awaiting a judicial decision, also called a disposition. These youth are referred to as **Pre-Disposition**.
- The youth has had a judicial disposition, but due to processing time needed for their placement or the unavailability of the proper placement, this youth must remain in secure detention. Since these youth are held pending the arrangement of a proper placement, they are referred to as **Pending Placement**.

For predisposition youth in detention, the Department uses a risk-assessment instrument to determine whether these youth should be held in a detention facility, given an alternative to detention such as electronic monitoring, or released to the care of a parent or guardian. Services for youth whose assessment determines the need for detention are discussed in Chapters 1. Alternatives to Detention are discussed in Chapter 2.

In-Treatment youth have been adjudicated, placed on probation or committed to the Department's custody by a judge. The Department assesses the youth using two basic measures:

- Security Risk - The risk that the youth will re-offend, flee, or cause harm to self or others
- Treatment Needs - The types of behavioral, psychiatric, educational, and/or other therapies that the youth requires

The results of the risk and needs assessments determine whether the youth can remain at home and receive services in the community, referred to as community-based treatment, or whether a residential placement is necessary. The Department has a five-level classification system for the security of its placements. The classifications range from the lowest risk, Level I, an in-home placement, to the highest risk, Level V, commitment to a secure treatment facility.

Community-Based Treatment

For youth whose profile indicates that they can remain at home yet they require services, the Department provides an array of Community-Based Services. In-home services are provided by counselors/therapists who come to the home and work with the family. Other community services are provided on an outpatient basis at providers' offices. Services for these youth are described in Chapter 4.

Residential Placements

Residential Placements are for youth who either because of security risks or treatment needs require placement in an out-of-home residential facility. This analysis uses a risk/needs matrix to categorize the different types of residential placements used by the Department. These placements are initially described in Chapter 1. A more complete discussion of these placements is in Chapter 3.

There are three types of residential placements discussed in this analysis:

A. Non-Secure/Non-RTC - These are placements for youth whose profile indicates no need for either a secure facility or the intensive psychiatric care provided by a Residential Treatment Center (RTC). These facilities are for youth with low- to medium-risk security profiles.

B. Residential Treatment Center (RTC) - In this analysis, a Residential Treatment Center refers to a specialized type of facility that offers intensive psychiatric care. RTC facilities must be licensed by the State of Maryland and have a specified set of psychiatrists, psychiatric nurses, and other mental health professionals on staff to meet the Residential Treatment Center (RTC) licensing requirements. These facilities can be secure or non-secure; what distinguishes them is that they provide intensive psychiatric services. These facilities are for youth with a range of security profiles.

C. Secure Treatment Facilities - These are placements for youth whose profile indicates a high risk of re-offending, flight, or harm to self or others. These youth have a broad range of emotional, behavioral and other needs.

The matrix below with two axes, shows security risk at the top and psychiatric need along the side. The three types of residential facilities are shown in the appropriate quadrants of the matrix.

Risk/Needs Matrix for Residential Placements

	Non-Secure	Secure
Needs other than Acute Psychiatric	A. Non-Secure/Non-RTC	C. Secure Treatment
Acute Psychiatric Need	B. Residential Treatment Center (RTC)	B. Residential Treatment Center (RTC)

Overview of the Department's Facilities

The Department owns and operates several different types of facilities to support its mission. Almost all of these facilities provide residential services of various types to youth. The Department's facilities house a little less than half of the average of 1,400 youth that need pre-adjudication or post-adjudication residential placement, with the rest of the youth being placed in private facilities both in and out of the state. The Department's facilities are classified as follows:

- **Detention** facilities for pre-treatment youth; and
- **Residential treatment** facilities for in-treatment youth.

Secure Detention

DJS is responsible for the operation of eight secure detention centers, in which youth who are considered a danger to the community or to themselves or who are considered unlikely to appear in court of their own volition, are placed until they are adjudicated. The total capacity of all eight centers is 418 males and 50 females. These facilities serve both pre-disposition and pending placement youth.

State-Owned Secure Detention Facilities

Name	Location/Region	Current # Male Beds	Current # Female Beds
Baltimore City Juvenile Justice Center	Baltimore City - I	144	
J. DeWeese Carter Youth Facility	Kent County- IV	27	
Cheltenham Youth Facility	Prince George's County- VI	86	
Charles H. Hickey Jr. School	Baltimore County- II	72	
Lower Eastern Shore Children's Center	Wicomico County- IV	18	6
Alfred D. Noyes Children's Center	Montgomery County- VI	47	10
Thomas J. S. Waxter Children's Center	Anne Arundel County- V		34
Western Maryland Children's Center	Washington County- III	24	
Total Capacity		418	50

Alternatives to Detention

The Department of Juvenile Services also provides short-term community based supervision of youth whose cases are pending a judicial disposition. This community based supervision is known as Alternatives to Detention (ATDs). For youth who would otherwise be placed in secure detention, ATDs utilize the least restrictive alternative to keep youth in their communities who meet low-to moderate-risk criteria based on the Department's Detention Risk Assessment Instrument (DRAI). These alternatives to secure detention are intended to reduce crowding, cut the costs of operating large juvenile detention centers, shield youth from the stigma of

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institutionalization, help youth avoid associating with peers who have more serious delinquent histories, and maintain positive ties between the juvenile and his or her family and community. ATDs provide a level of supervision sufficient to safely maintain youth in the community and to ensure their appearance in court.

ATDs fall into two broad categories, “individual-based” and “group-based.” Individual-based ATDs include non-electronic community detention (CD) and electronic monitoring (CD/EM), and allow the youth to function in the community. Group-based ATDs include evening reporting centers, day reporting centers, detention reduction and advocacy programs, and shelter care, which bring youth together in a particular building location with others. A more complete discussion of ATD is included in Chapter 2.

Residential Placements

There are various types of treatment programs (see Appendix I for complete details of the Maryland State Operated Model) and facilities to which youth are assigned following adjudication, classified according to level of security. The separation from a youth’s family begins at Level II and significant separation from the general community begins at Level IV. Level I youth are placed with their families and so are not included in the residential placements discussion. A more complete discussion of the classifications and placement types is included in Chapter 3. The following information provides a brief program description. This section discusses only those facilities that are owned by the State of Maryland and operated by the Department. Level II placements include Foster Care and Treatment Foster Care. The Department’s owned and operated residential treatment facilities begin at Level III.

Level III – Community-Based Residential

These facilities and programs, often classified as group homes, provide residential services to youth who need more structure and supervision than a relative or foster parent can provide. These programs utilize community-based services and organize community-based activities for the youth. Most such programs are privately operated; however, the Department owns the following Level III facilities:

State-Owned Level III Facilities

Name	Location and Region	Current # of Male Beds	Current # of Female Beds
Allegany County Girls Home	Allegany County- III		10
Green Ridge Youth Center	Allegany County- III	10	
Mount Clare House	Baltimore City - I	4*	
Redirect @ Cheltenham	Prince George’s County- VI	24	
William Donald Schaefer House	Baltimore City - I	19	

*Capacity is 12, but only 4 are assigned to the Department

Mount Clare House is shared with the Department of Human Resources and the Department of Health and Mental Hygiene. The Department also owns the Ferndale Group Home of which there are plans to relinquish control.

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Level IV – Special Programs/Youth Centers

These facilities and programs are referred to as staff secure, as they are not securely locked or fenced. They target moderate-to-high-risk youth with psychiatric problems, addictions, or cognitive disorders which can lead to delinquency and impede maturation. At Level IV facilities, most all services, including education, are provided on site. There is however, one Youth Center that focuses on substance abuse services. This is the Meadow Mountain facility.

The Department owns the Level IV facilities shown below:

State-Owned Level IV Facilities

Name	Location and Region	Current # Beds
New Directions (@ Hickey)	Baltimore County- II	26 male
Backbone Mountain Youth Center	Garrett County- III	48 male
Green Ridge Youth Center	Allegany County- III	30 male
Meadow Mountain Youth Center	Garrett County- III	40 male
Savage Mountain Youth Center	Garrett County- III	36 male

The New Directions program, which is privately operated, works with sexual offenders and is housed at the Charles H. Hickey Jr. School. Meadow Mountain treats those with substance abuse problems, and Green Ridge has a 10-bed section for substance abuse (listed under Level III). The other centers listed above, along with the other units at Green Ridge, operate a positive peer culture program that teaches youth to help others and help themselves. In addition to the state-owned facilities, there are a number of private providers, both in-state and out-of-state, that operate Level IV programs.

Level IV youth with acute psychiatric needs are also served in Residential Treatment Center (RTC) placements provided to the Department on a per diem basis.

Level V – Secure Confinement

These facilities are the most physically restrictive and are securely locked or fenced to prevent escape. Youth assigned to Level V are those who are chronic repeat offenders, have been unable to complete other programs successfully, or have committed the most serious offenses. The Department operates only two such programs:

State-Owned Level V Secure Treatment Facilities

Name	Location and Region	Current # Beds
Victor Cullen Academy	Frederick County- III	48 male
Thomas J.S. Waxter Children’s Center	Anne Arundel County- V	12 female

All other youth, male and female, requiring a Level V treatment program are assigned and transported to an out-of-state facility.

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Level V youth with acute psychiatric needs can also be served in Residential Treatment Center (RTC) placements provided to the Department on a per diem basis.

Community-Based Services

The Department of Juvenile Services has traditionally used a variety of community-based programs, that is, programs in which youth receive services in the community while remaining in their home residence. The traditional 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 Evidence-Based Programs (EBP) and residential treatment wraparound services, both discussed in Chapter 4.

Shelter Care

These youth are in the Department’s care because there is no suitable home environment for them to return to. Simply put, shelter care facilities provide temporary (1-45 days) residential care for homeless youth. The Department owns the following shelter care facilities:

State-Owned Shelter Care Facilities

Name	Location and Region	Current # Male Beds	Current # Female Beds
Catonsville Structured Shelter Care	Baltimore County- II	10	
Cheltenham Youth Shelter	Prince George’s County- VI	5	
Sykesville Structured Shelter Care	Carroll County- II		10
	Total	15	10

The Catonsville and Sykesville shelter care facilities are operated by private providers. The Department owns two additional facilities that are currently not in operation due to poor physical conditions: the Maryland Youth Residence Center (MYRC) located in Baltimore City and the Hurlock Center located in Dorchester County.

SECTION 2: REFORMING THE SYSTEM

Maryland Model for Juvenile Services

Under the leadership of Governor Martin O'Malley, Lieutenant Governor Anthony G. Brown, and Secretary Donald W. DeVore, the Department has launched a reform effort to develop and implement the Maryland Model for Juvenile Services. The 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 the 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, service providers, and child- and family-serving agencies. The Department's work to implement the Maryland Model is consistent with and supportive of the recently completed Maryland Child and Family Services Interagency Strategic Plan, which was initiated and supported by the Department of Juvenile Services.

GOALS TO ACHIEVE THE MARYLAND MODEL

In FY 2008, the Department initiated the implementation of the "Maryland Model" for juvenile services. The Maryland Model is a regionalized service delivery model, with an emphasis on evidence-based programs and community collaboration, validated assessment and treatment tools (with built-in continuous quality improvement), treatment, and successful reentry for youth requiring residential care. The Maryland Model encompasses four critical goals:

- 1. Treating Maryland's Youth in Maryland**
- 2. Improving Conditions of Confinement at all DJS Facilities***
- 3. Achieving Better Outcomes for Youth and Families by Becoming a More Data and Results Driven Agency**
- 4. Reducing juvenile homicides and non-fatal shootings by DJS supervised youth***
- 5. Aligning Organizational Development with Strategic Planning Goals**

* These goals are not discussed in the Gap Analysis.

Goal 1: Treating Maryland's Children in Maryland

Because of the State's diminished capacity to serve its youth at home, the Department has increasingly relied on costly and inefficient out-of-state placements for the treatment of the Department's most vulnerable youth. These out-of-state placements keep youth away from their families and hinder the transition back to the community and family life. The Department is committed to the provision of services in Maryland in order to achieve the best outcomes for Maryland's youth.

The lack of in-state treatment capacity has also led to an increased detention population. Committed youth unnecessarily wait in detention until an appropriate placement is available. The Department's strategy is to reduce its reliance on these placements and to build in-state capacity for the treatment of youth in its care. In addition to the expansion of in-state residential services,

the Department plans to increase its utilization of community alternatives to detention (ATD) and evidence-based programs (EBP) to treat youth with services in their community.

Goal 2: Improving conditions of confinement at all DJS facilities

In June 2005, the State and U. S. Department of Justice (DOJ) entered into a written agreement pursuant to which the State agreed to undertake certain improvements at DJS residential facilities. Cheltenham Youth Facility (CYF), Charles H. Hickey, Jr. School (CHHS) and the Baltimore City Juvenile Justice Center (BCJJC) are all part of the Settlement Agreement which requires that these facilities be brought into compliance with the Civil Rights of Institutionalized Persons Act (CRIPA). The Settlement Agreement requires the State to make improvements in several substantive areas related to service delivery, including protection from harm, suicide prevention, mental health, medical care, special education, and fire safety. On June 30, 2008, DJS achieved compliance with CRIPA at the Cheltenham Youth Facility and Charles H. Hickey, Jr. School. The Department continues to work with DOJ to bring Baltimore City Juvenile Justice Center into compliance by fiscal year 2010.

Goal 3: Achieving Better Outcomes for Children and Families by Becoming a More Data and Results Driven Agency

Transparency and agency accountability are core components of the O'Malley-Brown administration. The Department will meet this goal by improving data collection, engaging in performance monitoring and researching and then utilizing best practices in the field. In an effort to create an atmosphere of accountability, the Department is integrating data-driven decision-making using StateStat; implementing continuous quality improvement and accountability in all the Department's programs; expanding detention alternative reforms statewide; developing an integrated assessment, treatment planning, and tracking system; implementing gender-responsive and trauma-informed models of care for girls; improving interagency collaboration with other state child- and family-serving agencies; and promoting greater family and community involvement.

Goal 4: Reducing juvenile homicides and non-fatal shootings by DJS supervised youth

Ensuring public safety is a fundamental objective to the Department's mission. The Department is creating and implementing several new programs to support the achievement of this goal. As part of its violence prevention efforts, the Department, in collaboration with the police and health departments, has implemented a Violence Prevention Initiative (VPI) across the state to provide enhanced community-based case management and increased monitoring of high-risk juvenile offenders. DJS reviews all juvenile homicides and non-fatal shootings to improve case management practices and identify risk factors for youth violence. The Department is committed to reducing youth involvement in gangs. To bring about this reduction, the Department is participating in a Kaizen group, a Governor's Task Force that is focusing on curbing gang violence by developing a comprehensive and coordinated statewide gang intervention/prevention plan.

Goal 5: Aligning Organizational Development with Strategic Planning Goals

The Department is committed to assessing and restructuring its organizational structure so that it is capable of achieving its major goals. Maximizing its available resources, the Department is focusing on decentralizing business processes, strengthening the workforce, and expanding leadership development. The Department has undertaken a review of its organizational systems and resources to best align these with the strategic goals outlined in this plan.

Maryland is one of 13 states¹ in which the executive branch has across-the-board state control of delinquency services. Only seven states² have regionalized management structures. While the Department's proposed regional structure is consistent with these states, only Georgia has integrated the management of detention and probation services in a regional structure. The other states share control of pre-dispositional services with local jurisdictions or the judiciary.

The Department is in the process of reorganizing its structure to regionalize the following components:

- Community Services - Including intake, probation, aftercare, and community detention
- Residential Services – Including committed and detention programming
- Support Services - Including personnel, fiscal, procurement, information technology (IT), and quality assurance.

As part of the restructuring, the Department has regionalized its intake, probation, aftercare, community detention, and treatment options and decentralized programmatic and administrative functions. The Department has reorganized the former 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 programs. As discussed earlier, regionalization will result in more efficient administration of facilities and resources, and will ensure that youth under the Department's supervision stay connected to their families, service providers, and communities. Currently, detention centers predominantly serve youth by geographic area.

Specific Strategies to Achieve the Maryland Model Goals

The Department is actively implementing multiple cross-cutting strategies that effectively advance the four goals of the Maryland Model. The following discussion highlights implementation components and system benefits of three specific strategies: (1) reforming the secure detention system, (2) reducing pending placement, and (3) improving treatment programming.

1) REFORMING THE SECURE DETENTION SYSTEM

Eliminating the Inappropriate Use of Secure Detention

To use data to drive decision making, eliminate the inappropriate use of detention, and ensure youth appear in court, the Department is implementing the validated Detention Risk Assessment

¹Alaska, Delaware, Florida, Georgia, Kentucky, Maine, Maryland, New Hampshire, New Mexico, North Carolina, Rhode Island, South Carolina, and Vermont

²Alaska, Florida, Georgia, Louisiana, Missouri, North Carolina, and South Carolina

Instrument (DRAI). This objective tool is based on criteria that assess a youth's risk factors and current offense(s) to determine whether a youth should be placed in secure confinement, conditionally released to the community under close supervision with treatment services, or released with no conditions until a court hearing. This tool is discussed in Chapter 1.

Youth with high-risk DRAI scores are placed in detention, while youth with low-to-moderate risk scores are placed in an Alternative to Detention program. Alternatives to Detention (ATD) are short-term programs that utilize the least restrictive alternative to keep youth who meet low-to-moderate-risk DRAI criteria in the community while awaiting juvenile court hearings. ATD provides a level of supervision sufficient to safely maintain youth in the community and to ensure their appearance in court. ATD are cost-effective solutions for a large number of youth who are awaiting adjudication and disposition hearings. When implemented effectively, ATD reduce overall detention population, reduce the costs of operating large juvenile detention centers, shield youth from the stigma of institutionalization, helps youth avoid associating with peers who have more serious delinquent histories, and maintains positive ties between the juvenile and his or her family and community. Currently, the Department has an array of ATD services such as Community Detention, Evening Reporting Centers, the Detention Reduction Advocacy Program in Baltimore City, and Shelter Care.

Benefits to Using the DRAI and ATD:

- Prevents the over-placement of youth in detention centers, thus shielding youth from the stigma of institutionalization and helping youth avoid associating with peers with more serious delinquent histories.
- Reduces the overall detention population and relieves overcrowding.
- Cost-effective solution to help youth without incurring the high cost of detention.
- Allows youth to maintain ties to their home and community.

As discussed above, detention center populations are projected to continue to be reduced through the use of instruments and policies that place lower-risk pre-adjudication and pre-disposition youth in ATD. Further, as discussed in more detail in the section that follows, reduction in the detention population is being achieved by shortening the length of stay for youth who have been adjudicated and are waiting for a program placement opening. The Department's initiatives from October 2007 to May 2008 have resulted in a significant reduction in the average length of stay (ALOS) for post-adjudicated youth in detention centers.

2) REDUCING PENDING PLACEMENT

A substantial portion of the detention population includes youth with a court disposition who are awaiting a committed placement. These youth are referred to as pending placement. Youth in pending placement comprise roughly one-third of youth in detention.

In FY 2002, a change in Department policy resulted in the closure of the male secure treatment programs formerly offered at the Charles H. Hickey Jr. School and the Victor Cullen Center. As these programs began depopulation and eventually closed, the number of committed youth waiting in pending placement swelled because there was no appropriate facility available for their placement. While in pending placement in a secure detention facility, youth do not receive

the treatment services prescribed for their particular needs. The Department's strategy to reduce the pending placement population in secure detention is to:

- Build in-state capacity to accommodate Maryland youth requiring Level V, secure residential treatment care
- Improve case management processes and seek to shorten lengthy interagency approval mechanisms

Building In-state Capacity to Treat Level V Youth

The Department's current capital plan includes the construction of two new secure, state-run treatment programs that will be available to serve the Level V, high-risk male youth in Maryland. These facilities will supplement the existing 48-bed Level V male secure treatment facility at the Victor Cullen Center. As will be discussed in Chapter 3, the Department expects the construction of these new treatment facilities to reduce the number of youth in out-of-state programs.

Improving Case Management Processes

Case processing within DJS has been improved by a classification system used to determine the level of care needed for a youth and to control the admissions in the new committed programs. Further, recent interagency reforms no longer require the Department to get Local Coordinating Council/State Coordinating Council (LCC/SCC) approval to refer youth to RTCs. Together, these

Benefits to Increasing In-state Treatment Capacity and Diverting Youth from Committed Placements:

- Increasing in-state capacity will reduce significantly the waiting time for youth being placed in Level V care, and thus lower pending placement numbers. Moreover, this will also obviate the need to send youth out-of-state and treat Maryland's youth in Maryland.
- Reforms to the case management process will reduce pending placement ALOS.

case management reforms have helped reduced ALOS for youth while they are awaiting placements. The Department also expects that these strategies will result in an overall reduction of the pending placement population.

3) IMPROVING TREATMENT PROGRAMMING

The strategy to improve treatment programming includes two main components:

- Reducing Inappropriate Placements
- Expanding Community-Based Services, Treatment, and Placements

Reducing the Number of Inappropriate Placements

One of the Department's greatest challenges has been determining what the appropriate placement for treatment should be. A study discussed in Chapter 3 shows that youth who are inappropriately placed are often expelled from group home placements. This has resulted in high failure rates in committed placements: 40% of pending placement youth had at least one prior committed placement failure, and 65% of youth placed out-of-state had at least one prior in-state committed placement failure. When these youth are expelled, they must be held in pending

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placement in a secure detention facility until an appropriate placement can be found for them. As discussed earlier, the Department is working to reduce the number of youth in pending placement because while in pending placement, youth do not receive treatment services matched to their needs. The Department is now implementing a new tool, the Maryland Comprehensive Assessment and Service Planning (MCASP) assessment, to reduce the number of placement failures and get youth to the right placement the first time.

The Department has established its own classification tool based upon the Washington State Juvenile Court Assessment. Previous classification efforts in Maryland had been criticized for being too broad and not adequately reflecting the broad array of services that needed to be provided to match the needs of the youth. The resulting tool, the MCASP, is an innovative process that will be conducted on all committed youth throughout their involvement with DJS, and includes an ongoing assessment to address need and reduce risk. The 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 includes the ten major domains 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 the least restrictive and most appropriate settings, youth will be matched to placements within the state based on public safety considerations and the youth's individual treatment needs.

Expanding Community-Based Services, Treatment, and Placements

The Department uses a continuum of community-based services, treatment, and placements to serve youth both in their communities and in out-of-home placements. Traditional community-based programs include probation, home monitoring, court-ordered community services, victim restitution, and counseling. As discussed above, these options are now augmented with the use of innovative EBPs, to include Functional Family Therapy, Multi-Systemic Therapy, and Multi-Dimensional Treatment Foster Care. In addition to the expanded use of EBPs, the Department also provides educational, employment, structured recreation, assessment and treatment services, and family support to youth in community-based placements.

SECTION 3: GAP ANALYSIS OVERVIEW

The material in this chapter presents the method and findings of a “gap analysis” for the Department of Juvenile Services system. The content is divided into five chapters. The first two chapters discuss pre-treatment youth, while the third and fourth chapters examine placements for youth in-treatment.

- Chapter 1 discusses secure detention system and plans to reform it.
- Chapter 2 analyzes the Department’s Alternatives to Detention (ATD) and how their use will increase as Chapter 3 includes an overview of the residential treatment facilities used by the Department
- Chapter 4 presents the Department’s community-based treatment services, including Evidence-Based Services (EBS) and Wraparound care for youth with psychiatric needs.
- Chapter 5 summarizes the conclusion of this analysis.

Framework for the Gap Analysis

The analytical logic for developing the gap analyses is based on three concepts: (1) average daily population (ADP), (2) Pre-Reform/Post-Reform, and (3) a Gap Analysis. The first concept, average daily population (ADP), is used to measure the need for facility beds or community services. The mathematical formula for calculating the ADP for one year is:

$$\text{ADP} = \frac{\text{Admissions} * \text{Average Length of Stay}}{365 \text{ days}}$$

An average daily population is the average number of youth in a facility or on an ATD per day in a year. “Admissions” are the total number of youth in a year in a facility. The “average of length of stay” (ALOS) is the total number of days youth are in a facility for the entire year divided by the total number of youths. Multiplying the number of admissions times the ALOS and dividing by 365 yields the ADP. The ADP for facilities is often adjusted for “surge,” that is higher than expected average use. Additional beds are thus added to the ADP in order to accommodate this occurrence.

The second concept is Pre-Reform/Post-Reform. In this analysis the Pre-Reform refers to the measures of ADP, Admissions, and ALOS in a time period preceding reforms intended to decrease these three variables. The Pre-Reform measures are based on the ADP, Admissions, and ADP data for a baseline year, CY 2007. This baseline was chosen because data from this year is generally representative of previous years before the reforms efforts. A Pre-Reform ADP thus reflects the Admissions, ALOS, and ADP numbers in the CY 2007 baseline year.

In order to decrease the Pre-Reform ADP, the Department intends to implement institutional changes that will decrease the CY 2007 baseline Admissions and/or ALOS. These changes, that is, “reforms,” are various ways that the Department intends to decrease the Admissions and/or ALOS numbers in comparison to their baseline value. A Post-Reform ADP equation will thus reflect the expected decrease in the CY 2007 Admissions and/or ALOS values which will, in turn, result in a Post-Reform decrease in the ADP. This document will describe the various reforms whereby the Department will attempt to achieve the Post-Reform ADP decrease.

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The third analytical concept is the “Gap Analysis.” As determined by the Post-Reform ADP, the total number of beds needed is compared to the total planned supply of beds. The comparison will reflect either a “surplus,” “deficit,” or “equilibrium” in the relationship of the supply of beds to the demand for beds. These three possible comparative results thus provide an informational basis for capital planning in the DJS system.

For some placement types discussed in Chapter 3, the available data were insufficient to accurately assess the gap between need and capacity. A capacity utilization method was used for these placements, showing what percentage of the available capacity is utilized (on average) by the population served. Analysis of capacity utilization rates reveals that certain placement types are operating at nearly full capacity, and would be candidates for additional capacity, while others have large percentages of unutilized capacity and may be candidates for downsizing.

CHAPTER I: SECURE DETENTION

This chapter is divided into two sections: male secure detention and female secure detention. These sections analyze the need for secure detention beds for males and females who are either awaiting a judicial hearing or have been found delinquent and are waiting to be placed in an appropriate treatment setting. For both males and females, recent reforms are expected to decrease the need for secure detention beds. At the end of each of these sections will be an analysis of the existing number of detention beds, projected need for detention beds, and the difference, by geographic region for males and statewide for females.

Regional Detention: The Department's goal is to serve detained youth in their home region to the extent possible. This has not yet been achieved for males or females, however, efforts are underway to enable all male youth to be detained in their home region. Achieving this objective for female youth in secure detention would require providing a facility in each region. The small number of female youth in detention makes this impractical. For instance, as will be shown later in this chapter, the projected bed need for female secure detention in Western Maryland is less than three (3) beds. Providing a detention facility for the 3 female youth in that region would not be an effective use of the State's resources.

Alternatives to Detention: The reforms discussed involve diverting youth from detention facilities to Alternatives to Detention (ATD), using home-based methods such as electronic monitoring and community detention. The reductions identified in admissions to secure detention facilities will require the availability of additional ATD capacity. Alternatives to Detention will be discussed in the next chapter. These reforms are discussed in the overview of this chapter, and are followed by the analyses of the male and female secure detention needs and capacity.

A. Overview

Both the male and female secure detention populations are expected to change as a result of reforms undertaken by the Department of Juvenile Services (DJS) begun late in 2007. Because the effect of these reforms is not expected to be realized until after 2007, data for CY 2007 are used as a baseline that represents the "pre-reform" population. The adoption of these reforms is expected to decrease the need for secure detention beds, and these expectations are reflected in this analysis of the post-reform data. The expected results of these reforms are shown in this analysis as the "post-reform" data. The mechanisms for reducing this need will be discussed for each of the sub-populations.

The population of the secure detention system is composed of two sub-populations – pre-disposition and pending placement. Pre-disposition youth are awaiting adjudication of their cases. A youth adjudicated "delinquent" by a court then receives a "disposition," that is, a final judicial decision regarding what treatment program is required. Once a disposition occurs, a youth is committed to a placement by the Department of Juvenile Services. If time elapses before placement, a youth is sometimes returned to a secure detention facility in a pending placement status. The disposition date is the starting point for counting the number of days in pending placement. This count thus measures the length of stay, in number of days, a youth spends pending placement in a secure detention center.

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The sum of youth in Pre-Disposition and Pending Placement status is the total population for secure detention. The formula below can be used to determine the total number of admissions and the total average daily population (ADP) for secure detention.

$$\text{Pre-Disposition} + \text{Pending Placement} = \text{Secure Detention}$$

A standard measure of bed need for facilities is the average daily population (ADP). The mathematical formula for ADP is:

$$\text{ADP} = \frac{\text{Admissions} * \text{Average Length of Stay}}{365}$$

In order to reduce the ADP, one or both of the inputs, Admissions and/or Average Length of Stay, must be reduced. The impact of reforms on each of these two variables will be analyzed in this chapter, and the resulting “post-reform” ADP will be shown. This post-reform ADP will be the basis for the Gap Analysis.

MALE SECURE DETENTION

The male secure detention population is expected to show decreases in both the pre-disposition and pending placement populations. The decrease in the pre-disposition population will result from implementation of a new detention risk-assessment instrument that will reduce the number of pre-disposition admissions by diverting youth to alternatives to detention (ATD). The average length of stay for the pre-disposition population is expected to remain at the CY 2007 level of 17.2 days. For the pending placement population, a series of reforms is expected to both reduce the number of admissions to pending placement and the ALOS in pending placement.

Pre-Disposition

Admissions:

As discussed above, the DJS reform for reducing male admissions to secure detention facilities is to reduce the number of admissions by diverting youth to ATD. The Department's goal to divert 20% of male CY 2007 baseline admissions was based on two factors. The first factor was the adoption of the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI) to reduce the number of pre-disposition admissions in Maryland. The Department is now implementing the JDAI-sponsored Detention Risk Analysis Instrument (DRAI), a screening tool to assess whether detention, alternatives to detention, or release is appropriate at intake to the DJS system. For details about the DRAI, see Appendix II.

Implementation of the DRAI in other jurisdictions in the United States averaged a reduction in secure detention admissions of 27%³. Results of a Department study comparing actual detention decisions for two months in 2005 to detention decisions from the application of the DRAI to the same cases showed that the DRAI would have resulted in a decrease in detention admissions of 31%⁴. Reductions in admissions to secure detention were largely achieved because the assessment instruments indicated ATD were more appropriate than secure detention.

The preliminary results from implementation of the DRAI in the DJS system were the second factor which influenced the 20% target goal. Implementation began statewide in CY 2008. The preliminary results shown in Table 1-1 show the overall CY 2007 baseline ADP modestly decreased from 253 to 245 for males. The regional data shows the Western region, Eastern region, Central region and Montgomery County reduced their pre-disposition populations by more than 20% from calendar year 2007. The remaining jurisdictions, Baltimore City and Prince George's County, have encountered difficulties in the implementation of the DRAI. These jurisdictions continue to report a large number of discretionary overrides of the DRAI; that is, the DRAI indicated an ATD but was overridden at the discretion of the intake officer. The Department is working with the intake officers in these jurisdictions to reduce discretionary overrides to less than 10%, a rate consistent with other JDAI jurisdictions.

³ Publication can be found on the Annie Casey Foundation web site www.aecf.org.

⁴ Appendix I

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**Table 1-1
Percentage Change in CY 2007 Baseline ADP Due to
Early CY 2008 Implementation of the DRAI**

Residential Area	2007	2008*	Per Cent Change
Baltimore City	92.7	100.0	8%
Central	32.3	25.7	-21%
Western	15.0	11.9	-21%
Eastern	24.1	18.8	-22%
Southern	32.2	29.4	-9%
Montgomery	21.8	17.4	-20%
Prince George's	33.4	40.5	21%
Out of state	1.4	1.4	2%
Total	253.0	245.0	-3%

*Preliminary estimate based on the first 10 months of CY 2008

The Department has adopted a conservative approach in its determination of the goal for reduction of the number of youth entering secure detention in a pre-dispositional status. Three possible numbers have been introduced. The 27% average evidenced in other jurisdictions; 31% based on a 2005 DRAI analysis using DJS data; and 20% based on the preliminary results of the early implementation of the DRAI in the DJS system. A twenty percent (20%) reduction in the pre-dispositional ADP, a conservative goal, has been chosen as the target goal. It is assumed that as the overuse of overrides declines, and experience with the DRAI in the DJS system increases, achieving the 20% target is a reasonable goal.

Average Length of Stay (ALOS)

As mentioned earlier, there is no change expected in the ALOS for male pre-disposition secure detention population. The ALOS is expected to remain at the CY 2007 figure of 17.2 days.

Reform ADP

Table 1-2 below shows the statewide results of the 20% reduction for male admissions to secure detention facilities. The result is an estimated ADP decrease from 253 to 202, which translates into a decrease of 1,074 male admissions to secure detention. The ALOS remained unchanged at 17.2 days, thus this factor had no impact on the change in the ADP.

Table 1-2
Comparative Pre and Post Reform Differences in Admissions, ALOS,
And ADP for Pre-dispositional Youth in Secure Detention

	Admissions	ALOS	ADP
Pre-reform	5,369	17.2	253
Post-reform	4,295	17.2	202
Difference	1,074	0	51

Table 1-3 distributes the statewide Pre-reform and Post-reform total ADP across the six regional areas with secure detention centers for males. As described in Chapter 2, the reductions in each region will become important because they represent the numerical increase in the number of youth who will need ATD due to their diversion from secure detention. Finally, it is important to emphasize that the calculation of the need for beds results from the addition of three elements: (1) the Post-reform pre-dispositional ADP, (2) the Post-reform pending placement ADP, and (3) a “peaking” number calculated as a percentage of the addition of the pre-dispositional and pending placement populations. The number resulting from this percentage is intended to adjust bed need upward to account for the periods that a detention facility’s population will “surge” above its average. This total is the estimated need for beds in a region.

Table 1-3
Estimated Affect on ADP Due to a 20% Decrease in the Male Admissions
to Pre-Dispositional Secure Detention

		Pre-reform		Post-reform		Difference Between Pre and Post Reform	
Region	Residential Area	Admissions	ADP	Admissions	ADP	Admissions	ADP
I	Baltimore City	1,968	93	1,570	74	(397)	(19)
II	Central	686	32	552	26	(134)	(6)
III	Western	319	15	255	12	(64)	(3)
IV	Eastern	511	24	403	19	(108)	(5)
V	Southern	684	32	552	26	(132)	(6)
VI-MC	Montgomery	462	22	361	17	(102)	(5)
VI-PGC	Prince George’s	709	33	573	27	(136)	(6)
VI-DC	Out of state	29	1	21	1	(8)	(0)
Total		5,369	253	4,295	202	(1,074)	(51)

PENDING PLACEMENT

The pending placement population in secure detention is composed of youth awaiting transfer to commitment in three different kinds of facilities: (1) Non RTC/Non-Secure, (2), Residential Treatment Centers (RTC) and (3) Secure Treatment. Added to the pre-dispositional population

discussed in the previous section, the pending placement youth are the second population in secure detention facilities. As with pre-dispositional youth, reduction of this population's ADP would decrease the population size and need for beds in secure detention facilities.

Methods for reducing the pending placement ADP are the same as those used to reduce the pre-dispositional ADP: reducing admissions and reducing the ALOS. This analysis examines the expected changes in admissions and ALOS for each sub-population. At the end of this section, the post-reform ADP for each sub-population will be added to determine the total post-reform pending placement ADP. A preview of the total male pre- and post-reform pending placement admissions, ALOS and ADP is shown in Table 1-4.

**Table 1-4
Comparative Pre- and Post-reform Differences in Admissions, ALOS, and ADP
for Pending Placement Youth in Secure Detention**

	Admissions	ALOS	ADP
Pre-Reform	1,016	48	134
Post-Reform	958	31	81
Difference	58	17	53

In the aggregate, the decrease in total pending placement ADP is 53 (approximately 40%). This decrease results from a decrease of 58 admissions (approximately 6%) and 17 days in the ALOS (approximately 36%). The analysis below examines the three pending placement sub-populations, showing how changes in their admissions and ALOS contributed to the aggregate Post-reform reduction in the total pending placement ADP.

Pending Placement Sub-population: Non-RTC/Non-Secure Youth

This sub-population is composed of youth waiting for placement in one of the following five major types of facilities: (1) foster care, (2) therapeutic foster care, (3) group homes, (4) residential substance abuse, and (5) Youth Centers. "Non-RTC" means that these facilities do not serve youth with severe emotional problems requiring psychiatric treatment. "Non-Secure" means that while the facilities might have some features of security (e.g. locked doors), they lack the hallmark characteristics of "secure" facilities. The hallmarks are the presence of locked doors to prevent escapes and either a fence surrounding the facility or an outside-fenced recreation area.

The material below provides a brief description of the facilities mentioned above which serve Non-RTC/Non-Secure youth.

- Foster Care:** There are two basic kinds of foster care, regular and therapeutic. **Regular foster care** serves low-risk youth who cannot be managed in their own homes, so continuous 24-hour care and supportive services are provided to youth in DJS-approved family homes. Education and services for behavioral problems are usually accessed in the community. The foster family serves as a surrogate family and attempts to help youth through experiences within a family environment.

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- **Therapeutic Foster Care** provides continuous 24-hour home care and intensive support services in a family setting for youth with serious emotional, medical, and psychological conditions. Foster parents usually receive extensive pre-service training and in-service supervision and support, and they have been trained to work with youth with special needs. Therapeutic foster care homes are generally clustered within a program under the oversight and management of a mental health professional or specialist trained in dealing with these youth. Frequent contact between the foster parents and professionals and specialists is expected.

- **Group Homes:** Group homes are residential facilities located in the community that provide out-of-home services for four or more moderate-to high-risk youth. The youth generally need more structure and supervision than a relative, foster parent or treatment foster parent could offer.

Group homes vary in the type and intensity of services provided depending on the particular types of group home. The types include general group homes, specialty group homes (e.g. mother and baby, sex offender), and therapeutic group homes. Also, Alternative Living Units (ALU) for youth with developmental disabilities and Independent Living Programs (IL) which prepare youth to live on their own are generally included in the group home category.

- **Residential Substance Abuse:** These facilities have similar properties to standard group homes, but they include drug treatment certified under the Maryland Alcohol and Drug Abuse Administration. Certification requires attendance by youth at drug treatment for a specified number of hours per week and treatment programs are short (45 to 90 days) and long term (4 to 9 months).

- **Youth Center:** Youth Centers are “open” and “staff secure” facilities. “Staff secure” means staff provide sight supervision of youth movement and activities (24/7). The facilities are not physical plant secure, but they are located in western Maryland away from concentrated population centers, thereby providing a form of geographic security that greatly inhibits youth from escaping. The Centers serve moderate- to high-risk youth, that is, those adjudicated with serious offenses, having a history of multiple offenses or failed previous placements, lengthy histories with the Department, and having escaped from other types of residential placements. The Centers provide a cognitive-behavioral model within a positive peer culture. One of the Centers, Meadow Mountain, serves youth with substance abuse treatment needs.

Table 1-5
Males in Pending Placement Awaiting Non-Secure/Non-RTC Placement

	Admissions	ALOS	ADP
Pre-Reform	755	34.1	71
Post-Reform	755	25.9	54

Reforms to Reduce ALOS for Youth Awaiting Non-Secure/Non-RTC Placement

The Department's reforms focus on reducing the ALOS for processing youth needing a Non-Secure/Non-RTC placement from 34.1 to 14 days and a 20% reduction in admissions to pending placement for this sub-population. Since these reforms are only beginning, this analysis, takes a more conservative approach, projecting ALOS reductions consistent with CY 2008 data and no reduction in admissions.

ALOS: The Department is focusing on having all material necessary for a disposition, that is, a needs assessment, a pre-disposition investigation, and a treatment service plan/evidence-based services evaluation occur after adjudication but prior to disposition. Table 1-5 shows a projected reduction in the ALOS from the CY 2007 figure of 34.1 days to 25.9 days, the ALOS reduction achieved in CY 2008. As noted below, there is sufficient residential capacity to serve youth as the changes unfold. If the changes succeed, expensive group home utilization will decrease and youth will be served in the community with services whose efficacy has been validated with research.

Admissions: It is important to emphasize that the Department's future plans project a 20% decrease in the Non-RTC/Non-Secure group home youth in pending placement through diversion to community-based evidence-based services. In the CY 2007 baseline, approximately 240 youth were admitted to group homes from pending placement. The supply of EBP slots will ultimately determine the number of reduced admissions in the Non-RTC/Non Secure category. In turn, these diversions to community-based EBS will determine the degree to which the admissions for this sub-population will decrease.

Processing Time Reductions for Non-Secure/Non-RTC Placements

Foster Care and Group Homes

The placement process is the same for both treatment foster care and group homes. Time needed to place youth is reliant on the information known about the youth at adjudication. If the youth is new to the Department, then a pre-disposition investigation will need to be done and perhaps a psychological evaluation. If the youth is known to the Department, this information is most likely available and the decision making toward placement can begin with the staffing.

For clarification of terms - Disposition is the final decision of the Judge or Juvenile Master regarding the status of a youth who has been previously adjudicated delinquent. Among several possible judicial decisions is to place a youth on probation and leave the youth home or to commit the youth for placement by the Department. The disposition date is the starting point for

Reduce ALOS for Youth Awaiting RTC Placement

The Department's reforms focus on reducing the ALOS for processing youth needing an RTC placement. Table 1-6 shows a goal to reduce the ALOS from 71 to 48 days. RTC placement processing involves two tracks, one for in-state placements, and the other for out-of-state placements. Administrative processing for in-state placements has involved two phases, an internal DJS process and a subsequent external process involving Local Coordinating Councils (LCCs). Except for one change in the internal DJS process, administrative processing for out-of-state placements is the same as in-state placements. For out-of-state placements, the process involves two external agencies, the LCCs and the State Coordinating Council.

Processing Time Reductions for In-state RTC Placements

The internal processing phase within DJS is described below. Without inclusion of Step 2, processing time is 45 days. Its inclusion increases the time to between 66-73 days. However, sufficient information already exists to support an RTC placement for a great proportion of youth who are committed. Time for gathering information to support an application to RTC vendors is thus unnecessary. In light of this situation, this step has been excluded in counting the internal processing time.

(1) Youth assigned case manager;	{ 3 days }
(2) Case evaluation group (e.g. parents, resource specialist) provide/seek info about youth that supports likelihood of RTC placement;	or { 21 to 28 days }
(3) Case material forwarded to potential RTC vendors;	
(4) RTC vendor case review/decision about acceptance of youth;	{ 14 days }
(5) Vendor acceptances reviewed by DJS/selection of placement made;	{ 2 days }
(6) DJS prepares certificate of need (CON)/documents that establish medical necessity for an RTC placement;	{ 21 days }
(7) CON sent to RTC, County Core Service Agency, and MAPSMD reviews whether youth meets medical necessity criteria;	{ 2 days }
(8) RTC contacts MAPSMD to get medical necessity authorization necessary for approval of RTC placement.	{ 3 days }
*Subtotal:	45 Days

***Note:** Excludes Step 2.

The *external processing* phase for in-state RTC placements had formerly involved the Local Coordinating Councils (LCCs), interagency bodies at the County level that are composed of

individuals from DJS, the local Core Service Agency, the Department of Social Services (DSS), the Department of Health and Mental Hygiene, and the local education system. Among the functions of the LCC was to review and approve a proposed RTC placement. This took from 21 to 28 days, but recent reforms to streamline the placement process have eliminated the LCC review function. The total processing time before the LCCs' elimination from the process thus added 21 to 28 days to the 45 day processing time within DJS. The result was between 66 and 73 days for processing. With the elimination of this step, the processing time decreased to 45 days, the time for *internal* DJS processing only.

Processing Time Reductions for Out-of-state RTC Placements

RTC youth are sometimes placed in out-of-state RTCs, typically because these youth have specialized psychiatric needs that cannot be effectively served by in-state RTC facilities. The out-of-state RTC placement ALOS thus requires a different calculation than the in-state ALOS. The *internal process* phase within DJS for placement of out-of-state youth is the same as in-state youth with one addition. Fourteen days are added for out-of-state transportation arrangements. This results in 14 days being added to the in-state process of 45 days, thus increasing *internal* processing time to 59 days.

An additional *external* agency processing phase also formerly existed for out-of state placement. In addition to the LCC approval, an application for funding involved the State Coordinating Council (SCC). The SCC is an interagency body that serves as a committee of the Children's Cabinet. Application to the SCC for State funding was necessary if the LCC determined that a youth required out-of-state placement. This step, which has also been eliminated, required from three (3) to four (4) weeks. As a result, 21 to 28 days was added to the LCCs' 21 to 28 days, thereby increasing external processing time to between 42 and 56 days. Combined with the 59 days for internal processing, the total processing time prior to recent reforms was 101 to 115 days. By eliminating both external agencies in the process, total processing time was reduced to the 59 days for internal processing.

Admissions

Table 1-6 indicates the reduced ADP resulting from implementation of ALOS processing reforms. However, the Department has just begun implementation of reforms to divert RTC pending placement admissions to community-based services. Due to the recent initiation of these reforms, this analysis assumes no change in admissions for RTC pending placement youth. The following section will discuss these new reforms.

Pending Placement Reforms for Males Awaiting RTC

The above analysis highlights a reform involving the reduction in processing time for placements in Residential Treatment Centers. Pending placement waiting time decreases with reductions in processing time, thereby decreasing the pending placement ADP. It should be emphasized that the Department has only begun the processing reforms for diverting RTC youth entering pending placement. In addition to ALOS reductions, the Department also plans to reduce admissions to pending placement.

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Another major departmental reform is that DJS is collaborating with the Mental Hygiene Administration on the expansion of care management entities that provide community-based services to children and youth who are at-risk for entering a residential treatment center using High Fidelity Wraparound services.

Maryland uses a care management entity (CME) to provide care coordination using High Fidelity Wraparound as the service delivery model. Currently, there are four jurisdictions that are currently using a CME as the business and systems structure to support individualized care planning through Child and Family Teams: Baltimore City, Montgomery County, St. Mary's County, and Wicomico County. The care coordinators facilitate child and family team meetings and access to services and supports necessary to implement the plan of care. In addition to creating and maintaining a provider network, one of the hallmarks of the CME is the responsibility and accountability that the CME has for a particular population.

Baltimore City and Montgomery County were the first two sites in Maryland with CMEs providing Wraparound services. For the RTC-eligible population of youth, during the first three quarters of FY 2008, 106 youth were served in Baltimore City and 88 youth were served in Montgomery County using Children's Cabinet Funds. Of those youth, 85-86% had an increase in overall functioning, as measured by the Child and Adolescent Needs and Strengths (CANS) assessment tool 12 months after enrollment. Between 90-94% of those youth remained in a setting with low restrictiveness or moved to a lower level of restrictiveness 12 months after enrollment (Maryland Choices, 2008).

The Department plans to reduce admissions to youth on pending placement awaiting RTC placement by diversion to wraparound community-based services. Youth adjudicated "delinquent" and assessed as "wraparound eligible" will be diverted to wraparound at disposition and would be able to remain in the community. Processing for wraparound services in the pre-adjudication stage enables the court to adjudicate and reach a disposition at the same time, thereby facilitating diversion of "wraparound youth" from pending placement. In turn, the reduced admissions to the RTC pending placement population will reduce the ADP of this population.

The Department is adopting a conservative approach in not including diversions as a reform in the analysis since the expansion of current RTC wraparound has only begun recently. DHMH has indicated that RTC youth will likely be distributed into three categories: (1) youth immediately available for diversion to wraparound services; (2) youth who, due to the severity of their conditions, are likely to be served only in residential treatment facilities; and (3) youth who will begin treatment in a residential center, then "step down," when ready, to wraparound services. As yet, there is no research indicating the distribution of youth in these three categories.

Pending Placement Sub-population: Secure Treatment Youth

This sub-population is composed of youth waiting for placement in a Level V secure treatment facility. These youth are usually chronic repeat offenders, failures in completing other programs, or adjudicated for the most serious levels of offenses. The programs provide the most physically restrictive environments for the behavior management and treatment of youth within the juvenile system. Secure programs must be locked to prevent escape and have either a perimeter fence surrounding the facility or an outside-fenced recreation area. Level V placements are in-state

secure placements and non-RTC out-of-state placements for youth whose risk profile indicates the need for a secure placement.

Pending Placement Reforms for Males Awaiting Secure Treatment

Table 1-7 indicates a Post-reform decrease of 58 (approximately 45%) fewer admissions of pending placement secure treatment males. The admissions reduction, in combination with the 52 day decrease in ALOS (approximately 50%), results in an ADP reduction of 27 (approximately 73%).

Table 1-7
Males in Pending Placement Awaiting Secure Treatment Placement

	Admissions	ALOS	ADP
Pre-reform	129	105	37
Post-reform	71	53	10

Admissions Reductions

The admissions decrease in pending placement secure treatment admissions from 129 to 71 will result from the Department's reform to emphasize in-state services. Three new (one already operational and two proposed) in-state secure treatment facilities will enable many youth to move directly from disposition to their secure treatment placement. As a result, the additional secure treatment bed capacity will enable these youth to bypass pending placement entirely, thereby reducing secure treatment admissions to pending placement.

The reform, however, will not eliminate admissions to pending placement secure treatment completely. Of the estimated 71 Post-reform admissions, 53 will continue to be placed out-of-state due to their highly specialized programmatic needs (e.g. Asperger Syndrome). In addition, an estimated 18 additional youth will still wait for in-state secure treatment placement in pending placement.⁵ Avoidance of this pending placement group who need secure treatment would require a larger number of secure treatment beds than planned.

ALOS Reduction

The 50% decrease in the ALOS occurs because transfer to in-state secure treatment will occur more quickly than the historically long ALOS (105 days) needed for out-of-state secure treatment placements. Because of an anticipated deficit in the supply of in-state secure program slots, there will continue to be approximately 18 youth admitted each year to pending placement awaiting an in-state placement. These youth will have an ALOS of 34 days in pending placement. In addition to the youth who will be served in-state, the estimated 53 awaiting an out-

⁵ As will be discussed in Chapter 3, Section C, the expected bed need for male in-state secure treatment is 156. The Department is planning to increase this type of capacity to 144 in the near future. Even with this additional capacity, however, there will still be a deficit of 12 beds (156-144=12). The consequence of insufficient capacity is that youth will have to be admitted to pending placement in secure detention until an in-state secure treatment bed is available. The deficit is projected to result in 18 male secure treatment admissions to pending placement.

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of-state placement due to their particular programmatic needs will have an estimated ALOS of 59 days⁶. The Post-reform ALOS of 53 is a weighted average of the in-state and out-of-state youth.

Male Pending Placement Summary

Table 1-8 presents comparative Pre-reform/Post-reform data for pending placement males. Statewide, reforms are estimated to decrease the ADP by approximately 40%. ALOS decreases by 36% and Admissions by 6%. Examination of the three sub-populations suggests the sources for these decreases. The major changes occur with secure treatment pending placement, reflecting the reform impact of planned in-state secure treatment capacity. Estimated admissions decreases are approximately 45%, while estimated ALOS decreases by approximately 50%. The other source of changes in the overall ADP was from processing reforms which create an estimated decline in the ALOS for Non-Secure/Non-RTC sub-population and the RTC sub-population.

**Table 1-8
Comparative Pre-reform and Post-reform Admissions, ALOS, and ADP
For Pending Placement Males**

Pre-reform	Admissions	ALOS	ADP
Secure Treatment	129	105	37
RTC	132	71	26
Non-RTC/Non-Secure	755	34	71
Total	1,016	48	134

Post-Reform	Admissions	ALOS	ADP
Secure Treatment	71	53	10
RTC	132	48	17
Non-RTC/Non-Secure	755	26	54
Total	958	31	81

Finally, this analysis has presented the second key component in estimating the need for bed capacity for males in secure detention facilities. As noted earlier, the pre-dispositional post-reform ADP (202) was the first component. As indicated in Table 1-8 the pending placement Post-reform ADP is 81.

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Estimated Total Need for Beds

The post-reform pre-dispositional and pending placement ADP, shown in Tables 1-9 and 1-10 respectively, are two key elements in estimating the total adjusted need for beds. In calculating either a statewide Post-reform ADP or a regional Post-reform ADP, the pre- and pending

⁶ See the analysis of the out-of-state placement process in the previous section on RTC average length of stay (ALOS).

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placement ADPs are added together. In effect, these total ADP are a combination of the need for pre-dispositional beds and pending placement beds. These totals appear in the reform ADP column of Table 1-11. These “total ADPs” are then adjusted upward with a peaking factor (for details see Appendix III), a percentage that is multiplied by the total ADP. The result of this multiplication is then added to the total ADP to form a total bed need. The adjustment measures the increase in the need for beds that from surges in demand for beds. This adjusted total ADP, which is shown in the last column of Table 1-11, is the estimated bed need used in the Gap Analysis.

**Table 1-9
Pre-reform and Post-reform ADP for
Male Pre-Dispositional Youth**

Region	Residential Area	Pre-reform	Post-reform	Pre/Post-reform Difference
I	Baltimore City	93	74	(19)
II	Central	32	26	(6)
III	Western	15	12	(3)
IV	Eastern	24	19	(5)
V	Southern	32	26	(6)
VI-MC	Montgomery	22	17	(5)
VI-PGC	Prince George's	33	27	(6)
VI-DC	Out of state	1	1	(0)
Total		253	202	(51)

**Table 1-10
Pre-reform and Post-reform ADP for
Male Pending Placement Youth**

Region	Residential Area	Pre-Reform	Post-Reform	Pre/Post-reform Difference
I	Baltimore City	38	23	(15)
II	Central	21	12	(8)
III	Western	6	3	(2)
IV	Eastern	16	10	(6)
V	Southern	21	13	(8)
VI-MC	Montgomery	10	6	(4)
VI-PGC	Prince George's	22	13	(9)
VI-DC	Out of state	0	0	-
Total		134	81	(53)

Table 1-11 indicates that the statewide adjusted total ADP is 321, an estimated measure of the total need for beds. The 321 total is also broken down into its regional component elements. These regional totals are crucial because they are the adjusted total need for beds in each region where the secure detention facilities are located.

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Table 1-11
Total Bed Need Adjusted for Peaking
For Secure Detention Males

Region	Residential Area	CY 2007	Reform ADP	With 13.3% Peaking
I	Baltimore City	131	97	110
II	Central	53	38	43
III	Western	21	15	17
IV	Eastern	41	29	33
V	Southern	53	39	44
VI-MC	Montgomery	32	24	27
VI-PGC	Prince George's	55	40	45
VI-DC	Out of state	1	1	1
Total		387	283	321

Existing Bed Capacity

Table 1-12 displays the data necessary for a Gap Analysis. Projected bed need is taken from the last column of Table 1-11. The existing bed capacity in Table 1-12, the second column of figures shows the number of beds in each of the respective regions and statewide. Comparison of the two columns indicates whether a surplus, deficit, or equilibrium exists in comparing need and supply. The last column shows the surplus as a percentage of the existing capacity.

Table 1-12
Gap Analysis for Males in Secure Detention

Region	Male Detention Facilities by Region	Projected Bed Need	Existing Bed Capacity	Projected Surplus	% Surplus
I	Baltimore City Juvenile Justice Center	110	144	34	23%
II	Charles H. Hickey Jr. School	43	72	29	40%
III	Western Maryland Children's Center	17	24	7	27%
IV	J. DeWeese Carter Children's Center		27		
	Lower Eastern Shore Children's Center		18		
	Total Eastern Shore	33	45	12	26%
V	Region V Detention Center	44	0	-44	n/a
VI	Alfred D. Noyes Children's Center	28	47	19	40%
	Cheltenham - New Detention Facility	45	86	41	47%
	Total Metro	73	133	60	45%
	Statewide	321	418	97	23%

Gap Analysis Findings

Table 1-12 shows that there is a projected statewide surplus of 97 beds, equal to 23% of the 418 bed capacity. Of the six regions shown, only Region 5, Southern Maryland has a deficit, due to the lack of a detention facility in that region. The remaining regions have surpluses ranging from 23% in Region 1 (Baltimore City) to 45% for Region 6 (DC Metro).

Interpretation of the Gap Analysis

The regions in Table 1-12 can be placed into three categories: deficit, moderate surplus, and large surplus. For this analysis, a large surplus is defined as having a surplus greater than 40% of existing capacity. Table 1-13 shows the regions grouped according to this classification.

Table 1-13
Regions Grouped by Degree of Surplus or Deficit

	Deficit	Moderate Surplus (0-40%)	Large Surplus (>40%)
		I - Baltimore City (23%)	II - Central (40%)
Region	V - Southern Maryland	III - Western Maryland (27%)	VI- Metro (45%)
		IV - Eastern Shore (26%)	

As stated earlier, Region V - Southern Maryland, is the only region in the state without a male detention center. This is clearly at odds with the Department's goal to serve youth with detention centers in their home region. As such, a male detention facility should be constructed in Region V to serve youth from that region.

The second group consists of regions with moderate surpluses. In these regions, operational steps can be taken to temporarily decrease capacity by closing a portion of the facility. Given that the surpluses are relatively small, however, it would be advisable to keep any closed portion available in case the population increases to the point where temporarily closed space is again required.

For regions with large surpluses, an assessment should be made of how best to scale the capacity of the region to fit a significantly smaller population. This assessment should include a determination of the quality of existing space and if both the quality of space and quantity of space are inconsistent with the Department's needs, replacement of these facilities with ones suited to the quality and quantity of space required should be examined.

Conclusions

The Department has conducted an analysis of its facilities that is consistent with the recommendations described above. The Department has also been subjected to oversight by the United States Department of Justice (DOJ). After DOJ expressed concerns about the conditions of confinement at the Charles H. Hickey Jr. School (Region II) and Cheltenham Youth Facility (Region VI), the Department reached a settlement agreement with DOJ in 2005. In FY 2008, the Department developed a compliance strategy that allowed it to exit from the 2005 Settlement

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Agreement with the DOJ. As both the quality and quantity of space at the Hickey and Cheltenham facilities are inappropriate, that compliance strategy includes the construction of two smaller detention centers on the grounds of Hickey and Cheltenham.

Additionally, as suggested above, a new 48-bed detention facility is planned for Region V. In Region I, a 24-bed wing has already been taken offline, reflecting the reduced need for capacity in that region. This allows the facility to operate with fewer staff so that resources can be redirected to better use elsewhere in the Department.

FEMALE SECURE DETENTION FACILITIES

The analysis for females in secure detention has the same underlying logic as the preceding section on males with one exception. The detention system for females is not regional. The main secure detention facility, which is dedicated to females, is Thomas J. S. Waxter (30 beds). The other two facilities, Lower Eastern Shore and Alfred D. Noyes, serve both males and females. Each has dedicated beds for females, 10 in Alfred D. Noyes and 6 in the Eastern Shore. Despite this exception, calculations for the Gap Analysis are same for males and females.

PRE-DISPOSITION

Admissions: Table 1-14 shows that the reform to reduce female admissions to secure detention by 20% will result in an estimated decrease of six (6) in the female pre-dispositional ADP. This translates into a decrease in Admissions to secure detention facilities of 159. The reduction in admissions by region will be used to calculate the need for Alternatives to Detention (ATD) in the next chapter.

ALOS: The ALOS for pre-disposition female secure detention is expected to remain at the CY 2007 level of 14.2 days.

ADP: The Post-reform pre-dispositional ADP of 25 is the first element in computing the total bed need for females in secure detention facilities. The ADP by region pre- and post-reform is shown in Table 1-15.

Table 1-14
Comparative Pre- and Post-Reform Differences in Admissions, ALOS, and ADP for
Female Pre-Disposition Population in Secure Detention

	Admissions	ALOS	ADP
Pre-reform	797	14.2	31
Post-reform	637	14.2	25
Difference	159	0	6

Table 1-15
Female Reform Admissions to Secure Detention

Region	Residential Area	CY 2007		Reduced By 20%		Difference	
		Admissions	ADP	Admissions	ADP	Admissions	ADP
I	Baltimore City	180	7	144	5.6	(36)	(1)
II	Central	154	6	123	4.8	(31)	(1)
III	Western	51	2	41	1.6	(10)	(0)
IV	Eastern	103	4	82	3.2	(21)	(1)
V	Southern	129	5	103	4.0	(26)	(1)
VI	Metro	180	7	144	5.6	(36)	(1)
Total		797	31	637	24.8	(159)	(6)

Pending Placement

Table 1-16 indicates that the ADP for the female pending placement population will decrease by approximately 2 females. This results from an eight-day decrease in the ALOS. These aggregate pending placement numbers suggest that pending placement reforms on admissions and/or the ALOS had a modest impact on the overall reduction of the ADP for females in secure detention. The Post-reform ADP of seven (7) is thus the second key component to estimating the total bed need for females in secure detention.

Table 1-16
Female Pending Placement Population in Secure Detention

	Admissions	ALOS	ADP
Pre-Reform	86	38	9
Post-Reform	86	30	7
Difference	0	8	2

In Table 1-17 the Pre- and Post Reform ADPs for Non-Secure/Non-RTC pending placement females have only one difference, a reduction in the ALOS of 8 days. This reduces the ADP for this subpopulation by 1.2. As explained in the Non-RTC/Non-Secure section on pending placement males, changes in processing cases have been undertaken that could substantially decrease both Admissions and the ALOS. However, the changes have been so recent that only a small change in the ALOS could be supported in this analysis. However, as experience with the changes increases, data will provide a firmer basis for estimating reductions in these factors.

Table 1-17
Females in Pending Placement Awaiting Placement in Non-RTC/Non-Secure Placement

	Admissions	ALOS	ADP
Pre-Reform	50	34	4.7
Post-Reform	50	26	3.5

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Table 1-18 shows the ADP change (i.e. decrease of .7) for females in pending placement awaiting RTC placement. The decrease in the ALOS of 23 days resulted from case processing reform described extensively in the pending placement section on males.

**Table 1-18
Females in Pending Placement Awaiting RTC Placement**

	Admissions	ALOS	ADP
Pre-reform	12	71	2.3
Post-reform	12	48	1.6

Table 1-19 shows the Pre and Post Reform ADPs for females in pending placement awaiting secure treatment also did not change. Unlike the males, where secure treatment capacity will increase, the planned bed capacity for females will be unchanged. The 24 current admissions reflect both out-of-state placements and in-state placements. Females requiring out-of-state secure treatment placements spend time in pending placement while their transfer is processed. In-state placements also contribute to pending placement because releases from in-state secure treatment facilities do not occur at the same time a female is committed for placement to secure treatment. This “lag” between timing of entry and exit results in females entering pending placement while they wait for a facility opening.

**Table 1-19
Females in Pending Placement Awaiting Secure Treatment Placement**

	Admissions	ALOS	ADP
Pre-reform	24	30	2.0
Post-reform	24	30	2.0

Table 1-20 shows the distribution of the pre- and post-reform female pending placement populations by region.

**Table 1-20
Female Pending Placement by Region**

Region	Residential Area	Pre-Reform	Post-Reform	Difference
I	Baltimore City	1	1	0
II	Central	2	1	(1)
III	Western	0	0	0
IV	Eastern	2	1	(1)
V	Southern	2	2	0
VI	Metro	2	2	0
Total		9	7	(2)

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The estimated total need for beds results from adding the Post-reform ADP for pre-dispositional females to the Post-reform ADP for pending placement females. Table 1-15 shows that the post-reform pre-dispositional ADP is 24.8. Table 1-20 shows the post-reform pending placement ADP is 7. The sum of these two totals, 32, is then adjusted upward by a peaking factor of 27.9%. The peaking factor is derived using the same method of analyzing daily population trends as was used in the male secure detention section. The peaking analysis is available in Appendix III. The estimated total need for beds is 41, compared to a existing bed capacity of 50, resulting in a surplus of 8 beds statewide.

There are two basic conclusions from this data. First, Waxter, with 30 beds, is the central secure detention facility for females. It accounts for approximately two-thirds of the total secure detention bed supply for females, and is most likely to serve females from regions without secure detention facilities. Second, the approximately 4 bed surplus is relatively small, especially if the trend of increasing females in the adult correctional population also begins to materialize in the DJS system. It should be noted however, that analysis of trends in the DJS system shows no significant increase in the female population.

Table 1-21
Female Secure Detention Bed Need by Region

Region	Residential Area	CY 2007	Reform ADP	With 27.9% Peaking
I	Baltimore City	8	6.6	8.5
II	Central	8	6.0	7.7
III	Western	2	1.9	2.4
IV	Eastern	6	4.4	5.6
V	Southern	7	5.7	7.3
VI	Metro	9	7.3	9.3
Total		40	31.9	40.8

Findings

Table 1-22 presents the Gap Analysis for secure detention females in the State. The table shows a statewide surplus of 8 beds, representing 16% of the existing capacity. As discussed in the analysis of male secure detention, these findings warrant an analysis of the existing capacity for female secure detention, quantitatively as performed herein, and qualitatively, with respect to the age and condition of the existing facilities.

Table 1-22
Female Secure Detention - Projected Need, Capacity, and Gap

Female Detention Facilities	Projected Bed Need	Existing Capacity	Projected Surplus	% Surplus
Lower Eastern Shore Children's Center		6		
Alfred D. Noyes Children's Center		10		
Thomas J.S. Waxter Children's Center		34		
Statewide	40.8	50	9.2	18%

Conclusions

The existing capacity is more than enough to meet the Department's needs. A qualitative examination of the Waxter Center, however, reveals that conditions there are unsuitable for serving Maryland youth. As such, the Department plans to replace the Waxter facility with a new, smaller (by 4 beds), 30-bed facility for female secure detention. This reduction will result in a projected surplus of 5 beds, representing approximately 10% of capacity.

CHAPTER 2: ALTERNATIVES TO DETENTION

A. Overview

The Department of Juvenile Services also provides short-term community-based supervision of youth whose cases are pending a judicial disposition. This community-based supervision is known as Alternatives to Detention (ATDs). For youth who would otherwise be placed in secure detention, ATDs a less restrictive alternative which keeps youth in their communities. These youth meet low- to moderate-risk criteria based on the Department's Detention Risk Assessment Instrument (DRAI). These alternatives to secure detention are intended to reduce crowding, cut the costs of operating large juvenile detention centers, shield youth from the stigma of institutionalization, separate youth from peers with more serious delinquent histories, and maintain positive ties between the juvenile and his or her family and community. ATDs provide a level of supervision sufficient to safely maintain youth in the community and to ensure their appearance in court.

ATDs fall into two broad categories, "individual-based" and "group-based." Individual-based ATDs include non-electronic community detention (CD) and electronic monitoring (CD/EM), and allow the youth to function in the community. Group-based ATDs include evening reporting centers, day reporting centers, detention reduction and advocacy programs, and shelter care, which bring youth together in a particular building location. A description of the different types of ATDs is provided below.

INDIVIDUAL ATD

Community Detention (CD): Community Detention (CD) is a seven-day-a-week program with Community Detention Monitors responsible for face-to-face and telephone contact with youth. The frequency of the contact depends on the assessed supervision needs of each youth. Random unannounced visits will be made at home, school, work, and appointments regardless of a youth's supervision phase. The team of Community Detention Monitors is carefully trained to detect violations of the court-ordered release conditions or potential threats to public safety. Monitors report any changes in a youth's home or school situation. If a youth engages in any activity that places the public at risk, he/she may be withdrawn from the program and held in secure detention. The Community Detention program has created an avenue in which youth can continue with school or work and maintain their community ties, support systems, or alternative care. Community Detention is a program that can hold pre-disposition and pending placement youth. The ALOS for youth on CD is 30 days. In addition, youth are closely supervised, held accountable and are returning to court as required. Community Detention is the primary ATD program used by the Department.

Electronic Monitoring (EM): Electronic Monitoring (EM) is an additional level of supervision for youth who need enhanced supervision and structure. The youth's compliance is monitored electronically through an ankle bracelet that is placed on the youth by a court employee. A transmitting unit is attached to the family phone. A daily report for each youth is generated by the central computer and transmitted to the Electronic Monitor Coordinator. This information is examined and any violations of the authorized schedule are transmitted for further consideration and action as necessary.

GROUP-BASED ATD

Evening Reporting Center (ERC): An Evening Reporting Center is used to provide a structured environment and programming for youth. Evening Reporting Centers operate from after school into the evening hours, Monday through Friday. Evening Reporting Centers keep the youth involved in positive experiences, while ensuring they are productively occupied during the times they are most likely to recidivate.

Day Reporting Center (DRC): A Day Reporting Center is a highly structured, neighborhood-based center emphasizing accountability and competency development. The program focuses on academic improvement, employability, decision making and problem solving skills, through education and small group activities.

Detention Reduction and Advocacy Program (DRAP - Baltimore City): The Detention Reduction and Advocacy Program provides intensive, community-based intervention and advocacy services. Components of DRAP include monitoring, supervision, case management, anger management groups, parenting skills, individual, family and group counseling, treatment planning and advocacy for youth and families.

Shelter Care: Shelter Care facilities provide temporary residential care for youth who are in need of short-term placement outside the home (usually 1 to 45 days) due to parent/guardian unavailability. Shelter care facilities are generally non-secure or staff secure.

B. Need for Community Detention by Region

Successful reduction of admissions to secure detention depends on an adequate supply of ATDs, otherwise pre-dispositional youth may remain in secure detention. Community detention slots (CD), due to their flexibility in increasing supply, will be used to reduce severe detention admissions. They will include both its electronic and non-electronic forms. The equation below estimates the need for CD slots in each region. "Admissions" is the absolute number of youth needing CD and the ALOS is the average length of stay that youth remain in CD from each region. Since the Department's detention services have a regional organization, the analysis of community detention is organized on a regional basis.

$$\text{ADP} = \frac{\text{Admissions} * \text{Average Length of Stay}}{365}$$

The information in Table 2-1 outlines the current demand for Community Detention (CD) by region for CY 2007. As noted in the table, the statewide demand for CD totaled 518 in CY 2007. As expected, utilization of CD slots is heavily centered around the State's population centers in Regions I, II, and VI.

Table 2-1

Current Demand for Community Detention by Region – CY 2007		
Region	Residential Area	CD Average Daily Population CY2007
I	Baltimore City	163
II	Central	101
III	Western	25
IV	Eastern	57
V	Southern	82
VI	Metro	90
Total		518

In addition to the current use of community detention slots, implementation of the DRAI will increase the number of youth being shifted from pre-dispositional secure detention to ATDs generally and to community detention slots specifically. As previously discussed in Chapter 1 – Secure Detention, the implementation of the DRAI will result in a 20% increase in the use of community detention slots. Tables 2-2 and 2-3 indicate the total number of additional males (1,074) and females (159) who will be diverted from pre-dispositional secure detention to community detention slots due to the implementation of the DRAI. Since the ALOS for community detention slots varies by region, regional admissions were multiplied by the corresponding ALOS of each region. The resulting ADP, a total of approximately 100 for males and 16 for females, are distributed by region, thereby measuring the need for additional community detention slots in each region. Unsurprisingly, two heavily metropolitan areas, Regions I and VI, have the greatest additional need for CD stemming from the reforms. As shown below, the regional ADP are a key factor in calculating a Gap Analysis for community detention slots.

Table 2- 2
**Estimated Additional Community Detention Slots Needed for Males
Moving from Secure Detention to ATDs by Region**

Region	Residential Area	Admissions	ALOS	ADP
I	Baltimore City	394	26.6	28.7
II	Central	137	36.2	13.6
III	Western	64	32.3	5.7
IV	Eastern	102	44.8	12.5
V	Southern	137	37.7	14.2
VI	Metro	240	37.9	24.9
Total		1,074	33.8	99.6

Table 2-3
Estimated Additional Community Detention Slots Needed for Females
Moving from Secure Detention to ATDs by Region

Region	Residential Area	Admissions	ALOS	ADP
I	Baltimore City	36	26.6	2.6
II	Central	31	36.2	3.1
III	Western	10	32.3	0.9
IV	Eastern	21	44.8	2.5
V	Southern	26	37.7	2.7
VI	Metro	36	37.9	3.7
Total		159	35.5	15.5

Since CD slots are gender neutral, the additional ADP for females and males has been combined in each Region in Table 2-4. The regional ADP shown in Table 2-4 estimates the future increase (115) in the need for CD across all regions.

Table 2-4
Total Estimated Additional Community Detention Slots Needed
Due to Moving from Secure Detention to ATDs by Region

Region	Residential Area	Males	Females	Total
I	Baltimore City	28.7	2.6	31.3
II	Central	13.6	3.1	16.6
III	Western	5.7	0.9	6.6
IV	Eastern	12.5	2.5	15.0
V	Southern	14.2	2.7	16.8
VI	Metro	24.9	3.7	28.7
Total		99.6	15.5	115.1

Table 2-5 shows the total number of community detention slots needed in each Region. The regional distribution of CY 2007 Statewide ADP (518) is shown in the first column of Table 2-5. It shows the existing need for community detention slots in each Region. The second column shows the estimated additional future need (115) for community detention slots due to diversion to ATD. The last column, derived by adding the first two columns, shows the total Statewide and regional need for community detention slots (633).

Table 2-5
Total Need for Community Detention (CD) Slots

Region	Residential Area	CD Average Daily Population CY2007	Estimated Future Need for Additional CD slots	Total Need for CD Slots
I	Baltimore City	163	31	194
II	Central	101	17	118
III	Western	25	7	32
IV	Eastern	57	15	72
V	Southern	82	17	99
VI	Metro	90	29	119
Total		518	115	633

Gap Analysis for Community Detention Slots

The Gap analysis for community detention, which determines whether a “surplus” or “deficit” of such slots exists, is calculated by comparing the estimated demand for CD to the available supply in each region. Table 2-6 compares the supply and demand for community detention slots to determine whether there is a surplus or deficit in community detention slots.

At current staffing levels, Table 2-6 shows the current supply of CD in each Region (597 Statewide). The current supply is determined by multiplying the staff level times the number of youth on CD that one staff person can manage. The staffing numbers are 15 youth per staff for Baltimore City staff and 12 youth per staff for the remaining regions. The difference is attributable to population density. The City’s dense population brings youth in closer proximity to each other, enabling staff to manage a greater number of youth.

Table 2-6
Gap Analysis for Community Detention Slots

Region	Residential Area	Current CD Staffing Level	Current Supply of CD Slots	Estimated Total Need for CD Slots	Surplus/Deficit of CD Slots
I	Baltimore City	15	225	194	31
II	Central	8	96	118	-22
III	Western	3	36	32	4
IV	Eastern	4	60	72	-12
V	Southern	7	84	99	-15
VI	Metro	8	96	119	-23
Total		45	597	633	-36

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Comparing total current supply (Column 4) to total need (Column 5) in Table 2-6 indicates that four regions will have deficits and two will have surpluses in community detention slots. This suggests the need for additional community detention slots in Regions II, IV, V, and VI. Unless the Department addresses the deficits in these regions, youth possibly would remain in secure detention due to the absence of an alternative. Such an effect would increase the ADP of secure detention facilities in these regions, thereby undercutting the intention to reduce the ADP of secure detention facilities by decreasing the number of youth in pre-disposition.

Evening Reporting Centers

The Evening Reporting Center (ERC) is a court ordered alternative, used to provide a structured environment and programming for youth. Evening Reporting Centers operate from 3:00 p.m. to 9:00 p.m. Monday through Friday. Most participants will be involved for up to 30 days. The program operates during the hours which are high risk for juvenile offenses. The program provides highly structured supervised activities in a supportive and safe environment to youth with pending delinquency cases. The ERC is designed to reduce the likelihood of re-arrest while allowing youth to continue to attend school in their communities and live at home.

While attending the program, youth are engaged in educational activities, recreational programming and life development workshops. Group activities cover the following topics and are supplemented by special events and other outings such as field trips to educational, cultural and recreational venues: Conflict resolution, alcoholism and drug abuse, health and hygiene education, AIDS education and prevention, parenting skills, family problems, employment and life skills development. A meal is provided. The meal serves an incentive for the youth to attend. Minors are transported to and from the Center by program staff. This ensures that every youth is accounted for and arrives home by a specific time. On site security provisions are made by each provider.

As indicated in Table 2-7, in CY 2007 the Department had sufficient supply of Evening Reporting Center capacity in the regions in which ERCs were available. However, the high level of utilization of ERC capacity in Baltimore City suggests that additional ERC capacity is needed.

**Table 2-7
Gap Analysis for Evening Reporting Centers**

Region	Residential Area	Capacity	CY 2007 ADP	Surplus/Deficit of ERC Slots
I	Baltimore City	15	15	0
VI	Metro	15	11	4
Total		30	26	4

The Pre-Adjudication Coordination and Training (PACT) center is considered an enhanced ERC due to the additional requirement of youth being court ordered to electronic monitoring (EM). The PACT center is funded and staffed through The Mayors Office of Employment

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Development as a DMC reduction initiative. The target population for this program are African-American youth ages 14-17. The center opened its doors in August 07 with a capacity to serve 15 youth. The ADP for those five months was 10.

Prince George's County opened a second ERC on February 2nd 2009. This center has a capacity of 15 youth. It services youth throughout the southern region of Prince George's County.

Realizing the economic impact of the high school dropout problem, the Day Reporting Center (DRC) operating in Baltimore City was developed to establish a separate educational program for at-risk and troubled students involved in our system. These youth do not succeed in the standard high school program for a variety of reasons - typically poor attendance, habitual truancy and falling behind academically. Youth are court ordered to the program and they receive five (5) hours of daily instruction by MSDE certified teachers. The DRC has a capacity to serve 25 youth.

Day Reporting Centers

Data for this ATD are not available.

Detention Reduction and Advocacy Program (DRAP)

The DRAP had an ADP of 4 in CY 2007 with a capacity of 15. Only 27% of the available capacity for this program was utilized in CY 2007.

ATD Shelter Care

Shelter care is a non-secure residential placement used for youth who require a short-term residential placement as an alternative to detention. Youth served in this type of facility would ordinarily be released to their parents pending a juvenile court appearance, but do not have an appropriate home environment from which to receive services. As a youth's shelter care placement is short-term, similar to youth awaiting disposition in a detention facility, facilities should be provided on a regional basis consistent with the Department's regional service delivery structure.

Table 2-8 outlines the need for shelter care by region. As indicated in the table, statewide demand for shelter care totaled 68 in CY 2007. Over 70% of youth in need of a shelter care ATD placement are from Baltimore City. There is relatively little demand for shelter care from other regions. The Department does not have ADP data by gender for CY 2007. This data should be collected, tracked, and evaluated to enable a better understanding of the demand for shelter care facilities.

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Table 2-8
Demand for ATD Shelter Care by Region – CY 2007

Region	Residential Area	Male ADP	Female ADP	Total ADP
I	Baltimore City	n/a	n/a	49
II	Central	n/a	n/a	6
III	Western	n/a	n/a	4
IV	Eastern	n/a	n/a	1
V	Southern	n/a	n/a	4
VI	Metro	n/a	n/a	4
Total				68

Table 2-9 provides a summary of the current total bed capacity of the eight shelter care facilities functioning as an alternative to detention. As indicated below, the total capacity for shelter care ATD placements is 96. Most of the capacity, over 60%, is provided in the central Maryland area, Baltimore City and Baltimore and Carroll Counties. In contrast, Regions IV and VI, the Eastern and Metro regions, do not have shelter care capacity.

Table 2-9
Current Supply of ATD Shelter Care by Region

Region	Residential Area	Male	Female	Total Supply
I	Baltimore City	15		15
II	Central	28	16	44
III	Western	6	14	20
IV	Eastern			
V	Southern	17		17
VI	Metro			
Total		66	30	96

Table 2-10 compares the current capacity of shelter care facilities to the demand for shelter care facilities in CY 2007 by region. As indicated in the table, there are significant deficits in the number of shelter care placements available in Baltimore City. In contrast, the data indicate significant surpluses in shelter care capacity in Region II – Central, Region III – Western, and Region V – Southern.

Table 2-10 - Gap Analysis for Shelter Care ATD

Region	Residential Area	Current Capacity	CY 2007 ADP	Surplus/Deficit of Shelter Care
I	Baltimore City	15	49	-34
II	Central	44	6	38
III	Western	20	4	16
IV	Eastern		1	-1
V	Southern	17	4	13
VI	Metro		4	-4
Total		96	68	28

Although the data suggest that significantly more shelter care capacity is available than is needed, recent data suggest a far greater utilization of shelter care capacity (See Table 2-11). According to recent data from the fourth quarter of calendar year 2008, the ADP for shelter care was 87 with monthly ADP ranging from 94 in October 2008 to 82 in December 2008. This represents an average utilization rate of 90% of existing shelter care capacity. This data suggests a far greater utilization rate than suggested by the CY 2007 data. These rates are relatively high and warrant careful monitoring in order to assure sufficient availability of this service. The Department will carefully monitor shelter care utilization to better inform decisions about the future need for this type of facility.

**Table 2-11
Utilization of Shelter Care – CY 2008 – 4th Quarter**

Shelter Care	Capacity	CY 2008-Q4 ADP	% Utilization
Total	96	87	90.6%

Conclusions

Alternatives to detention are cost-effective solutions for a large number of youth who are awaiting adjudication and disposition hearings. These alternatives to secure detention are intended to reduce crowding, cut the costs of operating large juvenile detention centers, shield youth from the stigma of institutionalization, help youth avoid associating with peers who have more serious delinquent histories, and maintain positive ties between the juvenile and his or her family and community. Given the important role that ATDs play in the juvenile services system, every effort should be made to ensure that there is a sufficient supply of these services to effectively manage the State's juvenile population.

Based on the analyses presented in this chapter, the Department concludes the following:

Community Detention - Implementation of the new Detention Risk Assessment Instrument (DRAI) will result in increased use of community detention slots. Based on the analysis presented in this Chapter, the Department requires an additional 36 community detention slots to

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ensure that youth are served in the most appropriate setting pending a court disposition. Unless the Department addresses the projected community detention deficits in Regions II, IV, V, and VI, youth will remain in expensive out-of-home placements in secure detention.

Evening Reporting Centers – The analysis of the utilization of Evening Reporting Centers suggests that although there are only two of these centers, in Baltimore City and Prince George’s County, only 38% of the capacity is utilized. Of particular note is the 25% utilization of the ERC capacity in Baltimore City. The Department will evaluate the ongoing need for this form of ATD and if it is determined that ERCs are needed, what steps are necessary to increase their utilization.

Shelter Care – The analysis of shelter care utilization from CY 2007 suggests there is a surplus of shelter care capacity statewide. In contrast to this finding, there are significant deficiencies in shelter care capacity in Baltimore City.

According to recent data from the fourth quarter of calendar year 2008, the ADP for shelter care was 87 with monthly ADP ranging from 94 in October 2008 to 82 in December 2008. This represents an average utilization rate of 90% of existing shelter care capacity. This data suggests a far greater utilization rate than suggested by the CY 2007 data. These rates are relatively high and warrant careful monitoring in order to assure sufficient availability of this service. The Department will carefully monitor shelter care utilization to better inform decisions about the future need for this type of facility. In addition, the Department will collect data on shelter care utilization by gender to better inform decisions about the appropriate capacity and location of these facilities.

CHAPTER 3: RESIDENTIAL PLACEMENTS

The Department of Juvenile Services operates a system of rehabilitative program services for youth found delinquent by a court. These programs range from community-based services for youth living at home to programs for youth who must reside in a secure facility. This chapter will focus on out-of-home program placements for youth committed to the custody of DJS. Following the overview, the chapter is divided into three sections, using the same classifications that were used in the analysis of pending placement in secure detention. They are: Non-Secure/Non-RTC, Residential Treatment Center (RTC), and Secure Treatment. These are organized from the least to most restrictive environments. All of the programs discussed in this section are residential, that is, youth are served in a setting outside of their homes.

Each section will include analysis of the populations served by each type of facility in the system. Analysis of the population trends will yield an estimate of the expected demand or need for each type of residential facility. These needs will then be compared to the capacity of each type of facility. The comparison of need to capacity will determine whether there is a surplus or deficit of capacity for each type of facility. The first two sections, Non-Secure/Non-RTC and Residential Treatment Centers (RTC) use a utilization rate analysis. The analysis identifies the existing use of each type of facility by DJS and other users and what percentage of the available capacity is utilized by these users. The analyses use approaches suited to the data available for each of the three facility types:

Non-Secure/Non-RTC: Three agencies within the State of Maryland are the primary users for the non-secure/non-RTC facilities presented. These three agencies are the Department of Juvenile Services (DJS), Department of Human Resources (DHR) and the Department of Health and Mental Hygiene (DHMH). There are also out-of-state (OOS) users of these facilities. The sum of all of these users represents the total utilization of the facility type.

Residential Treatment Centers (RTC): While other state agencies, most notably the Department of Health and Mental Hygiene (DHMH) are major users of this service, data on non-DJS RTC users are not available. However, the vacancy rates for the RTC facilities are available. The analysis of RTC shows the number and percentage of DJS users and the utilization based on vacancy rates for this facility type.

Secure Treatment: The third section, secure treatment, benefits from the availability of data on admissions, average length of stay (ALOS) and average daily population (ADP). As such, this section of the analysis uses a bed need and peaking approach, similar to what was used in the chapter on secure detention. The bed need is then compared to existing capacity to determine whether a surplus or deficit exists.

The three facility types shown above serve youth at different classification levels. A full discussion of the Department's classification system is shown below. The Non-Secure/Non-RTC type includes youth from Levels II-IV. Secure Treatment is for youth classified as Level V. RTC youth can be classified at more than one level, such as IV and V; what distinguishes RTC youth from the other two types discussed is that they require psychiatric care.

DJS Classification System

The Department has established a new classification system based on two measures: security risk and treatment needs. Previous efforts had been criticized for being too broad and did not adequately cover services provided. The new classification system begins with nonresidential placement alternatives and ends with secure residential programs.

- Level I – Home With Services
- Level II – Family Foster Care / Therapeutic Foster Care
- Level III – Community Based Residential
- Level IV – Special Programs
- Level V – Secure Programs

As the levels increase, youths are removed further from their families and from the outside community in general. The separation from the youth's family (i.e. "out of home placement") begins at Level II, and significant separation from the general community begins at Level IV. Further, security in Levels 4 and 5 are much higher than Levels I-III. Level I is omitted from this analysis because youths are "placed" with their families, not in a separate residential setting.

Description of Classification System Levels

Level I Home with Services

Youth live at home with parents, guardians or extended family. Youth and, as needed, family receive services in the community. Living at home is considered the least restrictive environment for treatment. Youth served at home are low risk, and are not considered to be a threat to public safety. Additional services can be accessed through public community resources or procured by the Department. These may include family intervention services, supervision and/or specific services such as counseling or substance abuse treatment.

Level II Family Foster Care / Treatment Foster Care

Youth are served within a family environment with 24-hour care and supportive services provided by a child placement agency in an approved family home. Family foster care consists of homes certified by either Departments of Social Services (DSS) or DJS. The treatment foster homes are privately managed and are generally clustered within a program under the oversight and management of a mental health professional. The foster homes receive specialized training to deal with youth with special needs. Additional services and wraparound models of service delivery are also available to youth in foster care and are accessed in the community. Treatment foster care (TFC) provides more intensive support services in a family setting for children with emotional, behavioral, medical, and/or psychological conditions. Youth served in TFC range from low to moderate security risk, but the behaviors of the youth are not so severe that removal from the community is necessary.

Level III Community Based Residential Programs

Youth are served in out of home residential care. These programs serve youth who need more structure and supervision than a relative, foster parent or treatment foster parent could offer. These programs provide a formal program of basic care, social work, and health care services in residential neighborhoods. They vary greatly in the youth served and the type of program interventions provided. Most programs utilize community-based ancillary services and the local educational school system. Specialized programs address the needs of specific youth with client specific services built into the program. Community contacts are generally planned to serve as opportunities for the youth to learn healthy coping and adaptive life skills. Youth served range from low to moderate security risk but are not deemed to be dangerous to public safety. Programs included in this level of security include the following:

- Alternative Living Unit Developmental Disability (ALU)
- General Service Group Home (GH)
- General Services Group Home Serving Children with Special Characteristics (GH-Other)
 - Developmental Disability
 - Mother and Baby program
 - Sex Offender Program
 - Substance Abuse Program
- Treatment (sometimes called Therapeutic) Group Home (TGH)
- Independent Living (IL)
 - Substance Abuse
 - Mothers and Children
- Impact Programs

Level IV Special Programs

Youth are served in out of home residential care with minimal services sought from the community. Programs serve specialized populations considered to be of increased risk due to high need and/or delinquency. These populations include youth diagnosed as seriously emotionally disturbed, youth assessed with substance abuse and youth evaluated at moderate- to high-risk of re-offending. These programs are structured, self contained and comprehensive, providing most services and activities on site. Youth served are considered to pose risk to themselves or others and/or may be considered at risk to flee. Any community contact is planned and generally the result of positive behavior through a behavior modification program. Specific mental health programs may be secure environments because of the treatment needs of the youth served. Many of the special programs require specially trained staff, such as, psychiatrists, psychologists, psychiatric nurses and certified drug and alcohol counselors, for the populations served. Programs included in this level of security include the following:

- Residential Treatment Center (RTC)
 - RTC Sex Offenders
 - RTC Dually Diagnosed
- Non-RTC Mental Health Program (NON-RTC MH)
- Intermediate Care Facility for Addictions (ICFA)
- Youth Centers (YC)

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YC Substance Abuse
Enhanced Youth Center – Thomas O’Farrell Youth Center
Wilderness Program

Level V Secure Programs

Youth are served in structured, self contained, and comprehensive residential programs providing all services and activities on site. These include in-state and out-of-state secure treatment for committed youth. Youth served in these comprehensive secure programs are considered to be moderate to high risk because of the seriousness of the adjudicated offense, multiple offenses, failed previous placements, lengthy history with the department and/or escaping from other residential programs.

Youth who are court ordered for secure placement are served in the most physically restrictive environment for the behavior management and treatment of delinquent youth within the Juvenile Justice system. Secure programs must be locked to prevent escape and have either a perimeter fence surrounding the facility or a fenced outside area for recreation. Structure and supervision are essential elements of these programs. Youth served are chronic repeat offenders or have been adjudicated on the most serious offenses and are considered to be high risk for continued delinquent behavior. All services are provided on site and off campus activities and home visits are rare. Programs included in this level of security include the following:

Open Programs and Staff Secure Programs
Substance Abuse Program
In-state and Out-of-state Secure Programs

Determination of Classification Level for Committed Youth

In order to determine the appropriate placement for youth committed to the custody of DJS, an evaluation of each youth is performed and the results place the youth in a classification level. The Maryland Comprehensive Assessment and Service Planning (MCASP) assessment is an innovative process conducted throughout a youth’s involvement with DJS and includes an ongoing assessment to address treatment needs and reevaluate security risk.

The assessment process has four components:

1. Predicting a youth’s likelihood (risk) to re-offend and the level of security that is required to ensure public safety;
2. Identifying criminogenic risk, i.e. risk of continued criminal behavior, and protective factors in a youth’s life that are linked to delinquent behavior and required interventions;
3. Guiding case management planning and implementation to focus on reducing risk factors and increasing protective factors; and
4. Monitoring youth’s progress and reassessing criminogenic risk to determine if the interventions are effective and changing the service plan as needed.

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 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 implementation of the MCASP tool allows the Department to more accurately identify the population of youth that are most in need of secure treatment and assign youth to programs based on their risk profile. This tool will form the basis by which classification and placement decisions will be made by case managers. The implementation plan will include working with all stakeholders including the courts, prosecutors, public defenders, treatment providers, advocates and families. The Department plans to fully computerize the MCASP process by December 2009.

A. Non-Secure/Non-RTC Residential Placements

In operating the Juvenile Services delivery system, the Department uses a variety of different commitment programs. However, other types of residential commitment facilities also have a role in the DJS system. They are:

1. Foster care/ therapeutic foster care
2. Group homes of various kinds (e.g. regular, therapeutic)
3. Residential substance abuse
4. Impact program
5. Wilderness programs
6. Youth Centers
7. Psychiatric hospitals

There are four significant sources of demand for non-secure/non-RTC services:

1. Youth Pending Placement in Secure Detention
2. Youth Pending Placement in Alternatives to Detention (ATD)
3. Youth on Release status
4. Youth from other state agencies

Many of these facilities were discussed in Chapter 1, in terms of pending placement. These pending placement youth have a court-ordered disposition for one of the types of facilities listed above, but for various reasons must wait in a detention center before being admitted to their proper placement. However, not every youth admitted to one of these facilities comes from pending placement in secure detention. Commitments also arise from youth pending placement in an Alternative to Detention (ATD) or released to a guardian's custody. Youth pending placement in a detention facility or ATD, and those youth who have been released after receiving a court-ordered commitment (types 1, 2, and 3 above) are all considered in "waiting placement" status. In addition to the waiting placement youth, other users of these facilities may come from other State of Maryland agencies, usually the Department of Health and Mental Hygiene

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(DHMH) and the Department of Human Resources (DHR). Out-of-state (OOS) users and “other users,” generally privately funded, users make up a very small percentage of the overall demand.

These residential facilities are integral to the Department’s placement process. The availability of slots in each of them thus becomes essential to the efficient functioning of the Juvenile Services delivery system. If these facilities are over capacity, there are three possible consequences: overcrowding in the facilities, diversion of youth to inappropriate placements, or inappropriate use of secure detention facilities while a youth awaits placement.

In order to evaluate the available capacity in these facilities, this section of the Gap Analysis analyzes the demand and supply of slots for each type of facility. Demand, or need, is measured by Average Daily Population (ADP). Where available, calculation of the ADP includes the two sources of demand – DJS waited placement youth, and youth from other agencies such as DHMH and DHR. This section of the gap measures total demand. Just measuring DJS demand would understate the total demand, presenting an incomplete measure of capacity utilization. Capacity is measured by the total slots available for youth for a given type of facility. The percentage of capacity utilization, calculated by dividing ADP by capacity, measures the relative availability of slots for youth in a facility. A percentage under 100% suggests available slots, whereas percentages at or over 100% suggests the unavailability of slots.

$$\frac{\text{ADP}}{\text{Capacity}} = \text{Capacity Utilization (\%)}$$

Table 3-1 presents the CY 2007 ADP by agency for the majority of the non-secure/non-RTC facility types used by the Department. Table 3-2 presents capacity utilization rates for each type. These tables are followed by analyses of each facility type identified in the tables. Some of the program capacity figures in the tables are estimates, based upon the highest total ADP for the program. Other capacity figures are as reported by the providers.

**Table 3-1
CY 2007 Non-Secure/Non-RTC Average Daily Population (ADP) by User**

Name of Program	Level	Program Capacity	DJS	DHR	DHMH	OOS	Other	Total ADP
Treatment Foster Care	II	1,214	70	1,022	2	0	3	1,098
Alternative Living Unit	III	74	7	36	21	0	2	66
Group Homes	III	666	214	318	5	8	4	549
Group Homes-Other	III	25	0	22	0	0	0	23
Independent Living	III	192	21	140	14	0	0	174
Treatment Group Homes	III	180	24	95	17	2	4	142
New Dominion for Boys	IV	72	17	0	0	6	11	34
Substance Abuse	III-V	727	151	0	51	2	0	204
Total		3,150	503	1,632	110	19	25	2,290

Table 3-2
CY 2007 Capacity Utilization Rates by User

Name of Program	Level	Capacity	Percent Utilization of Capacity					Total
			DJS	DHR	DHMH	OOS	Other	
Treatment Foster Care	II	1,214	5.7%	84.2%	0.2%	0.0%	0.3%	90.4%
Alternative Living Unit	III	74	9.5%	48.4%	28.4%	0.0%	2.7%	88.9%
Group Homes	III	666	32.2%	47.7%	0.8%	1.2%	0.6%	82.5%
Group Homes-Other	III	25	1.6%	88.4%	0.0%	1.2%	0.0%	91.2%
Independent Living	III	192	10.7%	72.8%	7.3%	0.0%	0.0%	90.8%
Treatment Group Home	III	180	13.2%	52.7%	9.3%	1.1%	2.4%	78.8%
New Dominion for Boys	IV	72	23.6%	0.0%	0.0%	8.3%	15.3%	47.2%
Substance Abuse	III-V	727	20.7%	0.0%	7.0%	0.3%	0.0%	28.0%
Total		3,150	16.0%	51.8%	3.5%	0.6%	0.8%	72.7%

Foster Care - Level 2

Level 2 is composed of treatment foster care. As indicated in Table 3-1, the total ADP in CY 2007 was 1,098, which is 90.4% of the 1,214 program capacity. DHR is the heaviest user of this placement, accounting for approximately 84% of the utilized capacity. DJS, which accounts for approximately 6% of capacity, used far less of these services. Essentially, DHR and DJS account for most of the utilized capacity, and the capacity utilization measure suggests unused capacity. However, a caveat is important. In basic economic terms, 90% utilization of production capacity is often used a “warning signal” that capacity might need expansion. The possibility of future increases in demand for these services suggests careful attention as to whether full capacity utilization is being reached and whether additional capacity is needed.

Group Homes - Level 3 (A)

Level 3 (A) is composed of five placement types:

1. Alternative Living Unit (ALU) - Serves youth with developmental disabilities which require specialized living arrangements
2. Group Homes (General) - Described in Chapter 1
3. Group Homes–Other - There are two specialized group homes:
 - a. Mother and Baby program
 - b. Program for youth with developmental disabilities
4. Independent Living (IL) - Serves youth who need to become self-sufficient and learn responsible living because they are unlikely to return home
5. Treatment Group Homes - Specialize in emotionally or developmentally disabled youth

Tables 3-1 and 3-2 indicate that the Group Home, Treatment Group Home, and Group Homes-Other types have capacity utilization rates of 82.5%, 78.8%, and 91.2% respectively. “Alternative living” and independent living” have capacity utilizations of 88.9% and 90.8% respectively. Except for Alternative Living Unit, where DHMH youth are the second-highest users, DJS and DHR are the heaviest users of group home service capacity. Two types of group homes, General and Treatment are below the 90% threshold, suggesting potential excess capacity. As the Department implements its plans for the use of community-based Evidence-Based Programs (EBP), which will target group home youth for diversion to EBP, these utilization percentages will likely decrease. In conclusion, while certain types exceed the 90% threshold, analysis of use and capacity shows that there is sufficient capacity for all types of Level 3 (A) placements. A more complete discussion of EBP is included in Chapter 4.

Substance Abuse Treatment - Level 3/4.

Substance abuse youth can be classified as either Level 3 or Level 4. Group Home –Substance Abuse is a Level 3 placement and Intermediate Care Facilities for Addictions (ICFA) is a Level 4 placement. The ICFA type provides a more intensive level of residential substance abuse services than the group home category. Tables 3-1 and 3-2 indicate that DJS youth are the largest users of this type of facility, followed by DHMH. The most noteworthy finding in this table is the overall utilization percentage of 28%. This utilization rate would seem to signal significant excess capacity; however, the Department has evidence that this finding is the result of incomplete data, primarily for private-payment users.

Impact - Level 3

The Impact program provides short term, intensive intervention for low- to moderate-risk youth. Youth served are on probation and have failed to successfully respond to nonresidential interventions and present an imminent need for stabilization to prevent detention or other placement. These youth may have been belligerent in adhering to court directives and conditions of probation. They may have received additional charges while on probation. While they require close supervision, these youth are not deemed to be dangerous to public safety. These non-secure programs provide structure and routine. DJS operated programs provide all services on site. Youth attend school and participate in group counseling. The focus of the program is on the aftercare plan for return to the community that involves the youth, family, case manager specialist and service providers as needed. Services are to be ready to begin upon the youth’s discharge. DJS operates two programs for male youth, one at Cheltenham and one at the Youth Centers. The program length of stay is 30 to 90 days.

**Table 3-3
Impact Programs - Average Daily Population and Capacity Utilization**

Facility	Fiscal Year ADP		FY 2008	
	2007	2008	Capacity	% Utilization
Cheltenham - Redirect	7	15	24	61%
Green Ridge Youth Center - Redirect	4	8	10	82%
Total	11	23	34	67%

The Department began operating these programs in FY 2007. The capacity of each program was not established until FY 2008. Table 3-3 shows that the Green Ridge Youth Center program is highly utilized at 82%, but in the Cheltenham program two-fifths of the capacity is consistently not utilized. Overall, on average one of every three beds available for this program is not being used.

Wilderness Programs - Level 4.

Tables 3-1 and 3-2 also show capacity utilization figures for the New Dominion Home for Boys, one of the Wilderness programs used by the Department. The Wilderness program is a residential program operating year-round in an outdoor nature environment. Counseling and education services are integrated in the daily activities. Intensive intervention is based on a group problem-solving model through which youth learn more acceptable behaviors and how to resolve problems productively. The Department contracts with Wilderness providers other than the New Dominion Home for Boys, however, that program located in Allegany County, is the only in-state Wilderness provider. Data for out-of-state providers show a capacity of 200 male beds and 104 female beds. ADP data for the out-of-state providers are not available.

The data on the New Dominion Home for Boys show that DJS is the only Maryland agency that uses this program and the Department's youth represent half of the users of this facility. The overall facility utilization rate of less than 50% shows that the Department could be sending many more youth to this program. Data on waitlists for Wilderness programs are not available; however, if no such waitlists exist, the low capacity utilization rate suggests that this facility would be a candidate for downsizing. In consideration of this, the New Dominion Home for Boys was closed on September 22, 2008.

Youth Centers - Level 4

The Department owns and operates four Youth Centers: Backbone Mountain, Green Ridge, Savage Mountain, and Meadow Mountain. Unlike the placements discussed earlier in this section, only DJS youth use these facilities. As shown in Table 3-4, both the ADP and capacity⁷

²An additional 8 beds were added to the Backbone Mountain facility in 2008, increasing its capacity to 48.

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of Youth Center have increased in the past three calendar years, as the system has operated at or above its full capacity. The total combined capacity of the Youth Centers in the baseline year of CY 2007 is 156 and the capacity utilization rate is 101.5%³. Due to the high utilization rates, the Department added 8 beds at the Backbone facility in FY 2008, increasing the overall capacity to 164. Because nearly every available bed is occupied throughout the year, the peaking factor for this facility type is relatively low, in the 2-5% range in the period shown in Table 3-4.

**Table 3-4
Youth Center Population Profile and Capacity Utilization
CY 2006-2008**

CY	Admissions	ALOS	ADP	Capacity	% Utilization
2006	167	337	154	156	99.0%
2007	177	327	158	156	101.5%
2008	174	338	160	164	97.6%

As discussed earlier, 10 beds at the Green Ridge facility were converted for use in the Impact program in 2006. With this conversion, the total Level IV capacity declined from 156 to 146, as shown in Table 3-5. Examination of the utilization rates of individual Youth Centers using CY 2007 data in Table 3-5 reveal very high utilization. Meadow Mountain, which specializes as a substance abuse facility, operates at close to full capacity (98.9%). Two other Centers, Green Ridge Mountain (102.7%) and Savage Mountain (98.4%) also exhibit high utilization rates. The third, Backbone Mountain, functioned over capacity (114.9%). In light of the high systemic and individual facility utilization rates, the Department is evaluating the need for additional Youth Center capacity.

**Table 3-5
CY 2007 Level 4 Youth Center Capacity Utilization**

Youth Center	Capacity	CY 2007 ADP	% Utilization
Backbone Mountain	40	46	114.9%
Green Ridge Mountain	30	31	102.7%
Meadow Mountain	40	40	98.9%
Savage Mountain	36	35	98.4%
Total	146	152	104.0%

Psychiatric Hospitals - Level 2

There are two admissions figures available for psychiatric hospitals for CY 2007: 70 and 111. The 70 admissions were of youth held in DJS facilities. The remaining 41 youth were under the supervision of DJS at the time of their admission, but were not in a DJS facility. Data on the ADP and capacity of this facility type are not available. The Department has identified the need

³ At the end of CY 2006, 10 Level 4 beds at the Green Ridge Youth Center were converted for use as Level 3 Impact (Redirect) program beds. The figures shown count these as Level 4 beds in CY 2006 and Level 3 beds in CY 2007 and CY 2008. Admissions data are for all Youth Centers and may include admissions to the Level 3 program at Green Ridge.

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to collect this data and efforts are underway to begin collecting such data. Once collected, the data will be used to evaluate the adequacy of psychiatric hospital capacity.

B. Residential Treatment Centers (RTC)

As discussed in the overview of this chapter, what distinguishes RTC youth from other youth in committed placements is that in addition to criminogenic treatment, RTC youth committed to the Department's custody require psychiatric care. Depending on the criminogenic risk profile presented by the youth, services can be provided in a non-secure or secure setting.

The following definition of RTC was included in the Pending Placement section of Chapter 1, but merits repeating in this section:

A Residential Treatment Center provides the highest level of care for moderate-to-high-risk youth with a psychiatric DSM IV Axis I diagnosis for serious emotional disturbance (SED). Services generally include: group and individual counseling, close supervision, 24-hour crisis intervention, restraint capability, contained educational programs and medical management. RTCs are required to have psychiatrists, psychologists and psychiatric nurses on staff to lead treatment. Maryland RTCs are approved for operation through the State Certificate of Need (CON) process and are licensed through the Mental Hygiene Administration, a division of the Maryland Department of Health and Mental Hygiene (DHMH). Rates are approved by the Health Services Cost Review Commission, a DHMH regulatory board.

Some RTCs concentrate on specific populations of youth. For example, Secure RTCs focus on youth with behavioral problems and/or who are considered to potentially harmful to self or others. The RTCs are intended to stabilize the youth's emotional condition, provide services that increase the youth ability to manage their mental health illness as a potentially life long challenge, develop social skills for coping with both daily and difficult situations and interpersonal relationships and to transition the youth to a less restrictive environment or to home. This involves interventions with the family as well as the youth. The average length of stay is 12 – 18 months.

There are four subtypes of RTC:

1. General RTC
2. Secure RTC
3. RTC - Sex Offender
 - a. Non-Secure
 - b. Secure
4. RTC - Dually Diagnosed Youth

Population Data

Table 3-6 shows the trends in the overall RTC population for the Department's youth. After reaching a high of 346 ADP in FY 2003, the Department's RTC population steadily declined for the following five years.

Table 3-6
Historical Average Daily Population (ADP) for
Department of Juvenile Services RTC Youth - FY 2001-2008

	Fiscal Year							
	2001	2002	2003	2004	2005	2006	2007	2008
Average Daily Population	276	321	346	302	276	236	224	207

Table 3-7 examines the composition of the FY 2008 figure. The in-state and out-of-state per diem figures include youth in all four of the RTC types shown above. The Department operates the New Directions program at the Charles H. Hickey Jr. School serving male youth who require Secure RTC - Sex Offender care. The table shows that the overwhelming majority, 86% of the Department's RTC youth, are served in Maryland.

Table 3-7
Average Daily Population of RTC Youth by Gender and Placement

	Male	Female	FY 2008 Total	%
In-state Per Diem	103	49	152	74%
New Directions - Hickey	25	0	25	12%
Total - In-state	128	49	177	86%
Out-of-state Per Diem	28	1	29	14%
Total	128	49	207	100%

1. General RTC

In early 2007, the Department conducted a survey of all of its in-state and out-of-state RTC providers. Table 3-8, which shows the results of that survey, indicates a total of 1,249 General RTC beds were available from the Department's providers. Of these, 525 beds are in-state and 724 beds are out-of-state.

Table 3-8
CY 2007 Capacity Survey - General RTC

Location	Male	Female	Total
In-state	314	211	525
Out-of-state	474	250	724
Total	788	461	1,249

The Department conducted a more detailed survey of in-state providers in FY 2008⁸. The FY 2008 survey tracked monthly data on use of in-state RTC facilities by the Department's youth, as well as fluctuations in available capacity and vacancy rates. By July 2007, the in-state capacity was 597 beds. During the year there were two changes in capacity that increased capacity to 625 beds in October 2007 and decreased it to 593 beds in April 2008. As shown in Table 3-8, the average capacity for the year was 612 beds. Table 3-9 uses the percentage of RTC bed vacancies as a measure of utilization. In the period July 2007 to May 2008, DJS occupied approximately 24.9% of the 612 beds, while other users occupied 65.3% of the beds. The result was a reported vacancy rate of 10%, which indicates relatively high bed utilization, but with approximately 60 beds still available.

Table 3-9
Summaries of In-state General RTC Vacancies from July 2007 to May 2008

DJS In-state ADP	Total Vacant Beds	Average Capacity	Vacancy	Occupancy	DJS Occupancy	Other Users Occupancy
152	60	612	9.8%	90.2%	24.9%	65.3%

2. Secure RTC

Secure RTC facilities provide the same types of services as general RTC, in a secure environment with such features as locked doors and a fenced perimeter. These facilities are used for youth whose criminogenic risk profile indicates the need for a secure facility. Data showing the capacity of Secure RTC facilities are available from the 2007 capacity survey and are presented in Table 3-10. ADP data for this population are not available.

Table 3-10
2007 Capacity Survey - Secure RTC

	Male	Female	Total
In-state Per Diem	8	9	17
Out-of-state Per Diem	46	1	47
Total	54	10	64

¹¹Data for June 2008 are not available from this survey. The data provided are from the first 11 months of the fiscal year. The ADP data presented in this section are for all of FY 2008.

3. RTC - Sex Offender

Residential Treatment Center – Sex Offender is a subset of RTCs which serves adjudicated sex offending youth who have been determined to need RTC level of care and may be considered a threat to public safety in a less structured and supervised program. In keeping with the treatment focus of RTCs, a variety of individual, group and family counseling are provided. Sexual offender treatment approaches must assess youth on specific concerns in order to develop appropriate treatment and aftercare plans for both the youth and the family. Programs assess youth and family history, the youth’s understanding of the sexual abuse cycle and the arousal and fantasy pattern, victim empathy (including their own possible abuse), consequences of sexually abusive behavior, power and control, denial and minimization, cognitive distortions, positive sexuality and relapse. The average length of stay is 12 to 18 months.

Tables 3-11 and 3-12 show the results of the 2007 capacity survey for non-secure and secure RTC - Sex Offender facilities. ADP data are not available for this population.

Table 3-11
2007 Capacity Survey - Non-Secure RTC-Sex Offender

	Male	Female	Total
In-state Per Diem	55	0	55
Out-of-state Per Diem	0	0	0
Total	55	0	55

Table 3-12
2007 Capacity Survey - Secure RTC-Sex Offender

	Male	Female	Total
In-state - New Directions - Hickey	26	0	26
Out-of-state Per Diem	43	20	63
Total	69	20	89

4. RTC - Dually Diagnosed Youth

Residential Treatment Center for Dually Diagnosed Youth facilities serve youth who have been diagnosed with both mental illness and a substance abuse problem.

Table 3-13 show the results of the 2007 capacity survey for RTC - Dually Diagnosed Youth facilities. All of the capacity for this population is located out-of-state. ADP data are not available for this population.

Table 3-13
2007 Capacity Survey - RTC - Dually Diagnosed Youth

	Male	Female	Total
In-state	0	0	0
Out-of-state Per Diem	116	32	148
Total	116	32	148

CONCLUSIONS

The total number of RTC beds available to the Department is nearly 1,250, more than five times the RTC average daily population for FY 2008. One of the Department's key objectives is to serve Maryland youth in Maryland. Table 3-6 shows that this is the case for 86% of the youth in RTC placements. For certain RTC types, however, such as RTC - Dually Diagnosed Youth, there is no in-state capacity, so youth who require these services must be sent out-of-state. Furthermore, of the 14% of youth in out-of-state placements, some are there because of the lack of a specific service in Maryland (RTC-Dually Diagnosed), while others may be there because there is insufficient capacity at the facilities of in-state providers. The Department will begin collecting data on the distribution of the 14% by availability of service type in Maryland for further analysis of this issue.

Such an analysis is also suggested by the high capacity utilization rates of in-state RTC facilities. An examination of the approximately 600 RTC beds in Maryland shows that nearly 90% of the capacity is utilized (see Table 3-9). As discussed earlier in this chapter, in economic terms, a 90% utilization rate indicates that additional capacity may be required. An assessment of the ADP and vacancy trends over time by RTC type and gender would show where the greatest needs exist. The Department has already begun collecting these data and will examine it to identify whether youth are being sent out-of-state due to insufficient capacity at in-state facilities.

C: Secure Treatment

DJS Secure Treatment System Overview

As mentioned in the introduction to this chapter, there are five levels of treatment services provided by DJS, ranging from the least restrictive, Level I, home-based services, to the most restrictive, Level V, commitment to a secure treatment facility. Like the previous sections in this chapter, this section describes a population with a judicial finding of delinquency who have been committed to DJS custody. What distinguishes the Level V population is that the risk profile presented by these youth indicates that they must be served in a secure facility with such features as locked doors and a fenced perimeter.

One of the primary goals of the O'Malley-Brown administration is to treat Maryland's children in Maryland. To that end, youth with secure treatment needs should be served in-state. The Department's current secure treatment system includes out-of-state "per diem" providers (Table 3-14) and the two state-operated state facilities shown in Table 3-15.

Table 3-14
Out-of-State Per Diem Male Secure Treatment Capacity

Facility	Location	Gender	Capacity
Mid-Atlantic Youth Services Western PA	PA	Male	74
Mid-Atlantic Youth Services Luzerne	PA	Male	36
Southwest Indiana Youth Village	IN	Male	188
Turning Point	MI	Male	40
Total			338

Note: Information on out-of-state providers for the female population is not available.

Table 3-15
DJS-Operated Secure Treatment Facilities

Facility	Location	Gender	Capacity
Thomas J.S. Waxter Children's Center	Anne Arundel	Female	12
Victor Cullen Center	Frederick	Male	48

Forecasting Secure Treatment Needs

The secure treatment forecast methodology consists of examining:

- Historical context
- Secure Commitment Rate
- Male Secure Treatment Trends
 - Inappropriate placements
 - Special needs placements
- Female Secure Treatment Trends

Historical Context

At the beginning of the current decade, state-operated secure programs at the Charles Hickey Jr. School and the Victor Cullen Center admitted more than 300 males annually as shown in Table 3-16. In FY 2002, there was a major policy shift in the State to treat Level V youth out-of-state, and an effort began to dramatically reduce the secure treatment populations at these two facilities; Victor Cullen had been completely depopulated by FY 2003, Hickey was depopulated during FY 2006. Although some of the juveniles who had been served at Hickey and Cullen were diverted to out-of-state placements, the number of male admissions to secure facilities fell from 339 in FY 2001 to a low of 93 in FY 2006, a decline of more than 70%, as youth were diverted to less-secure residential placements such as group homes, or remained in pending placement in a secure detention facility until they could be transferred to an out-of-state per diem provider. The secure population data for males show large fluctuations, but the female population data is comparatively stable, as female capacity was not changed during this period.

Table 3-16
Secure Treatment Admissions - FY 2001-2007

	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	Average
Males	339	284	151	103	162	93	106	177
Females	17	16	13	13	16	14	10	14
Total	356	300	164	116	178	107	116	191

Using historical data for males is misleading, however, because secure treatment usage was artificially low after FY 2002, when capacity for male secure treatment was significantly reduced. In FY 2001 and FY 2002, secure treatment admissions averaged more than 300, but once the Department lost secure bed capacity for males, these admissions fell by more than 60%, to an average of 123 for FY03-FY07, the period following the policy change. This decline in secure bed capacity resulted in an increase in the male pending placement ADP, which rose from 115 in FY 2002 to more than 150 in three of the following four years (Table 3-17). Also, some youth were inappropriately placed in group homes and there was an increase in the number of youth being sent to out-of-state programs.

Table 3-17
FY 2001-2008 Male Pending Placement Average Daily Population (ADP)

Fiscal Year							
2001	2002	2003	2004	2005	2006	2007	2008
110	115	155	155	120	152	134	123

Secure Commitment Rate

Youth committed to DJS can be admitted to a variety of placements, as discussed earlier. The percentage of those commitments that result in admissions to a secure treatment facility is the Secure Commitment rate. This rate can be used as a tool to estimate the appropriateness of placing youth in a secure treatment facility. In certain past years, such as FY 2004, FY 2006, and FY 2007, the rate fell to 5% (Table 3-18). As will be discussed later in this section, this period also saw an increase in placement failures in non-secure placements such as group homes, indicating that youth who should have been in a secure facility were inappropriately placed in a non-secure facility.

The Department has analyzed the secure admissions as a percentage of total commitments and found that in FY 2001-2007, an average of 7% of all commitments required a secure placement. For forecasting purposes, the Department expects secure admissions to continue to represent 7% of all residential commitments. The data for CY 2007 are consistent with this assumption.

Table 3-18
Admissions to Secure and Non-Secure Commitments

	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	CY2007
Non-Secure	2963	2718	2650	2364	2461	2035	2046	1985
Secure	356	300	164	116	178	107	116	153
Total	3319	3018	2814	2480	2639	2142	2162	2138
% Secure	11%	10%	6%	5%	7%	5%	5%	7%

Note: These figures are not disaggregated by gender.

Male Secure Treatment Population

The Department has examined the impact of the depopulation of males from the Victor Cullen and Charles H. Hickey Jr. facilities and found that as a result of this change, certain youth were inappropriately placed in non-secure residences; these youth had risk profiles that indicated a need for the level of security provided by a secure treatment facility. Recognizing this issue, the Department has increased the appropriate placement of more youth in secure treatment since the beginning of calendar year 2007. As shown in Table 3-19, the male secure treatment ADP nearly doubled from the CY 2006 figure of 61 to 112 in CY 2008.

Table 3-19
Secure Treatment - Male ADP by Placement

Males	Fiscal Years				Calendar Years			
	2005	2006	2007	2008	2005	2006	2007	2008
Hickey Intermediate & Enhanced	57	23	0	0	58	61	0	0
Victor Cullen Center	0	0	0	22	0	0	8	33
Out-of-state Non-RTC Secure Per Diems	36	45	77	91	39	0	91	79
Total	93	68	77	113	97	61	98	112

Placement Reforms

Expediting Placements: The pending placement spike referred to in Table 3-17 was eventually lowered through a concerted focus by the Department to expedite the State Coordinating Council (SCC) process for placement of high-risk youth to out-of-state programs. As shown in Chapter 1, Local Coordinating Council (LCC) and SCC reviews involve a lengthy process that creates a backlog that taxes detention center populations and is a detriment to meeting the treatment needs of youth. The increase in the number of out-of-state per diem placements in CY 2007 is directly attributable to youth moving from pending placement status in detention centers to the committed placements that courts had ordered for them. The out-of-state average populations, which fell to zero in CY 2006, climbed to nearly 100 in CY 2007 under the Department's initiative. Pending placement ADP for males was reduced from a monthly peak of 185 in April 2006 to monthly averages of less than 100 by the end of CY 2008. These figures are consistent with the post-reform estimates for male pending placement in secure detention included in Chapter 1.

Improved Risk Assessment: The LCC and SCC review process has relied on clinical evaluations and does not consider risk/needs assessments. A youth must now fail in placements multiple times to be approved for out-of-state programs. Rather than using clinical evaluations, the Department will use the MCASP, a criminogenic risk/needs assessment tool described in the introduction to this chapter, to determine what the appropriate placement for the youth should be at the original judicial disposition. This will reduce the incidence of repeated placement failures in non-secure placements, such as group homes, and reduce the number of youth held in pending placement in secure detention facilities following placement failures.

Both of these reforms will reduce the number of youth in pending placement in detention centers. By their mandates, these facilities are for short-term placements, designed to hold pre-adjudicated youth before a court can decide whether they can safely and productively return to the community, or be committed to treatment. Detention facilities are not designed or equipped to deal with youth who have extended lengths of stay. Despite these limitations, prior to the implementation of these reforms, many youth who required secure care either ended up in pending placement status in detention centers or in inappropriate group home placements.

Average Length of Stay

Lengths of stay for high-risk youth can vary widely, from six months to multiple years, with some youth remaining in secure placements until 21 years of age. Historical data on average length of stay (ALOS) in secure committed programs have been inconsistent in recent years due to changes in the structure of the secure treatment system. Additionally, data collected by the Department are for length of stay as reported at release, which are not consistent with annual ALOS data.

**Table 3-20
CY 2007 - Male ADP, Admissions, and Annual ALOS**

	Admissions	Annual ALOS	ADP
Out-of-state	110	300.4	90.5
Victor Cullen	34	81.7	7.6
Total	144	248.8	98.1

Table 3-20 shows the ALOS data derived from ADP and admissions figures for CY 2007. Average length of stay for this population is thus a factor of admissions and length of stay. The ALOS for secure placements in CY 07 is 248.8 days. This is somewhat lower than would be expected, due to the reopening of the Victor Cullen Center mid-year. This facility was only able to admit youth for a portion of the year, and so their ALOS figures are artificially low.

The Department plans to operate three secure committed treatment facilities for male youth. The planned treatment program will have a duration of six to nine months, depending on the needs of the youth. As many of the youth will require the full nine months of programming, and others are likely to experience setbacks in treatment, the Department estimates that the ALOS in the program will be nine months, or 274 days.

Existing Need

The admissions baseline for secure treatment used in this analysis is CY 2007. The expected ALOS of 274 days is then applied to the 144 CY 2007 male admissions (see Table 3-20)⁹, yielding a base ADP of 108. The derivation of the 108 ADP is shown in the formula below.

$$\frac{144 \text{ Admissions (CY 2007)} * 274 \text{ days (nine month average for treatment)}}{365 \text{ days}} = 108 \text{ ADP}$$

Placement Failures from Non-Secure Group Homes

In addition to the existing need from the CY 2007 admissions shown above, there is another source of youth who require secure treatment: inappropriately placed youth. As was discussed previously, the Department lost significant secure treatment capacity during FY 2002. This

⁹ Table 3-18 shows the total number of secure treatment admissions for CY 2007 as 153. This is the sum of 144 male admissions and 9 female admissions.

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resulted in a significant increase in the number of pending placement youth. Over the past decade, systems have been put into place to attempt to serve youth in the “least restrictive environment.” The discussion below documents that for a certain well-defined segment of the committed population, this system has resulted in inappropriate placements due to the lack of in-state Level V capacity.

Youth who are inappropriately placed are often expelled from group home placements. This has resulted in high failure rates in committed placements. Forty percent of pending placement youth, i.e., those pending placement youth in detention centers awaiting a committed placement, had at least one prior committed placement failure. Of youth placed out-of-state, 65% had at least one prior in-state committed placement failure. The Department undertook an analysis of group home placements to determine the number of youth inappropriately placed. The study (see Appendix IV) found that 13% of group home youth should be in a secure program.

For this analysis, the Department undertook a study (the 2007 Group Home Study) that estimated that approximately 13% of youth currently in Group Homes would require Level V secure treatment. The estimate also concluded that this phenomenon occurred on a yearly basis. Applying the 13% to the 454 male group home placements in CY 2007 yields 59 admissions each year of youth served in group homes who should be served in secure care, but who are now being inappropriately placed in a group home. With an ALOS of 274 days in secure treatment, these 59 admissions yield an additional 44 ADP for secure treatment. The formulas demonstrating these findings are shown below.

$$454 \text{ (group home admissions in CY 2007)} * 13\% \text{ failure rate} = 59 \text{ admissions}$$

$$\frac{59 \text{ admissions} * 274 \text{ ALOS for Secure Treatment}}{365} = 44 \text{ ADP}$$

Forecast of Male Secure Treatment Need

The 144 admissions from CY 2007 serve as a proxy for the expected number of admissions to secure treatment in the system. To find the full expected need, the 59 admissions from inappropriate group home placements must be added to that figure. The total expected number of admissions to secure treatment, then, is 203, yielding an expected ADP of 152. The expected ALOS for the program is 274 days. The table below shows the sum of the 108 CY 2007 ADP and the 44 ADP calculated by the analysis of inappropriate placements to group homes. The total expected ADP for secure treatment is 152.

**Table 3-21
Estimated ADP for Male Secure Treatment**

	Admissions	ALOS	ADP
CY 2007	144	274	108
Inappropriate Placements	59	274	44
Total	203	274	152

Analysis of daily population counts from the last four fiscal and calendar years shows that there is significant volatility in the committed population. Using the same standard applied in the

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Secure Detention section, the peaking factors for this population were determined by the difference between the ADP and two standard deviations of the daily counts. Data from the last three calendar years show that the volatility has declined, markedly so in CY 2008. The average peaking in those three years is 27.8%, which will be used as the peaking factor for secure treatment. The peaking data are shown in Table 3-22. The forecast of secure treatment bed need will use the 27.8% as a peaking factor.

**Table 3-22
Male Secure Committed Peaking Factors**

	Fiscal Years				Calendar Years				CY '06-'08
	2005	2006	2007	2008	2005	2006	2007	2008*	Average
ADP	93	68	77	113	97	61	98	113	91
w/2 Std. Dev.	134	116	96	137	142	84	132	125	114
Peaking	43.7%	69.5%	23.6%	21.1%	46.1%	37.4%	35.0%	11.0%	27.8%

**First 10 months of 2008*

Level V Male Youth with Special Needs

The Department's state-operated secure treatment programs are not intended to serve youth with specialized needs or whose medical condition requires a residential treatment center (RTC) setting. Therefore, those youth who are not accepted by in-state RTC or who have specialized needs will continue to be placed out-of-state. DJS projects that 30 to 35 youth on any given day will continue to be served out of state because of their special needs or require an out-of-state RTC. The Department conducted two single-day counts, in October 2007 and February 2008 to determine what numbers and types of juveniles must be served out-of-state. The table below shows the results of that analysis. In calculating the overall need for secure treatment, the 30 ADP of youth will be excluded from the calculation of in-state secure treatment need, as they will continue to be served by out-of-state facilities.

**Table 3-23
Special Needs Out-of-State Level V Placements**

Reason for Out-of-State Placement	Oct-07	Feb-08
Fire Setters	7	10
RTC - Medically Ineligible for In-state Programs	11	12
Low IQ	3	5
Asperger Syndrome	1	1
Age Ineligible for In-state Programs (too old)	10	7
Total	32	35

As discussed earlier, due to special circumstances, approximately 30 youth will need to be placed in out-of-state secure treatment facilities. In order to determine the need for in-state capacity, 30 youth are subtracted from the total estimated ADP, and peaking factors are applied to both the out-of-state and remaining in-state populations. Table 3-24 shows the total estimated need for

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in-state and out-of-state beds with the 27.8% peaking factor. Application of the peaking factor resulted in a total bed need estimate of 195.

**Table 3-24
Estimated Need for Male Secure Treatment Beds**

	ADP	Peaking (27.8%)	Total Estimated Bed Need
In-state	122.4	34.0	156.4
Out-of-state	30.0	8.3	38.3
Total	152.4	42.4	194.8

CONCLUSION

Table 3-25 shows a projected in-state male secure treatment bed need of 156. This is 108 more than the existing 48-bed capacity of the Victor Cullen Center.

**Table 3-25
Existing In-State Secure Treatment Capacity for Males**

In-state Need	156.4
Victor Cullen Center (In-state Capacity)	48
Deficit	-108.4

In order to meet the objective of serving Maryland’s youth in Maryland, additional in-state secure treatment capacity for males is needed. The impact of this deficit is that youth have extended stays in pending placement in secure detention awaiting transfer to out-of-state secure treatment providers. By providing additional in-state capacity, the Department will be able to serve Maryland’s youth in Maryland and significantly reduce the use of pending placement for youth who require secure treatment.

Female Secure Treatment Population

While major reforms are planned for the male secure treatment population to serve youth in Maryland, this is not a concern for the female secure treatment population, as nearly all of them are already served in-state. Table 3-26 shows that more than 80% of treatment placements for females are in-state, at the Waxter facility, and that the annual ADP there has been in the range of 8 in recent years. As with the male population, the out-of-state placements are for special cases when in-state programs are not suitable. For forecasting purposes, this analysis uses the CY 2007 ADP of 8.5 for the Waxter population, a conservative estimate as that year was above the average. As there is more volatility in the out-of-state population, the CY average of 1.5 will be used for forecasting.

Table 3-26
Secure Programs - Historical Female ADP by Placement

Females	Fiscal Years				Calendar Years				CY
	2005	2006	2007	2008	2005	2006	2007	2008	Average
Waxter Maximum Security Treatment (in-state)	6.3	7.4	9.1	8.0	6.5	8.9	8.5	7.5	7.8
Out-of-state Non-RTC Secure Per Diems	0.0	2.2	1.5	0.3	1.0	2.3	0.5	2.2	1.5
Total	6.3	9.5	10.6	8.3	7.5	11.2	8.9	9.7	9.3

Table 3-27 below shows the peaking factors for the female secure committed population in recent years. The peaking factor is determined by taking two standard deviations from the daily population counts. The average peaking factor for the past four calendar years is 40%. The 40% peaking factor is applied in Table 3-28.

Table 3-27
Statewide Female Secure Treatment

	Fiscal Years				Calendar Years				CY '05-'08
	2005	2006	2007	2008	2005	2006	2007	2008*	Average
ADP	6.3	9.5	10.6	8.3	7.5	11.2	8.9	9.7	9
w/2 Std. Dev.	9.7	13.7	14.3	11.3	10.9	15.1	12.0	14.1	13
Peaking	53.8%	43.3%	34.3%	36.0%	45.5%	35.1%	33.7%	45.3%	40%
*First 10 months of 2008									

Forecast of Female Secure Treatment Need

Table 3-28 shows the estimated need for female secure treatment placements, both in-state and out-of-state. As shown in Table 3-26, the baseline CY 2007 in-state ADP is 8.5. The out-of-state ADP is 1.5, the average of CY 2004-2007.

Table 3-28
Estimated Need for Female Secure Treatment Placements

	ADP	Peaking (40%)	Total Estimated Need
In-state	8.5	3.4	11.9
Out-of-state	1.5	0.6	2.1
Total	10.0	4.0	14.0

Comparison of Projected Need to Existing Capacity

Table 3-29 shows that the in-state capacity at the Waxter facility is sufficient to meet the expected need.

Table 3-29
Planned In-State Secure Treatment Capacity for Females

In-state Need	11.9
Thomas J.S. Waxter Children’s Center (In-state Capacity)	12
Surplus	0.1

No increase in the female secure treatment population is expected. However, because of the small surplus, if such an increase were to happen, the system would have a deficit of secure treatment capacity for females.

CHAPTER 4: COMMUNITY BASED SERVICES

The Department of Juvenile Services has traditionally used a variety of community-based programs, that is, programs in which youth receive services in the community while remaining in their home residence. The traditional 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 Evidence-Based Programs (EBP) discussed in Part A below. A second innovation, residential treatment wraparound services, is discussed in Part B.

Community-based services represent a shift in the location of the provision of services from residential facilities to individuals living at home and receiving services in the community. The shift reflects several presumed advantages. First, youth living at home are in a “least restrictive setting” compared to the constraints of a residential facility managed by individuals with no personal relationships with the youth. Instead of institutional rules, a youth experiences freedom in a family setting with parental authority that is typical of youth in their homes.

A second advantage is that services focus on the youth and their family in order to strengthen the “natural family unit” which is the home of most youth. As a result, the focus is not on learning compliance to the institutional rules of a facility, but learning to live in a natural setting which is mixed with parental limitations and personal caring. In essence, the effort is to strengthen the family, a key social unit in society.

The third advantage involves the cost and efficacy of residential facilities. Residential facilities are believed to be more expensive than community based services, especially because domicile costs are eliminated with the child living at home. The costs thus center on organizing a care service system. In addition, the efficacy of the services is believed greater in a family setting than in a residential institution. Specifically, youth improve in their day to day functioning, thereby developing the basis to become an autonomous adult in the community.

A. Evidence Based Programs (EBP)

The Department has begun expanding the use of Evidenced Based Programs (EBP). The Center for the Study and Prevention of Violence has identified eleven model EBP programs which meet three key criteria: (1) evidence of deterrent effect (on violence/criminal behavior), (2) sustained effect of the program’s treatment intervention, and (3) multiple replications of the effects at different research sites. These three criteria compose the core meaning of evidence based.

DJS intends to use three of eleven models. They are: (1) Functional Family Therapy (FFT), (2) Multisystemic Therapy (MST), and (3) Multidimensional Treatment Foster Care (MTFC). The Department has chosen these three models because their program targets are applicable to the profiles of youth in Group Home placements. The Functional Family Therapy model’s target is for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. The Multisystemic Therapy model’s target is chronic, violent, or substance abusing male or female juvenile offenders, ages 12 to 17, at high risk of out-of- home placement, and the offenders’ families. The Multidimensional Treatment Foster Care model’s target are

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teenagers with histories of chronic and severe criminal behavior at risk of incarceration and those with severe mental health problems at risk for psychiatric hospitalization.

The Department uses a modified version of the Washington State Juvenile Court Assessment (WSJCA) instrument to assess the appropriateness of youth for the EBP models called the Maryland Comprehensive Assessment Service Planning (MCASP) instrument. MCASP is scale-based; that is, it produces a score that places youth in risk levels that vary from low to high. Data is collected within eleven domains: (1) Criminal History, (2) Demographics, (3A) School History, (3B) Current School Status, (4A) Historic Use of Time, (4B) Current Use of Free Time, (5A) Employment History, (5B) Current Employment, (6A) History of Relationships, (6B) Current Relationships, (7A) Family History, (7B) Current Living Arrangements, (8A) Alcohol and Drug History, (8B) Current Alcohol and Drugs, (9A) Mental Health History, (9B) Current Mental Health, (10) Attitudes/Behaviors, (11) Aggression, and (12) Skills.

The risk factors associated with each domain are as follows:

1. Criminal History: Youth with extensive criminal histories that started at an early age are at higher risk of criminal offenses in the future.
2. Demographics: Youth with certain demographic characteristics are at higher risk of criminal offenses in the future.
3. School: Youth with performance problems in school are at higher risk of criminal offenses in the future.
4. Use of Free Time: Youth who spend free-time in pro-social and constructive activities are at lower risk of criminal offenses.
5. Employment: Youth who have been successfully employed and have developed good relationships with employers and co-workers are at lower risk of criminal offenses.
6. Relationships: Improving a youth's relationships with pro-social adults and peers and weakening the relationships with anti-social peers reduce risk of criminal offenses.
7. Family: Youth in families with parental criminality, substance abuse problems, and mental health problems are at greater risk of criminal offenses.
8. Alcohol and Drugs: Youth with an early behavioral history of experimentation with drugs are at greater risk of criminal offenses.
9. Mental Health: Youth who rely on physically aggressive ways at an early age are more likely to continue such behavior in the future, resulting in increased likelihood of criminal behavior.
10. Attitudes/Behaviors: Youth with anti-social attitudes, values, and beliefs are more likely to commit criminal offenses.
11. Aggression: Youth with a history of aggression are at higher risk for later serious and violent behavior.
12. Personal Skills: Youth with difficulty in personal skill areas such as dealing with emotions, problem solving, situational perception, and impulse control are at higher risk for criminal behavior.

Each domain has many survey items that solicit specific information used to measure a youth's level of risk regarding each domain. The scoring of these domains is the basis for assigning a risk level to a youth. For more details about MCASP, see Appendix V.

Reform Effort

The Department has developed a protocol to identify eligible youth for evidence-based services (EBS) as a diversion from out-of-home placement. The MCASP will be completed prior to a juvenile's disposition hearing to gain an understanding of his/hers risk and protective factors and to help develop a treatment service plan (TSP) based upon this information. EBS services will be paired with probation or intensive supervision.

Recommendation at Staffing: The EBS eligibility will be determined during a resource staffing. The Department will apply EBS criteria at all resource staffing for which a youth is at risk of out-of-home placement. The EBS criteria have two parts: the score from the pre-screen risk assessment combined with the EBS Family Assessment Checklist which consists of a subset of questions from Domain 6 of the Maryland Comprehensive Assessment and Service Planning (MCASP). This domain includes questions about a youth's family history and current family situation. This instrument was validated in Washington State to identify youth at risk for out of home placement who would be better served by FFT, MST and MTFC. The youth must have a score that places him/her in moderate to high risk and have a score of 7 or above on the checklist to qualify for EBS. The results of the youth's eligibility for EBS will be documented in the staffing summary. The target population for EBS is as follows:

- Juveniles identified by the Court to be at risk of out-of-home placement;
- Juveniles who are in pending placement status in a detention facility or community;
- Juveniles in a detention facility who are likely to be identified as in need of out-of-home placement; or
- Juveniles currently in out-of-home placements, especially in out-of-state placements.

All youth who meet the EBS criteria will be referred first to FFT and MST if services are available. The referral to MTFC will be made in those instances when the family/home requires more intensive intervention to prepare for the youth's return. The Regional Director must approve the out-of-home placement of a youth who meets eligibility for EBS criteria.

Resource Specialists will be trained on the needs and risk instruments and the eligibility criteria for EBS in order to correctly apply these to decision making during staffing. The first training introducing the risk and needs instruments and EBS criteria for the Resource Specialists is June 16, 2008.

Placement: EBS programs will be added to the Certificate of Placement (COP) process which is the Department's formal authorization of placement in residential programs and specific nonresidential programs. A statement of effort to place youth into EBS will be added to the Certificate of Placement:

- Was youth found eligible for EBS?
- If the youth is eligible for EBS and is being placed elsewhere, explain why?
- Name of authorization.

Reassessment: Case Manager Specialists will reassess youth in EBS every four weeks after admission to review progress and/or to adjust the Treatment Service Plan as needed. The same needs assessment will be used for the reassessment by using those domains of the MCASP that correlate with the criminogenic factors included in the treatment service plan.

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Utilization Review: Youth placed in out-of-home placement will be reassessed quarterly prior to his/her release from placement, to determine current risk level and appropriateness for EBS. The review is to assure that no youth remain in a placement longer than is necessary to address the problems that brought the youth into care, and to project a date when the youth will be ready to return to the community. The utilization review will apply EBS criteria to identify youth for whom the length of placement can be shortened by participating in EBS in the community.

Data: The following data will be collected regarding EBS:

1. EBS criteria will be applied to all youth at staffing at risk of out-of-home placement regardless of whether EBS services exist in the county or region. This will document future need for EBS in the county / region.
2. The Regional Director over rides for placement of EBS eligibility youth will be reported in the monthly regional statistics provided to the Director of Regional Operations and the Research Unit.
3. EBS programs will submit monthly reports that include program participants, number of visits, referrals, start and end dates, successful/unsuccessful program completions and school attendance.

The Research Unit will provide Region Directors with regular reports about the participation of youth referred to EBS in their region.

Gap Analysis

Based on a Risk Assessment Study in November, 2007, which used WSJCA, the Department has determined that approximately 20% of youth placed in group homes met the EBP criteria and could be served by FFT, MTFC, and MST.

Based on the data from the risk assessment study, the Department has set a goal of reducing all Non-Secure/Non-RTC admissions by 20%. Using CY07 as a baseline this would translate to a reduction of 161 admissions.

Table 4-1 indicates that with 54 EBP slots would be needed to serve 161 youth in the community.

**Table 4 – 1
Needed Evidence Based Program Slots**

Region	Residential Area	Reduction in Admissions	Needed EBP Slots
I	Baltimore City	40	14
II	Central	27	9
III	Western	9	3
IV	Eastern	19	6
V	Southern	26	8
VI	Metro	40	14
Total		161	54

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The total DJS EBP slot capacity was 193 as of January 2009 (footnote). One Hundred (100) additional MST slots will be added by the end of May 2009, bringing the overall slot total to 293. Table 4-1 shows that an additional 54 slots are needed to meet the 20% goal exceeding the need by 46 slots for the total of 100 additional slots. Table 4-2 below reflects the EBP slots by region.

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**Table 4-2
Projected FY 2009 EBP Capacity by Region**

REGION	JURISDICTION	EVIDENCE-BASED SERVICES	VENDOR	FY09 DAILY CAPACITY
Baltimore City	Baltimore City	Functional Family Therapy	Building Communities Today for Tomorrow	0
			Progressive Life Center, Incorporated	0
		Multisystemic Therapy	North American Family Institute, Incorporated	80
			MST Total:	80
Central	Baltimore County	Multisystemic Therapy	Community Solutions, Incorporated	20
		Multisystemic Therapy	North American Family Institute, Incorporated	5
	Carroll County	Functional Family Therapy	Vision Quest	6
		Multisystemic Therapy	North American Family Institute, Incorporated	5
	Harford County	Functional Family Therapy	Vision Quest	6
		Multisystemic Therapy	North American Family Institute, Incorporated	5
	Howard County	Multisystemic Therapy	North American Family Institute, Incorporated	5
			FFT Total:	12
			MST Total:	40
Western	Allegany County	None	N/A	0
	Frederick County	None	N/A	0
	Garrett County	None	N/A	0
	Washington County	None	N/A	0
Eastern Shore	Eastern Shore Counties	Functional Family Therapy	Vision Quest	18
		FFT Total:		
Southern	Anne Arundel County	Functional Family Therapy	Center for Children, Incorporated	45
	Calvert County	Functional Family Therapy	Center for Children, Incorporated	12
	Charles County	Functional Family Therapy	Center for Children, Incorporated	12
			FFT Total:	69
Metro	Montgomery County	Functional Family Therapy	Vision Quest	12
	Prince George's County	Functional Family Therapy	Progressive Life Center, Incorporated	57
		Multisystemic Therapy	Community Counseling & Mentoring Services	5
			FFT Total:	69
			MST Total:	5
			EBS Total	293

EBS Summary:

Total FFT Slots: 168
Total MST Slots: 125
Total EBS Slots: 293

B. Residential Treatment Center Wraparound Services

Residential Treatment Center Wraparound Services is also a community based service, but differs from EPB in that it is intended to serve youth with more serious emotional problems than youth placed in group homes. The wraparound services are community based services for youth

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with serious emotional disturbances who have historically received services in a residential treatment facility (RTC). The “wraparound” metaphor originated from the idea that youth could best be served in their communities by “wrapping” individualized services around them in their home, mainstream educational classroom, and the community. “Wraparound” is a process for developing an individualized service plan for children at-risk of Emotional and Behavioral Disabilities and their families.

The process has several distinctive characteristics.

- It is “family-centered,” focusing on strengthening child-family relationships under stress from children with serious emotional/behavioral problems.
- The services for strengthening the family relationships are based in the community where the child lives. Services are thus “at home” in the community where a youth lives, instead of in distant facility from a youth’s “natural home.”
- The services in the “individualized plan,” not a “standardized” treatment modality for “everyone with that problem.” The plan will include formal services and interventions (e.g. therapy, inpatient care), community services (e.g. recreational activities, educational mentoring), and “natural supports” from family members, friends, and other individuals in the family’s social network that are specifically adapted to the specific needs of a family.
- The service plan is developed by a team composed of individuals of the family, “natural support providers” (e.g. friends, relatives) and different individuals that involve the various aspects of a youth’s life (e.g. medical, educational, recreational). The team size generally ranges from four (4) to ten (10) individuals.
- The team’s function is to develop and implement the individualized plan, as well as evaluate its success using measurable outcome objectives. In performing these functions, it also serves as the family’s support network.
- A resource coordinator is hired to facilitate the wraparound process, perform a strength/needs assessment of the youth and his/her family, identify and seek available resources, manage the implementation of the service/support plan, and promote development of the “family team.”

In Maryland, a care management entity (CME), Maryland Choices performs the care coordinator function described above and delivers a specific, individualized set of specialty mental health services to a youth and his/her family for a set payment rate. The CME also facilitates development of the complete individualized service plan, develops the support team of the family, and ties the service plan to “natural supports” and other services in a youth’s home community.

Another major function of the CME is its receipt of wraparound referrals from a “custodial agency” responsible for a youth (e.g. DJS). The CME assists in obtaining the evaluations required to document medical necessity for receipt of wraparound services. The documentation is referred to MAPS-MD, an Administrative Service Organization, an entity retained by the State to provide technical support services such as utilization review and provider credentialing verification. Its function with the wraparound application is to determine whether the medical necessity required for wraparound approval has been met.

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Gap Analysis

There are 70 youth currently being served by wraparound services funded by the State. A Residential Treatment Center (RTC) Waiver (1915 RTC Waiver) is scheduled to be implemented in four jurisdictions during FY09. This waiver will permit, youth who meet medical necessity criteria for an RTC placement and other eligibility criteria to receive community-based services through a care management entity using a Wraparound service delivery model. Participation in the waiver will entitle these youth to receive eight new services that are being funded by Medicaid through the Waiver. By making these new services Medicaid reimbursable, the state is able to draw down matching funds from the federal government. It is estimated that with the addition of federal funds, the population served can be doubled. Once that process is complete, the Waiver will open up to new RTC eligible youth in four jurisdictions, Baltimore City and Montgomery, Wicomico, and St. Mary's Counties. Additional jurisdictions to the Waiver are expected to be added beginning October 1, 2009.

For the purposes of the 1915(c) RTC Waiver, the financing model is fee-for-service, with the CME being funded through the Medicaid Administrative Claim while Medicaid eligible services are purchased from vendors on a fee-for-service basis. Financial risk under the Waiver is held by the Department of Health and Mental Hygiene, which is responsible for ensuring cost neutrality to the federal government under the Waiver. The supply of additional wraparound slots depends on available funding. Medicaid requires a fifty per cent (50%) match from the State. It is anticipated that funding will be sought for three federal fiscal years, for a total of six million dollars (\$6,000,000) per year over three federal fiscal years. Since the State must provide a fifty per cent (50%) match for each fiscal year to get the \$3,000,000 in federal funds, funding in the three federal fiscal years will depend on the availability of \$9,000,000 in State funds.

DJS would like the EBP goal of 20% to be the same goal for RTC wraparound services. However, assessment data supported the EBP 20% goal and such assessment data is not currently available for RTC wraparound services.

GAP ANALYSIS FINDINGS AND RECOMMENDATIONS

Summary of Findings for Secure Detention

Secure Detention Facilities for Males

- Statewide, secure detention facilities for males have an existing capacity of 418 beds and a projected need of 321 beds, resulting in a projected surplus of 97. This is 23% of the total statewide bed capacity.
- On a regional level, only Region V has a deficit (-44) in beds and that is due to the absence of a detention facility in the region.
- The remaining five regions have surpluses that vary in magnitude. Three regions have a bed surplus less than 30% of their existing bed capacity: (1) Western Maryland's 7 bed surplus is 27% of existing bed capacity; (2) the Total Eastern Shore's 12 bed surplus is 26% of existing bed capacity; and (3) Baltimore City's 34 bed surplus is 23% of its existing bed capacity.
- Two regions have a bed surplus of 40% or more of existing bed capacity: (1) Central's 29 bed surplus is 40% of its existing bed capacity; and (2) Metro's 60 bed surplus is 45% of its existing bed capacity.

Secure Detention Facilities for Females

- Statewide, secure detention facilities for females have an existing capacity of 50 beds and a projected need of 41 beds, resulting in a projected surplus of 9 beds. This is 18% of the total statewide bed capacity.

Recommendations for Secure Detention Facilities

1. In light of the deteriorated physical condition of the existing facilities at the Cheltenham Youth Center, a new, smaller 48 bed secure detention facility should be constructed for this region.
2. In light of the projected surplus of male detention beds in Region II and the deteriorated physical condition of the existing Charles H. Hickey, Jr. secure detention facility, a new, smaller 48 bed secure detention facility should be constructed for this region.
3. Construct a new 48 bed detention facility for males in Region V – Southern Maryland. In light of the projected surplus of male detention beds in Region VI, once the Region V facility is online, the capacity of the Alfred D. Noyes Center should be reduced to 30 beds either through renovation or the construction of a new facility.
4. In light of the projected surplus of female detention beds and the deteriorated physical condition of the Thomas J.S. Waxter Children's Center, a new 30-bed detention center should be constructed.

Summary of Findings for Alternatives to Detention

Community Detention

- Statewide, the capacity for community detention, the primary type of alternative to detention, totals 597 and a projected need of 633, resulting in a projected deficit of 36 community detention slots. This represents a 6% deficit in this type of ATD program.
- On a regional level, two regions, Baltimore City (31) and Western (4) have projected surpluses of community detention slots. The remain four regions each have projected deficits, Regions II – Central (22), IV – Eastern (12), V – Southern (15), and VI – Metro (23).

Evening Reporting Centers

- Statewide, the capacity for evening reporting centers totals 70 and the projected need is for 51 slots, resulting in a surplus of 19 ERC slots. This surplus is attributable to the addition of 15 evening reporting center slots brought online in Prince George's County in CY 2009. These slots were brought online because the utilization rate for the CY 2008 capacity of 55 slots was 93%.

Shelter Care

- Statewide, the capacity for ATD shelter care totals 96 slots and a project need for 68 slots, resulting in a surplus of 28 slots, or about 30% of existing capacity.
- On a regional level, three regions have surpluses in ATD shelter care capacity, Region II – Central (38), Region III – Western (16), Region V – Southern (13).
- In contrast, three regions have deficits in ATD shelter care capacity, Region 1 – Baltimore City (34), Region IV – Eastern (1), and Region VI – Metro (4).

Recommendations for Alternatives to Detention

1. Additional staff is needed to increase supply of community detention slots. Specifically, additional staff is needed in Regions II – Central, IV – Eastern, V – Southern, and VI – Metro.
2. The Department should examine the utilization rates by jurisdiction for the Evening Reporting Centers before making future plans on capacity changes for this ATD.
3. Data collection regarding shelter care facilities should be improved. Systematic data regarding admissions, length of stay, and average daily population by gender should be collected to better inform decisions about the need for and utilization of this type of ATD.
4. Consideration should also be given to expanding shelter care capacity in Baltimore City. This may be accomplished by contracts with private vendors or through the construction of a state-owned facility.

Summary of Findings for Residential Placements

- There are seven different types of Non-Secure/Non-RTC residential programs. The Department primarily utilizes three types; Group Homes, Youth Centers, and Residential Substance Abuse Treatment facilities.
- Statewide, the utilization of General Group Home capacity totals 82.5%, which suggests there is sufficient Group Home capacity to accommodate future increase in utilization if needed. DJS youth account for approximately 40% of the utilized Group Home capacity.
- Statewide, the utilization of residential substance abuse treatment capacity totals 28%. The remaining substance abuse treatment capacity is utilized by private pay or insured patients.
- Statewide, the capacity of the State's four Youth Centers totals 146 and the systemic utilization rate this capacity is 104%. Individually, Meadow Mountain, and Savage Mountain had utilization rates of 99% and 98% respectively. Two Youth Centers, Backbone Mountain and Green Ridge Mountain operated over capacity at 115% and 103% respectively, which caused the utilization rate to exceed the capacity at the system level.
- There are two categories of Residential Treatment Centers (RTCs); general RTCs and special RTCs. The Department primarily utilizes general RTCs.
- The total number of RTC beds available to the Department is nearly 1,250, more than five times the RTC average daily population for FY 2008. An examination of the approximately 600 RTC beds in Maryland shows that nearly 90% of the capacity is utilized.
- Statewide, the capacity for male secure treatment beds totals 48 and the projected need totals 156.4, resulting in a deficit of 108 male secure treatment beds.
- Statewide, the capacity for female secure treatment beds totals 12 and the need totals 12.

Recommendations for Residential Placements

1. Construct additional state-owned and operated secure treatment beds. As noted above, the statewide deficit for male secure treatment beds totals 108. As State law limits the size of these facilities to 48 beds, the Department should construct two additional secure treatment facilities. These facilities should be located in the State's population centers in the Baltimore and Metro regions. Additional male secure treatment capacity beyond these 96 beds is also needed. The Department should consider building a smaller facility in either Southern Maryland or the Eastern Shore to accommodate the remaining need for male secure treatment beds.

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2. An assessment of the ADP and vacancy trends over time by RTC type and gender should be completed in order to evaluate the State's needs. The Department has already begun collecting these data and will examine these data to identify whether youth are being sent out-of-state due to insufficient capacity at in-state facilities.
3. Data should be collected for all residential facilities which includes: (1) the total number of youth who need the services of each kind of facility (including other Agencies than DJS), (2) the total number of admissions for this service to each facility, (3) the ADP of each facility, and (4) the total capacity of the particular service used in the facility. Collection of this data will enable the Department to more effectively determine its facility and programmatic needs.

Summary of Findings for Community Based Services

Evidence-Based Practices

- Based on a Risk Assessment Study conducted in November 2007, the Department has determined that approximately 20% of youth placed in group homes met the Evidence-Based Practices (EBP) criteria and could be served by one of three treatment models; Family Functional Therapy (FFT), Multidimensional Treatment Foster Care (MTFC), and Multisystemic Therapy (MST). The CY 2007 baseline admissions to group homes were 583, twenty per cent (20%) of which is approximately 117 individuals. The Department has applied the 20% goal to the reduction of non-secure/non-RTC pending placement admissions.
- An additional 100 EBP slots will be added in CY 2010. Of these 100 new slots, the Department has identified a need for 54 slots. The remaining 46 slots represent a surplus.

RTC Wraparound Services

- Statewide, 70 youth will be served in RTC wraparound slots by the end of the current federal fiscal year (September 30, 2009).
- The need for RTC wraparound services is uncertain.

Recommendations for Community Based Services

1. In light of the apparent surplus of available EBP capacity, the Department should evaluate whether additional youth from the Non-Secure/Non-RTC category are eligible for EBP services.
2. In light of the uncertainty about both the demand and supply for RTC wraparound services, DJS should gather information from professional experts in the field who have gathered systematic information about the costs and ALOS of wraparound slots. In addition, the Department should gather information about ways to estimate youth the number of youth eligible for wraparound services after more definitive assessment protocols have been developed.

APPENDICES

APPENDIX I - Maryland's New State Operated Treatment Model

DJS Classification System

The Department has established a new classification model based on both security concerns and cluster of services. Previous efforts had been criticized for being too broad and did not adequately cover services provided. The new classification model begins with nonresidential placement alternatives and ends with secure residential programs.

- Level I – Home with Services
- Level II – Family Foster Care / Therapeutic Foster Care
- Level III – Community Based Residential
- Level IV – Special Programs
- Level V – Secure Programs

Description of Levels within the Classification System

I. Home with Services

Youth live at home with parents, guardians or extended family. Youth and, as needed, family receive services in the community. Living at home is considered the least restrictive environment for treatment. Youth served at home are low risk, and are not considered to be a threat to public safety. Additional services can be accessed through public community resources or procured by the Department. These may include family intervention services, supervision and/or specific services such as counseling or substance abuse treatment.

II. Family Foster Care / Treatment Foster Care

Youth are served within a family environment with 24-hour care and supportive services provided by a child placement agency in an approved family home. Family foster care consist of homes certified by either DSS or DJS. The treatment foster homes are privately managed and are generally clustered within a program under the oversight and management of a mental health professional. The foster homes receive specialized training to deal with youth with special needs. Additional services and wraparound models of service delivery are also available to youth in foster care and are accessed in the community. Treatment foster care (TFC) provides more intensive support services in a family setting for children with emotional, behavioral, medical, and/or psychological conditions. Youth served in TFC range from low to moderate risk, but the behaviors of the youth are not so severe that removal from the community is necessary.

III. Community Based Residential Programs

Youth are served in out of home residential care. These programs serve youth who need more structure and supervision than a relative, foster parent or treatment foster parent could offer. These programs provide a formal program of basic care, social work and health care services in residential neighborhoods. They vary greatly in the youth served and the type of program interventions provided. Most programs utilize community-based ancillary services and the local educational school system. Specialized programs address the needs of specific youth with client specific services built into the program. Community contacts are generally planned to serve as opportunities for the youth to learn healthy coping and adaptive life skills. Youth served range

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from low to moderate risk but are not deemed to be dangerous to public safety. Programs included in this level of security include the following:

- Alternative Living Unit Developmental Disability (ALU)
- General Service Group Home (GH)
- General Services Group Home Serving Children with Special Characteristics (GH SC)
 - Developmental Disability
 - Mother and Baby program
 - Sex Offender Program
 - Substance Abuse Program
- Therapeutic Group Home (TGH)
- Independent Living (IL)
 - Substance Abuse
 - Mothers and Children
- Impact Programs

IV. Special Programs

Youth are served in out of home residential care with minimal services sought from the community. Programs serve specialized populations considered to be of increased risk due to high need and/or delinquency. These populations include youth diagnosed as seriously emotionally disturbed, youth assessed with substance abuse and youth determined to be moderate to high risk of re-offending. These programs are structured, self contained and comprehensive programs providing most services and activities on site. Youth served are considered to pose risk to themselves or others and/or may be considered at risk to flee. Any community contact is planned and generally the result of positive behavior through a behavior modification component. Specific mental health programs may be secure environments because of the treatment needs of the youth served. Many of the special programs require specially trained staff, such as, psychiatrists, psychologists, psychiatric nurses and certified drug and alcohol counselors, for the populations served. Programs included in this level of security include the following:

- Residential Treatment Center (RTC)
 - RTC Sex Offenders
 - RTC Dually Diagnosed
- Non RTC Mental Health Program (NON RTC MH)
- Intermediate Care Facility for Addictions (ICFA)
- Youth Centers (YC)
 - YC Substance Abuse
 - Enhanced Youth Center – Thomas O’Farrell Youth Center
- Wilderness Program

V. Secure Programs

Youth are served in structured self contained and comprehensive residential programs providing all services and activities on site. These include out-of-state open programs and staff secure programs and secure confinement for committed youth. Youth served in these comprehensive open and staff secure programs are considered to be moderate to high risk because of the seriousness of the adjudicated offense, multiple offenses, failed previous placements, lengthy history with the department and/or absconding from other residential programs.

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Youth who are court ordered for secure placement are served in the most physically restrictive environment for the behavior management and treatment of delinquent youth within the Juvenile Justice system. Secure programs must be locked to prevent escape and have either a perimeter fence surrounding the facility or a fenced outside Region for recreation. Structure and supervision are essential elements of the programs. Youth served are chronic repeat offenders or have been adjudicated on the most serious offenses and are considered to be high risk for continued delinquent behavior. All services are provided on site and off campus activities and home visits are rare. Programs included in this level of security include the following:

- Open Programs and Staff Secure Programs
- Substance Abuse Program
- In-state and Out-of-state Secure Programs

Integrated Assessment and Service Planning

The results of the Maryland version of the Washington State Juvenile Court Assessment Instrument will be used to develop a treatment services plan while the youth is in the treatment facility. The Maryland Comprehensive Assessment and Service Planning (MCASP) is an innovative process that will be conducted throughout a youth's involvement with DJS and includes an ongoing assessment to address need and reduce risk.

The assessment process has four components:

5. Predicting a youth's likelihood (risk) to re-offend and the level of security that is required to ensure public safety;
6. Identifying criminogenic risk and protective factors in a youth's life that are linked to delinquent behavior and required interventions;
7. Guiding case management planning and implementation to focus on reducing risk factors and increasing protective factors; and
8. Monitoring youth's progress and reassessing risk to determine if the interventions are effective and changing the service plan as needed.

The initial assessment will help DJS to identify youth who could safely be diverted from residential placements and benefit from EBPs such as FFT and MST.

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 risk level score from Maryland version of the Washington State Juvenile Court Pre-screen instrument that can be found in the attached resource documents provides the foundation for determining the level of security required. To help the department and the courts determine whether a youth requires placement in the community, group home or treatment facility, the department is developing a grid that considers the risk level, the seriousness of the current offense, the chronicity of offending, and the youth's success/failure in community-based EBP services. The department is currently reviewing the grid developed in Georgia.

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The MCASP will include the ten major domains 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 Implementation of the MCASP tool will allow the Department to more accurately identify the population of youth that are most in need of secure treatment and assign youth to programs based on their level of risk and risk profile. This tool will form the basis by which classification and placement decisions will be made by case managers. The implementation plan will include working with all stakeholders including the courts, prosecutors, public defenders, treatment providers, advocates and families. The Department plans to fully computerize this process by December 2009.

Programs Listed By Levels of Security

Specific programs used by the Department are listed below under assigned categories. Information regarding age and gender served and total program capacity for instate per diem programs is taken from the online Resource Directory from the Governors Office for Children.

Level I - HOME WITH SERVICES

A. Home with Services is youth living at home with parents, guardians or extended family. Youth and, as needed, family receive community based services. In-home services are provided by counselors/therapists who come to the home and work with the family. Other community services are provided at offices.

B. Examples of additional services that can be provided to youth at home:

1. Evidenced based treatment models for family interventions - FFT and MST
2. Behavioral tracking programs - Youth Advocacy and Choice
3. Supervision – Probation, Intensive Aftercare Program and Electronic Monitoring
4. Community Services - In-Home Family Services
 - Mental Health Counseling /Therapy
 - Substance Abuse
 - Recreation Opportunities

Level II - FAMILY FOSTER CARE / THERAPEUTIC FOSTER CARE

A. Regular Family Foster Care (FC) is continuous 24-hour care and supportive services provided to a youth in a DJS approved family home. The foster family serves low-risk youth who cannot be managed in their own homes. Youth served may be experiencing behavioral problems and may need a respite from family or neighborhood issues. Foster care also serves youth who need a long term placement primarily because home may not be appropriate for them to return. The youth must be able to accept the closeness that a foster care environment creates. Services and education are accessed in the community. The average length of stay is 6 months, though some youth may stay as long as 2 years. DJS and

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Department of Social Services (DSS) set rates separately for family foster care. Additional services and wraparound models of service delivery are also available to youth in Foster Care, such as services for natural parents toward reunification and mental health, counseling /therapy, substance abuse counseling and recreational opportunities.

B. Treatment Foster Care (TFC) is continuous 24-hour care and intensive support services operated by a licensed child placement agency or local Department of Social Services in a family setting for children with serious emotional, behavioral, medical, and/or psychological conditions. The behaviors of the youth served are not so severe that removal from the community is necessary. The homes are generally clustered within a program under the oversight and management of a mental health professional or Developmental Disabilities Administration (DDA) staff depending on the specialty of the homes. These foster homes receive specialized training to deal with youth with special needs. The youth must be able to accept the closeness that a family foster care environment creates. Frequently, individual, group and/or family counseling is provided by the program, as well as in-home services to help the foster family deal effectively with the youth. Education is accessed in the community. The average length of stay is 6 months, though some youth may stay as long as 2 years. Most TFC programs are privately operated child-placing agencies with rates established by the Interagency Rates Committee. Programs are licensed by DHR. The Child Placement License allows flexibility in the number of homes a provider may recruit and in the use of those homes for male and female youth. Some homes can accept both male and female youth and are used interchangeably.

<u>Treatment Foster Care (TFC)</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Concern	PG	0-21	M/F	78
Pressley Ridge (PRYDE)	SMD/City/WMD	0-21	M/F	105
Alternatives for Youth TFC	Charles	5-17	M/F	16
Family Ties Treatment Foster Care	Mont.	0-21	M/F	24
Chosen (Baptist Family & Child Services)	Mont/Pg/How	0-19	M/F	60
MentorMD	BCo/Shore/Mont/PG/How	0-21	Male	240
Martin Pollak Project	City	0-21	M/F	70
Greenleaf, NCCF	Mont.	6-21	M/F	30
Ass. Catholic Char/Center for Family Serv.	City/Harf	0-21	M/F	82
Arrow Project	BCo	0-21	M/F	21
Progressive Life Center	PG	2-17	M/F	66
Foundations for Home and Community	PG	0-21	M/F	120
Contemporary Family Services TFC	PG	0-21	M/F	200
BATGO	City	14-20	M/F	60
Maple Shade TFC and Respite	E Shore	2-21	M/F	70
				1242

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C. *Therapeutic Foster Care – Sex Offender serves males who have been charged and/or adjudicated with physical or sexual abuse or sex offending behavior. Youth must be able to be maintained and served in a family-like setting and not identified as a risk to public safety. Services include crisis intervention, clinical treatment, family and multi-family counseling and parent skills training. Group and individual services are provided under management of a mental health professional. Youth learn about the cycle of abuse and methods of control, victim awareness, social skills training and sex education.*

<u>Therapeutic Foster Care</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Mentor MD STEP (Sex Offender Program)	BCo	12-18	Male	12

On a case by case review, these TFC programs already listed can serve specific sex offenders: Mentor Clinical Care TFC
Alternatives for Youth Triad
DJS Foster Care

Level III - COMMUNITY BASED RESIDENTIAL

A. **Alternative Living Unit – Developmental Disability (ALU)** *provides residential services for low-to-moderate-risk youth, who because of developmental disability require specialized living arrangements. Programs are limited to no more than 3 youth and are licensed under Developmental Disabilities Administration regulations for Community Residential Services for Individuals with Developmental Disability. A criterion for admission is eligibility of the youth for DDA services. These youth generally have IQ scores under 70. The program is structured to provide required services, i.e., daily living activities, habilitation services, home management and self-help skills. The average length of stay is 9 months, though some youth may stay as long as 18 months. Because DDA serves individuals into adulthood, it is possible for a youth to move into an adult ALU or group home as he/she ages out of the youth program. Rates for these programs may be set by the Interagency Rates Committee or through Developmental Disabilities Administration rates’ methodology.*

<u>Alternative Living Unit Development Disability (ALU)</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
REM	BCo	13-21	M/F	17/13
NCIA	BCo	13-21	M/F	40/7

B. **General Service Group Home (GH):** *A residential program licensed by DHR, DJS or MHA/DHMH to provide out-of-home care for 4 or more youth, who are moderate-to-high-risk and need more structure and supervision than a relative, foster parent or treatment foster parent could offer that provides a formal program of basic care, social work and health care services. Youth served are not deemed dangerous to the community. Most group homes serve youth in homes located in residential neighborhoods. Group Homes can be small (up to 12 youth) or large (13+ youth). Group home programs vary in intensity for care and supervision, clinical, educational, health, medical and family support. Group homes vary*

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greatly in the youth served and the type of program interventions provided. Some programs include specific services within the facility while others use services located in the community, such as, counseling, therapy and substance abuse education and counseling. Programs may be gender specific or coed, serve younger or older youth, focus on DDA populations, delinquent youth, abused children and youth being prepared for independent living. Most programs utilize community-based services for ancillary services and the local educational school system. A small number of programs have on grounds educational programs. Community contacts are generally planned to serve as opportunities for the youth to learn healthy coping and adaptive life skills. Some programs are considered staff-secure environments, in which youth movement is more closely supervised. Group homes are expected to develop services plans, provide appropriate services to meet the needs of the youth and transition the youth back their homes. The average length of stay is 6 - 9 months. (DHR & DDA may have programs serving younger youth.) Either the Interagency Rates Committee or Developmental Disabilities Administration sets the rates for these programs.

<u>General Service Group Home (GH)</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Adventist GH at Crownsville	AA	13-18	Male	18
All That Matters	PG	14-18	Female	8
Board of Child Care	BCo	9-21	M/F	45/40
Cedar Ridge	Washington	6-21	Male	28
Children's Home Long Term	City	8-20	M/F	26/22
Big Pine Children's Home	Washington	7-16	Male	14
Shiningtree Children's Home	Washington	7-16	Male	14
Allegany County Girl's GH	Allegany	13-18	Female	9
Mt. Clare House	City	15-18	Male	12
Florence Crittenton	City	13-20	Female	38
Helen Smith Girl's GH	Mont.	13-17	Female	8
Jane Egerton	City	13-21	Female	12
John C. Tracey	Mont.	13-17	Male	8
Kemp Mill	Mont.	13-17	Male	8
Karma Rockville	Mont.	14-18	Male	13
Karma Randallstown	BCo	14-18	Male	8
Langworthy	PG	12-18	Male	8
Kent Youth Residential	Kent	14-18	Male	10
Larrabee House	Kent	14-17	Female	8
KOBA Mansion (3 programs)	PG/Mont	13-20	Male	24
KOBA Mansion (2 programs)	PG/Mont	15-20	Female	16
Maple Shade – Linkwood Girls Home	Dorch.	12-18	Female	8
MD Sheriff's Youth Ranch	Fred.	10-21	Male	28
Mom Mom's Place	City	13-17	Female	6
One Love Group Home	City	14-16	Male	8
Salem Residential	Alleg.	6-18	M/F	32
Greentree Adolescent	Mont.	12-20	M/F	10/10
San Mar Residential Program	Washington	13-18	Female	21
Tuttie's Place (3GH)	City	12-16	Male	21

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Eastern Point	AA	12-21	Male	12
Oak Hill House	Washington	14-18	M	14
Liberty House	City	10-16	Male	10
Starflight Enterprises	How.	14-18	M/F	30/13

General Service Group Home Serving Children With Special Characteristics: *The same definition for general service group homes applies to this group of programs. These facilities specifically provide services for the following characteristics: Aggressiveness, Sex Offending, Fire Starting, Runaway, Teen Mother/ Pregnant/ Mother-Infant, Addictions.*

1. *Group Home – Developmental Disability Program is a subset of the above group home description that is licensed by Developmental Disabilities Administration regulations for Community Residential Services for Individuals with Developmental Disability. A criterion for admission is eligibility of the youth through DDA. These youth generally have IQ scores under 70. The program is structured to provide required services, i.e., daily living activities, habilitation services, home management skills and self-help skills.*

<u>GH – Developmental Disability Program</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Washington County ARC, Foundations	Washington	15-21	M/F	5/5
Starflight Enterprises	Howard	14-20	M/F	30/13
NCIA (2 homes)	BCo/City	16-21	Female	7
NCIA (11 homes)	BCo/City	13-21	Male	40

2. **Group Home – Mother & Baby Program** *is a subset of group homes licensed by Department of Human Resources. This program serves young women who cannot be served in their home or foster care. The Mother & Baby program prepares young women for the realities of adolescent motherhood. Mothers and infants room together. With supervision, mothers care for their infants themselves and attend a full curriculum of parenting classes. Childcare is built into the program to allow mothers to attend school or work.*

<u>Group Home – Mother and Baby Program</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
St. Ann’s Residential Prenatal & Mother Baby	PG	13-18	Female	52
Florence Crittenton Mother/Infant	City	13-20	Female	19

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3. **Group Home – Sex Offender program** is a subset of group homes licensed by Department of Juvenile Services. This program serves males who have been charged and/or adjudicated of less serious physical or sexual abuse or sex offending behavior. These youth frequently have accompanying problems that also need to be addressed in services, i.e., attention deficit disorder, conduct disorder, personality disorder, and substance abuse. Youth must be able to be maintained and served in the community and not identified as a risk to public safety. Emphasis is on a highly structured environment and teaching socially acceptable behavior alternatives. Family involvement is encouraged and program components include family, group and individual therapy, multiple family therapy, victim awareness, sex education and vocational and life skills training. Services are provided primarily on site.

<u>Group Home – Sex Offender Program</u>
Karma Rockville
Karma Randallstown

On a case by case basis, the following programs, which are already listed above as GH, will consider sex offenders:

Futurebound (IL)
Big Pine Children’s Home (GH)
Oak Hill House (GH)
Muncaster Mill (TGH)
Greentree Adolescent (GH)
Alternatives for Youth (TFC)
Greenleaf (TFC)
New Dominion for Boys (Wild)

4. **Group Home – Substance Abuse Programs** may resemble large or small group homes and have similar properties. These programs, however, include a component of drug treatment that has been certified under the Drug Abuse Administration (DAA). These certifications require specific hours of drug treatment per week sometimes including participation in NA and/or AA groups. The hours of service depends on the program’s certification of outpatient drug treatment program or outpatient intensive drug treatment program. There are short term (45 to 90 days) and long term (4 to 9 months) drug treatment programs.

<u>Group Home – Substance Abuse Program</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Morningstar, Vision Quest	Dorch.	14-18	Male	52
Wm Donald Schaefer House	City	14-19	Male	19
Catoctin Summit	Frederick	14-21	M/F	11/9
Jackson Unit	Alleg.	8-17	M/F	20/13
The Way Home	BCo	14-18	Female	15
Right Turn of Maryland(Adult)	BCo	18+	M/F	115/55

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C. Therapeutic Group Home (TGH) *is a residential program for youth in out-of-home care that is licensed by MHA and must be a non-profit organization.* TGH provides youth who are moderate-to-high-risk and are emotionally or developmentally disabled access to a range of diagnostic and therapeutic mental health services. Like group homes, therapeutic group homes provide structure and supervision within a formal program of basic care, social work and health care services. Services generally consist of case management, individual, group and family counseling and medical management. The services are generally integrated into the residential program and are provided on-site with trained clinicians. Depending on the severity of mental health needs, additional services may be accessed off-site. Most TGHs use off-site schools, though some programs have on-site educational programs for some youth.

TGHs serve youth who have been assessed as needing a program with mental health services and who can be served in a community based environment. TGHs try to keep youth attached to the community. This reduces the transitional issues for the youth upon discharge to home or to a less intense living arrangement. The community contacts also serve, as in all out-of-home placements, as opportunities for the youth to learn healthy coping and adaptive life skills. TGHs also serve as a step down placement for youth exiting residential treatment centers (RTC), and who still require structure, supervision and continued mental health services. The average length of stay is 6 - 12 months. The Interagency Rates Committee sets the rates for these programs.

<u>Therapeutic Group Home (TGH)</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Triad House	Calvert	12-17	Male	8
Cedar Ridge Faith Cottage	Washington	11-17	Male	8
Jack E. Barr	Washington	13-18	Female	8
Children's Guild (2 programs)	City.	12-18	Male	24
Children's Guild Harford House	City	12-18	Female	8
Guide TGH (2 Programs)	City/PG	13-18	Male	12
Muncaster Mill	Mont.	13-17	Male	7
Redl	Mont.	6-12	Male	7
Maple Shade Mardella Special Care	Wico.	10-18	Male	8
Villa Maria TGH	BCo.	9-14	Male	6
Alternatives for Youth, Lighthouse	Chas	12-17	Female	8
All That Matters	PG	13-17	M/F	8/6
Royal Oak	Wico	10-18	Male	8
San Domingo Special Care	Wico	11-18	Female	4
Wetipquin Ranch	Wico	10-18	Male	4
Fordham Cottage	BCo.	12-18	Male	8
Dulaney House	Howard	12-18	Female	8
Mosaic I & II	Howard	12-18	Male	12

These programs are not licensed as Therapeutic Group Homes but provide mental health services:

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Adventist at Crownsville
Karma Rockville
Karma Randallstown
Mt. Clare House
Maple Shade – Home for Girls

D. Independent Living (IL) is a program implemented by a child placement agency licensed by DHR for youth 15 to 21 years of age who need to become self-sufficient and learn responsible living because they are unlikely to return home. The youth will reside in either group homes or supervised apartment units, and must enroll in high school, college, vocational training, or be gainfully employed. Services may include assisting the youth to graduate from high school or complete vocational/job training; connecting youth to resources for somatic and mental health services; teaching interpersonal skills; money management; job readiness; conflict management; positive leisure opportunities and communication skills. Lengths of stay vary from 6 to 12 months. Either the Interagency Rates Committee or Developmental Disabilities Administration sets the rates for these programs. Some of these programs consist of supervised apartments and as such use the apartments interchangeably for male and female youth as needed.

<u>Independent Living (IL)</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Alternatives for Youth (TFC)	TriCo	16-21	M/F	10
Mentor MD IL (TFC)	BCo.	18-21	M/F	20
Starting Over	PG	16-21	M/F	14
Martin Pollak (TFC)	City	15-17	M/F	20
Future Bound	Mont.	16-20	M/F	11/10
Independence Plus	City	17-21	M/F	75
Our House	PG	16-21	Male	16
Transition Age Youth Program	BCo	17-21	M/F	12
Jumoke	City	16-21	M/F	20
Youth Services Agency (Job Corps access)	PA	16-21	Male	60
Job Corps	BCo/AA	18+	M/F	Not known

- 1. Independent Living – Substance Abuse** is a subset of the IL programs and is focused on getting substance abusing individuals on their feet and on their own. The program tends to be highly directive with program expectations. Young adults participate in alcoholics or narcotics anonymous including individual counseling and daily groups.

Right Turn of Maryland (Adult program)
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- 2. Independent Living – Mothers and Children** is a subset of the IL programs which assist young mothers with children by providing a residence, parenting skills, job training, day care and employment.

<u>Independent Living Mother and Children</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Second Generations	City	16-21	Female	12
Damamli	BCo.	16-21	Female	24

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- E. **Impact Program** *provides short term, intensive intervention for low to moderate risk youth.* Youth served are on probation and have failed to successfully respond to nonresidential interventions and present an imminent need for stabilization to prevent detention or placement. These youth may have been belligerent in adhering to court directives and conditions of probation. They may have received additional charges while on probation. While they require close supervision, these youth are not deemed to be dangerous to public safety. These non-secure programs provide structure and routine. DJS operated programs provide all services on site. Youth attend school and participate in group counseling. The focus of the program is on the aftercare plan for return to the community that involves the youth, family, case manager specialist and service providers as needed. Services are to be ready to begin upon the youth's discharge. DJS operates two programs for male youth, one at Cheltenham and one at the Youth Centers. Program length of stay is 30 to 90 days.

Impact Program	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Mountain Quest Green Ridge	Aleg	13.5 – 17.5	Male	15
Cheltenham Redirect	PG	13.5 – 17.5	Male	15

Impact like beds for females are purchased from per diem providers. Youth attend public school from these private programs:

Florence Crittenton
KOBA Mansion

Level IV - SPECIAL PROGRAMS

- A. **Residential Treatment Center (RTC)** *provides the highest level of care for moderate-to-high-risk youth with a psychiatric DSM IV Axis I diagnosis for serious emotional disturbance (SED).* Services generally include: group and individual counseling, close supervision, 24-hour crisis intervention, restraint capability, contained educational programs and medical management. RTCs are required to have psychiatrists, psychologists and psychiatric nurses on staff to lead treatment. Maryland RTCs are approved for operation through the State Certificate of Need (CON) process and are licensed through the Mental Health Administration. Some RTCs concentrate on specific populations of youth. For example, locked RTCs focus on youth with behavioral problems and/or who are considered to potentially harmful to self or others. The Mann RTC has units for the Lisa L population of youth from psychiatric acute care hospitals. The RTCs are intended to stabilize the youth's emotional condition, provide services that increase the youth ability to manage their mental health illness as a potentially life long challenge, develop social skills for coping with both daily and difficult situations and interpersonal relationships and to transition the youth to a less restrictive environment or to home. This involves interventions with the family as well as the youth. The average length of stay is 12 – 18 months. Villa Maria and one unit at the Jefferson School can serve younger youth. Rates are approved through Hospital Review Commission.

<u>Residential Treatment Center (RTC)</u>	<u>Location</u>	<u>Age</u>		<u>Total</u>
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			<u>Gender</u>	<u>Program Capacity</u>
Potomac Ridge Behavioral Health of AA	AA	13-17.5	M/F	13/13
Potomac Ridge Behavioral Health of Rockville	Mont.	12-18	M/F	50/25
Potomac Ridge Behavioral Health, Eastern Shore	Dorch.	12-18	M/F	
Pines Cooperative Living Boy's & Girl's (DDA)	VA	12-17 11-17	M F	34 30
Pines Adolescent	VA	13-18	M/F	25/5
Pines Visions Program	VA	13-17.5	Female	14
Pines Wings	VA	12-17	Female	12
Pines Child/Young Adolescent	VA	11-13	Male	12
Pines Project Right Track	VA	13-18	Male	35
Pines Young Men's Program	VA	14-17	Male	20
Pines Young Women's Prog.	VA	14-17	Female	32
Villa Maria	BCo.	6-13	M/F	73/13
RICA Baltimore	City	12-18	M/F	30/15
RICA Rockville	Mont.	11-18	M/F	48/16
Good Shepherd Center	BCo.	13-17.5	Female	107
Jefferson School	Fred.	13-17.5	M/F	36/12
Sheppard Pratt Towson RTC	BCo	12-17.5	M/F	20
Woodbourne Center	City	13-17	Male	54
Devereux of Florida	FL	5-17	M/F	100/28
Devereux of Georgia	GA	5-17	M/F	112/75
New Hope Treatment Center	SC	12-21	M/F	40/22
Southern Peaks	CO	13-21	M/F	96/32

Secure Residential Treatment Centers:	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Sheppard Pratt Towson MANN	BCo.	12-18	M/F	8/9
North Spring Behavioral Healthcare	VA	13-17 9-17	M F	46 18

- 1. Residential Treatment Center – Sex Offender is a subset of RTCs which serves adjudicated sex offending youth who have been determined to need RTC level of care and may be considered a threat to public safety in a less structured and supervised program. In keeping with the treatment focus of RTCs, a variety of individual, group and family counseling are provided. Sexual offending treatment approaches must assess youth on specific concerns in order to develop appropriate*

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treatment and aftercare plans for both the youth and the family. Programs assess youth and family history, the youth's understanding of the sexual abuse cycle and the arousal and fantasy pattern, victim empathy (including their own possible abuse), consequences of sexually abusive behavior, power and control, denial and minimization, cognitive distortions, positive sexuality and relapse. The average length of stay is 12 to 18 months.

Residential Treatment Centers - Sex Offender	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Potomac Ridge Behavioral Health	Mont.	12-18	Male	25
Jefferson School	Howard	10-17	Male	16
Woodbourne Center	City	12-17	Male	24

Secure RTC's for Sex Offender	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
New Directions	BCo	16-20	Male	26
North Spring Behavioral Healthcare	VA	13-18	Male	23
Pines Behavioral Studies	VA	12-17	M/F	20/20

2. **Residential Treatment Center for Dually Diagnosed Youth serves youth who have been diagnosed with both a psychiatric diagnosis for mental health and assessed substance abuse problem.**

Residential Treatment Center for Dually Diagnosed Youth	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Pines Adolescent Treatment and Recovery	VA	14-18	Male	20
Southern Peaks	CO	10-20	M/F	96/32

B. Non RTC Mental Health Program (NON RTC MH) represents a variety of out-of-state programs that serve moderate-to-high-risk multi-problem youth. These are youth who may be exhibiting moderate psychiatric symptomatology, or who have histories of unsuccessful or repeated placements and/or hospitalizations. Accompanying issues may include difficult to manage aggressive behavior, learning disabilities, developmental disabilities and poor social skills. Youth may be difficult to place and may be assessed as being dangerous to themselves or others. Individualized treatment plans set forth the specific strategies and goals to promote the youth's ability to function successfully in a less restrictive and less intensive setting. The treatment model of NON RTC MH varies depending on the client focus of the program but all are comprehensive in services, highly structured, treatment oriented and behaviorally focused. The average length of stay is 10 – 18 months. The rates for these programs tend to be set by the host state. MSDE reviews the rates of out-of-state programs.

Non RTC Mental Health Program (NON RTC MH)	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
AdvoServ	DE	11-21	M/F	130
Bennington School	VT	9-21	M/F	82/45
CONCERN (PA)	PA	14-18	Male	18

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Secure NON RTC MH	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Turning Point (KidLink)	MI	12-17	Male	40
Cornell Abraxas Firesetters	PA	12-21	Male	36

On a case by case basis the following program will consider sex offenders:

Bennington School

- C. Intermediate Care Facility For Addictions (ICFA) *is the most intensive level for residential substance abuse services providing drug and alcohol abuse assessment, treatment, and/or education for moderate-to-high-risk youth.* Youth served may have problems in other Regions of their lives, i.e., mental health, school, family, peer group and community. ICFAs are approved for operation through the State Certificate of Need (CON) process. These programs are intense, closed programs able to serve not only substance abusing youth, but also dually diagnosed youth, that is, youth who have both a psychiatric diagnosis for mental health and assessed substance abuse problem. These programs are intended to stabilize the youth, initiate drug treatment and/or counseling services, and develop recommendations for services upon discharge. The average length of stay is 1 to 4 weeks. Rates for these programs are set through DHMH, Medicaid. However, payment for services is limited from Medicaid because substance abuse treatment has been relegated to somatic health and therefore must be authorized through assigned HMOs, which are reluctant to approve extended stays at these programs.

Intermediate Care Facility For Addictions (ICFA)	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Mountain Manor	BCo	12-20	M/F	69
Jackson Unit at Finan	Alleg.	8-17	M/F	20/13

- D. Youth Centers (YC) *provides a cognitive-behavioral service model within a positive peer culture for moderate risk youth. Locations of these programs are removed from communities but are not physical plant secure.* Youth served have been adjudicated for various delinquencies but have been found appropriate for these separated open programs. The daily group process focuses on correcting cognitive distortions which have contributed to delinquency, problems with relationships, and/ or poor school adjustment. The program teaches youth to help one another and thus help one's self which is a cornerstone of the program model. Education services are on-site and extend from regular education to special education services. Youth Centers are operated by the Department of Juvenile Services. The length of stay is 6 to 9 months.

Youth Centers (YC)	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Backbone Mountain	Gar.	14-18	Male	40
Savage Mountain	Gar.	14-18	Male	36
Green Ridge	Aleg	14-18	Male	40

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- Youth Centers – Substance Abuse** *is a subset of Youth Centers that serves youth assessed with substance abuse treatment needs.* The Drug Abuse Administration (DAA) has approved its drug treatment component which requires specific hours of drug treatment per week. These programs seek to establish linkages with community based drug treatment upon discharge, including AA and NA groups.

Youth Centers Substance Abuse	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Meadow Mountain	Gar.	14-18	Male	40

- Enhanced Youth Center is a subset of Youth Centers that serves youth with mild mental health problems and special education needs.* The Department has a standard contract with North American Family Institute to operate a program based on Youth Center group principles with added individual and group counseling, psychosocial education groups and special education to serve youth requiring over 60% special educational services per an individual education plan.

Enhanced Youth Center	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Thomas O'Farrell Youth Center	Carr	13-18	Male	43

E. Wilderness Program *is a residential program operating year round in an outdoor nature environment. Counseling and education services are integrated in the daily activities. Intensive intervention is based on a group problem-solving model through which youth learn more acceptable behaviors and how to resolve problems productively. Individual counseling, family counseling, substance abuse counseling/education are available. Youth served are low-to-moderate-risk to public safety. The length of stay is 8 to 12 months.*

The Interagency Rates Committee approves rates for in-state programs.

<u>Wilderness Program</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
New Dominion for Boys	Aleg.	12-17	Male	72
New Dominion for Girls	VA	12-17	Female	44
Youth Services Agency	PA	10-21	M/F	200/60

Level V - SECURE CONFINEMENT

- Open Programs and Staff Secure Programs** *are structured, self contained and comprehensive residential programs providing all services and activities on site.* Youth served are considered to be moderate to high risk because of seriousness of the adjudicated offense, multiple offenses, failed previous placements, lengthy history with the department and/or absconding from other residential programs.

Programs are referred to as open programs or staff secure programs based on the intensity of staff supervision and independent movement of youth. In staff secure programs, staff provide sight supervision 24/7 of youth movement and activities. In open programs, staff do not supervise all youth movement on the program grounds. Most programs are located in

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remote Regions away from cities that provide a form of security that greatly inhibits youth efforts to abscond.

A common feature of these programs is the establishment of a positive peer culture or standards of behavior that defines behavioral criterion for youth conduct with imposed feedback, sanctions and rewards. Programs use a cognitive behavioral approach to help youth understand behaviors that contribute to delinquency. Interventions include case management, group counseling, drug treatment or education, medication management, on-site regular and special education, GED preparation, tutoring, computer programming, prevocational or vocational programs, and recreational activities. Length of stay is 6-12 months (or longer per specific court order).

Open Programs and Staff Secure Programs	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Open Programs:				
Canyon State Academy	AZ	12-18	Male	280
Clarinda Academy	IA	12-18	Male	141
Glen Mills	PA	15-19	Male	952
Natchez Trace	TN	12-18	Male	80
Woodward Academy	IA	13-18	Male	48
Staff Secure Programs:				
Cornell Abraxas I	PA	12-18	Male	274
Summit Academy Traditional	PA	14-18	Male	175

1. **Substance Abuse Programs** *have treatment programs provided by certified drug and alcohol addiction counselors.*

<u>Substance Abuse Programs</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Open Programs:				
Cornell Abraxas – Ohio	OH	12-18	Male	108
Staff Secure Programs:				
Cornell Abraxas I	PA	12-18	Male	274
Summit Academy Drug and Alcohol	PA	14-18	Male	175
Pines Adolescent Treatment and Recovery	VA	14-18	Male	20

- B. **SECURE PROGRAMS** *are residential programs that serve high-risk youth committed to this level of care by the courts. These youth are chronic repeat offenders, have been unable*

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to successfully complete other programs, or have been adjudicated on the most serious offenses. Youth may also have mental health, behavior, family, school or substance abuse difficulties. These programs provide the most physically restrictive environments for the behavior management and treatment of youth within the juvenile justice system. Secure programs must be locked to prevent escape and have either a perimeter fence surrounding the facility or an outside-fenced recreation Region.

Structure and supervision are essential elements of the programs. A standard of behavior for youth conduct is defined with feedback, sanctions and rewards. Cognitive behavior programs include intensive programming and skill-building. Interventions include case management, daily process groups, social skills curriculum, victim awareness, conflict resolution, anger management, drug treatment and medical management. On-site education is available from regular to special education services, including GED preparation and vocational training. The length of stay is 12 – 18 months or longer per specific court order, to age 21.

<u>Secure Confinement</u>	<u>Location</u>	<u>Age</u>	<u>Gender</u>	<u>Total Program Capacity</u>
Mid-Atlantic Youth Services Western PA	PA	12-20	Male	74
Mid-Atlantic Youth Services Luzerne	PA	12-18	Male	36
Southwest Indiana Youth Village	IN	9-18	Male	188
Turning Point	MI	12-17	Male	40
Thomas J.S. Waxter Children's Center	MD	12-21	Female	10
Victor Cullen	MD	15-20	Male	48

APPENDIX II - DRAI

The Department has developed a Detention Risk Assessment Instrument (DRAI) that provides DJS staff with an objective tool to guide their decision-making about whether a youth should be placed in secure detention, conditionally released to the community with close supervision or released outright while waiting adjudicatory and disposition hearings

Two specific risks are measured by a detention risk assessment:

- **Public safety risk**—the risk of committing a new offense prior to adjudication and disposition of the case.
- **Failure to Appear (FTA) risk**—the risk of failure to appear in court if not detained. This risk is also sometimes referred to as flight risk.

Public safety and FTA risks should be assessed through objective, valid and reliable means. The Detention Risk Assessment Instrument (DRAI) must be based on the following key principles:

- **Objectivity.** Detention decisions should be based on neutral and objective factors rather than on pure subjective opinion. Objective criteria anchor detention decisions in ascertainable facts such as the number of prior referrals and the youth's history of flight from custody.
- **Uniformity.** Criteria should be uniform in the sense that they are applied equally to all youth referred for a detention decision. To achieve the desired level of uniformity, the criteria must be
In written (or electronic) format and must be incorporated into a screening process that is standardized for all referrals.
- **Risk based.** The criteria should be "risk-based." This means that criteria should measure the detention-related risks posed by the youth, specifically the risk of re-offending before adjudication or disposition, and the risk of failing to appear at a court hearing.

Development of the DRAI was based on a combination of validation results tempered with critical policy decisions. The validation of the DRAI involved statistical analysis to identify risk factors and their relative weights (score). The validation model examined the relationship between predictor risk factors and the likelihood of re-offending and failure to appear. The DRAI has a standardized template that will be used statewide allowing for variation in scoring reflecting region-specific differences. Full computer-based statewide implementation is tentatively scheduled for the end of FY 2008.

The standardized template that will be used in all six DRAI's is comprised of the following eight validated questions (each DRAI uses the same items for all Regions, but the scores are adjusted based on the local validation):

1. **Number of felony controlled dangerous substance (CDS) referrals within the past three years**

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(1 or more; none)

2. Complaints forwarded to the State's Attorneys Office (SAO) within the past 12 months that were not denied by SAO

(Consideration of offenses by level of severity and number of previous charges)

3. Prior Severity Scale

(Prior referral within previous 24 hours; Prior referral within previous 7 days; 6 or more referrals within past 12 months; 1-5 referrals within past 12 months; no referrals within past 12 months)

4. Current Supervision Status

(Active DJS supervision; Informal supervision (at intake); no active supervision/Investigation Status)

5. History of Failure to Appear

(2 or more FTA: 1 FTA: No FTA)

6. History of Runaway

(Within past 12 months, warrant issued, not including DSS placements or escapes; 2 or more runaways; 1 runaway; no runaways)

7. Aggravating Factors

(Victim/witness intimidation; multiple offenses in referral (separate incidents); child refuses to accept parental supervision; history of assaultive behavior)

8. Mitigating Factors

(Offender age less than 13 years; no prior intakes; no history of FTA or runaway writ/warrant with prior delinquency referral; currently attending school or participating in structured community activities (e.g., community service, volunteer, mentor, athletics); currently employed not as part of academic program)

The DRAI point scale quantifies level of risk to ensure that low-risk youth charged with non-serious crimes are not placed in detention. Conversely, the DRAI also identifies youth who pose a more moderate-risk, so they are not released without proper supervision.

DJS developed a decision matrix that balances the pure risk-scale with the severity of the current offense to derive a recommendation for release, placement into a detention alternative, or secure detention. The matrix is necessary because the severity of a current offense is only predictive of re-offending when the youth is high-risk, and thus can not be fully factored into the risk scoring. The decision matrix allows DJS to incorporate the use of severity of the offense in circumstances in which it would be predictive of re-offense or failure to appear. There are "special" circumstances including outstanding warrants and youth awaiting an adult hearing that would override the decision matrix.

DRAI Validation Analysis

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DRAI questions that measure the two specific risks (youth re-offending and failure to appear at the disposition hearing) utilized by a detention risk assessment were evaluated during the validation process to determine whether they were predictive of the likelihood of a youth re-offending and failure to appear, along with what weight should be assigned to each question.

The basis of the DRAI validation analysis is a statewide data set capturing information for all youth referred to DJS in June and July 2005. This data set included approximately thirty potential predictors, selected based on a review of the literature and discussions with internal (DJS) and external stakeholders, as well as the outcome measures of new arrest for non-petty offenses and failure to appear in court where available. Delinquency and supervision/placement history was obtained from DJS' ASSIST system. Other data that is not available through ASSIST was obtained by DJS field staff at the time of the intake interview and was captured using a data collection form or the existing un-validated DRAI currently used in Baltimore City. The data set included 7,120 cases reflecting the first referral of each youth during the two month period. Of these, 6,726 of cases involved youth who were released pending a case forwarding decision and potential court date. The cases that were detained until the first court appearance were not used in the validation analysis, as they had no "time at risk" or "street time."

The initial analysis involved the development of a statewide DRAI. The 6,726 cases were randomly split into two roughly equal-sized samples: construction and validation. The construction sample was used to identify and develop scores for those items that are statistically significant predictors of failure as shown through a survival analysis. The statistical model developed using the construction sample was then tested on the validation sample, showing virtually identical results. This approach ensures that the model is not affected by unidentified quirks in the data.

Scores for each predictor were assigned based on the statistical model, and the summation of those scores is the generated Risk Score which ranges from negative 3 to 22 points. This was then translated into an appropriate Risk Level identified as Low, Moderate, and High Risk based on the failure rate for each score. The failure (re-arrest or failure to appear) rates for each Risk Level are listed in Table 6.

Table 6 Failure Rates by Risk Level (Re-arrest or Failure to Appear)			
Risk Level	Risk Score Range	Number of Cases	% Failed
Low	-3 to 2	4,978	10.4%
Moderate	3 to 7	1,402	25.9%
High	8 to 22	346	38.7%
Total		6,726	15.1%

This was followed by the development of locally validated DRAIs. The department decided to develop locally validated instruments for the five largest jurisdictions (Anne Arundel County, Baltimore City, Baltimore County, Montgomery County, and Prince George's County) and a separate instrument for the remaining nineteen counties, giving a total of six locally validated DRAIs. This local validation was conducted using the same data set as was used in the statewide analysis. Due to concerns over sample sizes for the local jurisdictions, the data set was not split into construction and validation samples, and all cases for each jurisdiction were used for that

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jurisdiction's validation analysis. Other than that, procedures for developing the locally validated DRAIs were identical to the procedures used for statewide validation. The six resulting DRAIs are similar, but have different scoring and there are some differences in which items are scored in each jurisdiction.

All results presented from this point forward are based on local scoring and decision-making summated into system-wide totals. Using this methodology, the failure rates for each Risk Level based on local scoring are shown in Table 7. The Risk Score ranges for each Risk Level are not shown, as they vary by jurisdiction.

Risk Level	Number of Cases	% Failed
Low	4,335	8.4%
Moderate	2,015	24.5%
High	376	41.5%
Total	6,726	15.1%

Applicability of DRAI Validation

Recognizing that the DRAI validation was based on data from a two month period in 2005, there is a need to confirm the applicability of the results of the validation analysis to the time periods utilized in our forecasting of the need for detention beds. Since the DRAI has only recently been implemented, the DRAI validation cannot be replicated for other time periods because many of the predictive items that are not routinely captured in ASSIST are not available. To help address concerns about the applicability of the validation, the types of offenses referred to DJS during the two month pilot test period were compared with the rest of CY 2005 as well as with CY 2003 through 2007.

A comparison of the two pilot-test months with the full CY 2005 cases shows only slight differences in referrals for Category 4 and 5 offenses, Table 8, which are the least serious offenses and are rarely detained.

Offense Category	CY 2005		June 2005		July 2005	
	# Cases	% Cases	# Cases	% Cases	# Cases	% Cases
1	2252	4%	194	4%	182	4%
2	3644	7%	365	7%	243	6%
3	6570	12%	605	12%	528	12%
4	18784	36%	1570	32%	1364	31%
5	21455	41%	2200	45%	2022	47%
Total	52705	100%	4934	100%	4339	100%

Source: DJS ASSIST Data

A comparison of CY 2003 through 2007, Table 9, shows that the numbers and types of cases referred to DJS has remained remarkably stable.

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Table 9 Number and Types of Cases Referred to DJS										
Offense Category	CY 2003		CY 2004		CY 2005		CY 2006		CY 2007	
	# Cases	% Cases	# Cases	% Cases	# Cases	% Cases	# Cases	% Cases	# Cases	% Cases
1	2406	5%	2017	4%	2252	4%	2523	5%	2446	5%
2	4610	9%	4435	8%	3644	7%	3848	7%	3524	7%
3	6347	12%	6312	12%	6570	12%	6388	12%	6108	12%
4	17434	34%	18462	35%	18784	36%	18119	35%	17915	35%
5	21056	41%	21230	40%	21455	41%	21345	41%	21296	42%
Total	51853	100%	52456	100%	52705	100%	52223	100%	51289	100%

Source: DJS ASSIST Data

The consistency of the types and numbers of referrals to DJS during the time period analyzed strongly suggests that the DRAI results for the data from the two month pilot test are applicable to the time period that forms the basis of our detention need analysis. First, the current offense largely drives who is recommended for detention through the decision matrix as discussed below. Second, it is unlikely that the associated risk level distribution (low, moderate or high) of youth referred to DJS will change much over relative years unless there is a change in the type of offenses being referred to DJS. As such, the DRAI results presented can be applied to the broader time range under consideration in this gap analysis.

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APPENDIX III - Peaking Factors

Statewide - Male Secure Detention Peaking Factor Analysis

	Fiscal Years				Calendar Years			
	2005	2006	2007	2008	2005	2006	2007	2008*
ADP	335	406	405	374.7	352	429	387	356
w/2 Std. Dev.	381	495	458	424	419	490	431	403
Peaking	13.9%	22.2%	13.3%	13.3%	18.9%	14.2%	11.3%	13.2%

*First 10 months of
2008

Statewide - Female Secure Detention Peaking Factor Analysis

	Fiscal Years				Calendar Years			
	2005	2006	2007	2008	2005	2006	2007	2008*
ADP	48	50	44	39	47	49	40	41
w/2 Std. Dev.	58	65	56	50	58	66	51	53
Peaking	20.9%	29.3%	27.0%	29.9%	23.1%	34.1%	27.1%	28.8%

*First 10 months of
2008

	Fiscal Years				Calendar Years				CY '06-'08
	2005	2006	2007	2008	2005	2006	2007	2008*	Average
ADP	93	68	77	113	97	61	98	113	91
w/2 Std. Dev.	134	116	96	137	142	84	132	125	114
Peaking	43.7%	69.5%	23.6%	21.1%	46.1%	37.4%	35.0%	11.0%	27.8%

*First 10 months of 2008

	Fiscal Years				Calendar Years				CY '05-'08
	2005	2006	2007	2008	2005	2006	2007	2008*	Average
ADP	6.3	9.5	10.6	8.3	7.5	11.2	8.9	9.7	10
w/2 Std. Dev.	9.7	13.7	14.3	11.3	10.9	15.1	12.0	14.1	14
Peaking	53.8%	43.3%	34.3%	36.0%	45.5%	35.1%	33.7%	45.3%	40%

*First 10 months of 2008

APPENDIX IV – Group Home Assessment Study

Risk Assessment Study

In order to properly calculate the need for secure treatment beds, the Department recently conducted a sample of 94 youth of the 303 youth then in group home placement using the Washington State Juvenile Court Assessment, a validated tool which measures risk and needs. To conduct this study, a staff team was trained on the use of the Washington State Tool and was dispatched to group homes throughout the State to perform the assessment by interviewing youth and their families, and reviewing the youths' criminal history.

The study found that 71% of the sampled youth were classified as high-risk, 27% medium-risk and 2% low-risk.. There results are not surprising given the fact that Maryland ranks 4th amongst the states with the lowest rate of committed youth. These results help explain the high rate of failure among youth placed in group homes that end up in pending placement, out-of-state placements, or in the adult system.

The Department established the following criteria to project how many youth could require secure treatment: Youth who scored as high-risk and had a Criminal Risk score of 20 or more (scale of 0 to 31) were classified as requiring secure treatment. The study found that approximately 13% of youth in group homes met this criterion.

For forecasting purposes the Department estimates that approximately 13% of youth currently in group homes would require secure treatment. This would result in an average of 33 youth each year of the 250 male youth served in group homes that would be served in secure care, who would otherwise be inappropriately placed in a group home. See chart below for group home ADP:

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**Average Male Daily Population of Group Homes
FY 2007**

County of Residence	FY2007 ADP
Allegany	2
Anne Arundel	17
Baltimore City	59
Baltimore County	26
Calvert	5
Caroline	5
Carroll	10
Cecil	4
Charles	7
Dorchester	3
Frederick	13
Garrett	0
Harford	3
Howard	8
Kent	1
Montgomery	21
Out of State	3
Prince George`s	21
Queen Anne`s	0
Somerset	4
St. Mary`s	3
Talbot	1
Washington	9
Wicomico	20
Worcester	4
Group Home Total	250

The Department also established a criterion to project how many male youth should be in a non-secure residential setting. Youth who were high-risk and had a criminal history score below 20 or moderate-risk with a criminal history score of 20 or above were classified as requiring this level of placement. The study found that approximately 67% of youth currently in group home placement required that level of care. Applying this figure to the overall group home population, the Department estimates an average of 168 youth each month should be in group home care.

The Department established a criterion to project how many youth should be served via community-based services such as FFT, MST or MDTFC. Youth who scored moderate-risk with a criminal history below 20 or low-risk were classified as eligible for this type of service. The study found that approximately 20% of youth met this criterion. Applying this figure to the overall group home population, the Department estimates an average of 50 youth each month should be in this type of service.

APPENDIX V – MCASP

Maryland Juvenile Services Comprehensive Assessment and Service Planning

The Department is implementing the Maryland Comprehensive Assessment and Service Planning (MCASP) process. The MCASP is a process that is conducted throughout a youth's stay with DJS and includes an ongoing assessment of risk and services needed to reduce the risk. The Department has adapted an instrument that was developed and validated in the state of Washington to meet the needs of Juvenile Court in that jurisdiction.

The assessment process has four components:

1. Assessing a youths likelihood (risk) to re-offend an the level of restriction that is required to ensure public safety;
2. Assessing risk and protective factors in a youth's life that are linked to criminal behavior;
3. Case management planning and implementation that is focused on reducing risk factors and increasing protective factors; and
4. Monitoring youth's progress and reassessing risk to determine if the interventions are effective and changing the service plan as needed.

The risk assessment will help the department identify those youth who are at highest risk for re-offending and those who could safely be diverted from residential placements and benefit from evidence based community services such as Functional Family Therapy and Multi-Systemic Therapy.

The Department plans to have this process fully implemented by December 2009. The implementation plan will include informing all stakeholders including the courts, prosecutors and public defenders; community case managers; families; and advocates in the new process.