Chapter 1—Introduction

The purpose of this Treatment Improvement Protocol (TIP) is to spell out a strategy for diverting appropriate youth with alcohol and other drug (AOD) abuse problems from further penetration into the juvenile justice system (JJS), by placing them in AOD abuse treatment. Members of the consensus panel responsible for developing this TIP designed a process for communities to use in building new linkages and partnerships among treatment programs, public health services, social services, and juvenile courts in order to plan juvenile AOD diversion programs.

Such partnerships are built by developing consensus regarding the extent of AOD abuse by adolescents in the community, the safety needs of the community, and the array of treatment options required to address the problem. The strategy proposed in this TIP requires each partner to assume responsibility for finding a solution to the problem of AOD-abusing juvenile offenders and for ensuring the overall success of the collaborative efforts of juvenile courts and AOD abuse treatment programs to divert youth away from or out of the justice system.

In recent years, two key factors, the increasingly high number of juveniles involved in crime and the decreasing availability of funding for programs, have reduced the ability of juvenile courts to impose immediate sanctions for juvenile crime. As a result, many JJSs struggle to develop program responses that can meet the complex needs of the youthful offender and the community's need for safety.

A contributing factor to the inability of many JJSs to reconcile often divergent needs is the considerable public concern over the last decade about the prevalence of and increase in violent juvenile crime. Opinion polls indicate that the public has grown less tolerant of many delinquent acts. The JJS was designed to protect and rehabilitate juvenile offenders. Since people in many communities have seen little evidence of successful rehabilitation, they have lost patience. They have thus begun to push for the imposition of adult penalties for juveniles who come before the courts.

Many JJSs struggle to develop program responses that can meet the complex needs of youthful offenders as well as the community's need for safety.

AOD Use: Another Complicating Factor

Juvenile use of AODs presents a fundamental threat to the well-being of children and their families and is significantly associated with serious crime. AOD abuse indisputably
is a pervasive and harmful influence; it must be taken into account by juvenile justice planners who seek to balance the needs of court-involved youth, their families, and the community.

Although juvenile courts historically have functioned within a network of community social service and treatment agencies, these networks' responsiveness to AOD-abusing youth has at best inconsistently met the needs of courts, youth, and families. Many AOD abuse treatment programs were developed to serve only those adolescents and families who seek help.

Youth who have severe behavioral or emotional problems may need AOD treatment configured differently from that which is readily available. These special needs, compounded by resistance to treatment, have placed many youth in the JJS beyond the scope of AOD abuse treatment providers.

For all these reasons, judges and staff in juvenile courts may have had little opportunity to see AOD treatment be successful. They also may not fully understand or have much patience with the relapses typical of addiction and the behavior associated with these relapses. Consequently, many judges and juvenile court services personnel seek to remove AOD-using or -abusing adolescents from the community by committing them to training schools, boot camps, or other residential facilities instead of to AOD abuse treatment.

**Strategy Needed To Halt Youth Involvement with the JJS**

The purpose of this TIP is to articulate a strategy for diverting youth with AOD abuse problems from an escalating involvement with the JJS. Members of the consensus panel responsible for developing this TIP formulated a new approach to designing and implementing a program for providing AOD treatment to youth who were appropriate candidates for diversion: the AOD abuse treatment system acts as a partner with the JJS and with community health and social services. This approach depends on the development of new linkages and partnerships among these four groups.

This approach contrasts with what often occurs in the justice system, in which plans for treatment are developed and then a treatment program is contacted to arrange for service delivery. The treatment program, in an effort to provide comprehensive services to justice system clients, often refers them to other treatment providers or to public health or social services agencies. Thus, the combined services that youth need often are linked haphazardly, if they are provided at all. The delivery of collaborative and comprehensive care depends to a large extent on the efforts of individual personnel in the treatment system to arrange for it. Juvenile justice personnel are less frequently involved in making formal referrals to public health or social service agencies.

In the model proposed by the consensus panel, treatment personnel and representatives of health and social service agencies in the community participate from the beginning and function as partners with the JJS in designing the program. In this model, these partners
collaborate to develop consensus regarding the extent of AOD use by adolescents in the community, the safety needs of the community, and the array of treatment options required to address the problem.

The model proposed in this TIP requires the four partners to share responsibility for the overall success of the collaborative diversion efforts of juvenile courts and AOD abuse treatment programs. The collaborative model requires each partner—the JJS, AOD abuse treatment programs, and community health and social services -- to assume responsibility for finding a solution to the problem presented by juvenile offenders who have substance use disorders.

**Definition of Diversion in This TIP**

Traditionally, diversion has been seen as a mechanism for removing appropriate youth from the juvenile court process before they are formally adjudicated or even, in some cases, petitioned. For the purpose of this TIP, however, a broad definition of diversion is used. Diversion, as used in this TIP, refers to an alternative to the further penetration of an individual youth into the JJS. Diversion from formal juvenile court processes may occur at any point within the JJS short of incarceration. For example, a youth may be diverted to AOD abuse treatment informally before adjudication takes place.

Treatment personnel and representatives of health and social service agencies in the community collaborate to develop consensus regarding the extent of AOD use in the community, the safety needs of the community, and the array of treatment options required to address the problem.

A youth may be diverted to AOD abuse treatment after formal disposition; for example, potential commitment to a training school may be held in abeyance until the youth successfully completes treatment. (An equally important need -- programs to divert youth from entering the JJS in the first place -- is also deserving of attention. However, these programs are not the subject of this TIP, which only considers programs for youth who are already involved with the JJS.) *Diversion*, as referred to in this TIP, is a strategy for increasing effective collaboration between the juvenile courts, the AOD abuse treatment field (including public health and social services), and community organizations. It empowers the treatment community with the authority of the juvenile court to require compliance and attendance, while providing the juvenile court with another intervention for juvenile offenders and youth at risk of an escalating involvement in the JJS.

This linkage and collaboration between AOD abuse treatment programs, the community, and the JJS addresses the following needs:

- Individualized screening, assessment, and treatment for young offenders
- The opportunity for youth to be accountable to themselves and the community
- The opportunity for youth to acquire competence in social, vocational, coping, and communication skills and to receive educational services
- The protection of the community.
This TIP provides "hands-on" information and instruction about the process of collaborating to establish a juvenile court diversion program for youthful offenders whose court involvement is associated with AOD abuse. Specifically, this TIP

- Identifies the key issues and policy goals for combining AOD abuse treatment with juvenile justice diversion
- Explores the practical and legal ramifications of this type of diversion
- Provides a greater understanding from a number of perspectives of the opportunities and problems associated with diversion
- Provides communities with a detailed "road map" for collaborative planning and implementation of such diversion programs.

The TIP should be useful to juvenile justice planners, community planners, human service practitioners, and others in addressing AOD abuse in court-involved youth in a multidisciplinary, collaborative manner. The approach to diversion described in this document will be useful in reducing stress on the JJS by encouraging the treatment of AOD-abusing youth earlier and more effectively.

The Center for Substance Abuse Treatment (CSAT) has developed a chart to help planners and others gain an overview of points in the JJS continuum at which collaboration and integration may be most effective. The CSAT Juvenile Justice Treatment Planning Chart is presented in Appendix C.

**Description of Chapter Contents**

Chapter 2 presents an overview of a diversion program for AOD-abusing youth in the juvenile justice system. It introduces the concept of forming a collaborative group from sources within the community to design and implement the program.

In Chapter 3, the collaborative planning process is described, with emphases on the five major types of decisions that have to be made by the planning group. Four of these decisions pertain to the community and community organizations: 1) the JJS, 2) the AOD abuse treatment system, 3) community health and social services, and 4) the community itself.

The fifth type—management decisions -- affects the other four and enables the collaborative planning group to bring the diversion program to life. The consensus panel recommends that members of the planning group join forces to address all these areas, with the group most directly affected leading the discussion as appropriate.

Chapter 4 describes the five areas of decisionmaking and presents a systems approach to collaborative planning, leading to a juvenile AOD abuse treatment diversion program.

Chapter 5 presents guidelines for use by the collaborative planning group in its implementation activities and for developing a procedural manual for implementation.
Several appendices follow, providing literature sources and documents that can be useful to planning groups.

Chapter 2 -- Goals of AOD Treatment-Focused Diversion Programs

As the nature of juvenile crime changes, the abilities of State, county, and local juvenile justice systems (JJSs) to manage offending youth are being tested as never before. The public is increasingly concerned about juvenile crime, and society has become less empathetic toward and more critical of the JJS.

Alcohol and other drug (AOD) abuse has become a significant factor in cases referred to juvenile court. Yet AOD abuse in youth is often not recognized as a harmful influence on delinquent behavior; rather, it is viewed with ambivalence or minimized by some youth in an effort to avoid personal responsibility, or it is dismissed as "normal" behavior. Recognizing an AOD abuse problem can be the key to action by the JJS that may help reduce risk factors and decrease the likelihood of continued offending behavior.

Diverting juveniles already in the JJS away from further penetration into the system has long been a goal of juvenile justice. Today, the diversion of AOD-abusing juveniles into AOD abuse treatment programs is one method of achieving this goal. Under this approach, youth for whom AOD abuse is a problem are placed in treatment rather than incarcerated. If AOD abuse treatment is successful, it helps youths develop skills for daily living and enables them to control their behavior and avoid further penetration into the JJS.

The concept of juvenile diversion can have different meanings for different professionals involved in the process. The prosecutor may see diversion as a means of allowing a youth to avoid legal consequences. For the defense attorney, diversion may mean keeping the youth from being incarcerated. AOD abuse treatment personnel may speak of diversion as an alternative to further enmeshment in the JJS.

In this Treatment Improvement Protocol (TIP), a broad definition of diversion is used. Diversion, in this TIP, refers to an alternative to further escalated involvement of an individual youth in the JJS. Diversion from formal juvenile court processes may occur at any point within the JJS, short of incarceration.

Diversion to AOD abuse treatment can occur any time after an offense has been reported or after a complaint or petition has been filed. The purposes of, methods of, and criteria for diversion may differ. Many treatment options are available as part of probation or disposition. Diversion offers the juvenile offender a treatment option that might not otherwise have existed.

The purpose of diversion is not to take away the discretion or power of the court but to use the power of the court to facilitate treatment. The AOD abuse treatment services to which the juvenile offender is diverted must be sensitive to the court's involvement in the
treatment process. Treatment staff must understand that diversion to AOD abuse treatment does not extinguish the court's formal authority and oversight over the juvenile. The court gives authority to the treatment program in which the juvenile is placed, but its role remains central and it may impose further sanctions if the juvenile does not comply with treatment requirements. To be effective, a juvenile AOD abuse treatment diversion program must provide sufficient assurances to the court and to the community that the youth will participate seriously in treatment.

Diversion refers to an alternative to the further penetration of an individual youth into the JJS. Diversion from formal court processes may occur at any point within the JJS, short of incarceration. The purpose of diversion is not to take away the discretion or the power of the court, but to use this power to facilitate treatment.

Diversion to AOD abuse treatment does not remove the juvenile from the JJS. Rather, diversion is an alternative disposition of the case. The authority of the court to impose more progressive sanctions is held in abeyance pending the youth's successful completion of AOD abuse treatment. Discharge from court supervision upon successful completion of treatment can be a strong incentive for some juveniles to participate in treatment. In other cases, diversion to AOD abuse treatment may be only one part of a broader agreement, supervision plan, or court order. For example, restitution or community service may also be mandated.

A Community-Based Approach to AOD Abuse Treatment Diversion

Members of the consensus panel on juvenile diversion to AOD abuse treatment took the position that each community is responsible for its young people and must recognize that the problems of youth reflect the problems of the community. To deal with juvenile crime associated with AODs, all human service systems in a community must collaborate to build on the strengths of the youth, the family, and the community. At a minimum, these systems should include the juvenile courts and AOD abuse treatment services as well as physical and mental health services, the education system, social services, and public policy bodies. All must collaborate as partners in finding solutions. Communities can no longer rely on local AOD treatment services to accept the major responsibility for ensuring that a referred youth receives all the services he or she needs. A thoughtfully developed, collaborative approach is critical.

In many cases, a youth's involvement with AODs may not come to the attention of the juvenile court or court services until late in the youth's delinquent career. Early and accurate identification of a juvenile offender's AOD issues is needed to ensure that appropriate corrective steps are taken. Another TIP in this series, *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents*, provides useful guidelines for recognizing AOD abuse and providing appropriate interventions.

Within the collaborative partnership, the JJS can provide the influence or mandate to encourage compliance with treatment. For youth, such encouragement is a much-needed tangible support. For communities, a well-planned and clearly articulated strategy of
diverting appropriate AOD-abusing youth from the JJS presents three important opportunities:

- The JJS has access to AOD abuse intervention and treatment when needed.
- The AOD abuse treatment community can use the authority of the court to encourage compliance.
- A continuum of services (including AOD abuse treatment services, physical health and mental health care, and other social services) designed to meet the needs of these youth can be brought together in one coordinated plan that responds to the individual youth's multiple needs for treatment and other services.

**Characteristics of an Effective Program To Divert Youth to AOD Abuse Treatment**

A treatment-focused diversion program for youth with substance use disorders should be the product of a collaborative planning process. Many organizations, ranging from AOD abuse treatment services to physical and mental health and social services, as well as other community organizations, churches, and businesses, can play a role in designing and implementing the diversion program. A continuum of comprehensive services will be needed to provide the level and type of treatment needed by each juvenile referred to AOD abuse treatment. Innovative approaches will be needed to fund a comprehensive program fully. The consensus panel believes that the collaboration of these organizations is essential to maintaining services during times of limited funding, as such collaboration increases the opportunity to combine or reconfigure services to meet the identified needs of the community's youth.

The following sections address each of the important aspects of a collaborative planning process: creating a multidisciplinary partnership, providing comprehensive screening and assessment, and ensuring adequate funding.

**Creating a Multidisciplinary Partnership**

An effective program of diversion to AOD abuse treatment depends on collaboration among all the professionals involved in the care and management of substance-using juvenile offenders. These professionals include juvenile court judges, juvenile court services staff, and probation officers; AOD abuse treatment providers; community physical and mental health practitioners; and social services providers to whom the youth may be referred (or with whom the youth already may be involved). Because substance abuse is often a significant contributor to antisocial and offending behavior that leads to juvenile involvement with the JJS, a juvenile court judge must assert community leadership in the collaborative effort.

The local juvenile court judge has the most clearly defined responsibility for youth offenders and is generally perceived as a key leader in the community. The juvenile courts have a unique and vital role in protecting the best interests of youth, families, and
communities. The role of the judge should be to help convene, develop, and sustain a community's collaborative effort to develop a program of juvenile diversion to AOD abuse treatment.

In order to develop a collaboration among these groups, each must acknowledge that it has different needs and resources and different responsibilities to the target population. Initially, each collaboration will require strong leadership, either on the part of an individual or a group of key leaders, to bring together all the pertinent agencies, providers, planners, and community members to encourage and sustain the effort. The effectiveness of this overall effort depends on the success of this initial development process.

Active communication and continuing dialogue among all key parties are essential. Therefore, representatives of each of the groups involved should meet regularly to share information, assess progress, participate in cross-training, and determine future direction. It is imperative that juvenile court judges and court services staff understand the complex issues related to AOD abuse. Defining terms and agreeing upon procedures at the top policymaking level will facilitate the referral of youth to treatment and improve the services provided to them. For example, it is essential that all parties agree on procedures for the release of information that do not violate the juvenile's privacy or confidentiality. Some States require that a parent sign a written consent to release information when more than one type of agency is providing services to a juvenile (see Appendix D, Oregon's Department of Human Resources Multiagency Release).

Before the AOD abuse treatment diversion program is implemented, a consent form should be approved by all systems involved. This form helps establish the formal linkage among all systems dealing with youth and will make it easier to establish an information-sharing protocol that specifies

- The information to be exchanged
- The reason the information is needed
- The way the information will be used
- The agency that will receive the information
- The date on which a consent to release information expires.

For many AOD abuse treatment programs, this effort may be a first-time opportunity to educate members of the collaboration in the extent and scope of pertinent confidentiality laws and regulations. (See the CSAT TIP entitled Screening and Assessment of Alcohol-and Other Drug-Abusing Adolescents, for a further discussion of confidentiality.)

Providing Comprehensive Screening And Assessment

The earliest possible intervention must be the aim in order to identify the needs of juveniles with AOD abuse problems. Any referral of a juvenile to the JJS should include an initial screening for involvement with AODs and, if indicated, a comprehensive AOD assessment. The initial contact does not have to be formal, such as an arrest or a formal
referral to court. For example, in some States, parents who believe their children are abusing AODs may make status referrals of their children to the juvenile court. Whether the contact is formal or informal, a well-designed and smoothly functioning screening, assessment, and referral process must be in place. (In the context of this TIP, "referral" includes placing the youth in appropriate treatment.)

Screening

The consensus panel saw the need for establishing a consistent method for identifying AOD abuse risk factors. Screening should be instituted at the earliest point of contact. The screening can be as simple as a brief decision tree focusing on one or more of several predetermined factors, including the nature of the offense (for example, was it AOD-related?); self-disclosure of an AOD problem by the youth or family; and suspicion based on appearance, language, or intuition. This strategy can be augmented and improved by the implementation of a reliable and valid self-administered screening instrument (Thomas, 1993). (Screening instruments are described later in this chapter.)

Initially, each collaboration will require strong leadership, either on the part of an individual or a group of key leaders, to bring together all the pertinent agencies, providers, planners, and community members to encourage and sustain the effort.

A trained staff member of the court or a certified AOD counselor (who might also be a member of the court staff), mental health counselor, or appropriate personnel from a public clinic may conduct the screening.

Assessment

If the screening identifies a risk of an AOD abuse problem, then a broader assessment should be done to further define the nature and extent of the problem. AOD abuse is considered a biopsychosocial disease, stemming from biological (physiological), psychological, and social factors. Adolescents' AOD use is embedded in the structure of their families, their peer groups, and their greater social environment. Hence, an AOD assessment should consider physical health, family, educational, economic, mental, and psychosocial status, as well as court history and, in some cases, police record.

Many instruments have been developed to help in assessing the extent and severity of AOD problems in youth. (Navaline et al., 1990).

An AOD assessment should consider physical health, family, educational, mental, and psychological status, as well as court history and, in some cases, police record.

The consensus panel that developed the TIP entitled Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents recommended that assessment information be gathered in the following critical areas:
- **History of AOD abuse:** Use of over-the-counter or prescription drugs, tobacco, caffeine, or other psychotropic drugs; age of first use; frequency, duration, and pattern of use; how the drugs are taken
- **Medical health history and physical examination:** Previous illnesses, infectious diseases including tuberculosis, medical trauma, pregnancies, HIV infection and other sexually transmitted diseases
- **Developmental issues:** Problems related to psychosocial development
- **Mental health history:** Depression; suicidal ideation or attempts; influences of traumatic events such as physical or sexual abuse; presence of hallucinations unrelated to AODs and the like; summaries of information from evaluation and treatment of mental disturbances, if available
- **Strengths or resiliency factors:** Self-esteem; coping skills; motivation for treatment; support of family, other community supports
- **Family history:** The parents' or guardians' history of AOD use and abuse, mental and physical health problems, chronic illnesses, incarceration, or illegal activity; traumatic family events; losses of significant people; the family's view of the youth's AOD abuse and ideas about its management; child-rearing concerns; the family's cultural, ethnic, and socioeconomic background and degree of acculturation, if appropriate
- **School history:** Academic and behavioral performance, learning-related disabilities, attendance, available input from the responsible school district
- **Vocational history:** Paid and volunteer work, skills training, and preemployment development
- **Sexual history:** History of sexual abuse, sexual orientation, age of onset of sexual activity
- **Peer relationships:** Interpersonal skills, gang involvement, and neighborhood environment (presence of drug sellers, in particular), significant loss of friends, community and church programs with youth involvement
- **JJS involvement and delinquency:** Types and incidence of offending or delinquent behavior engaged in and attitudes toward such behavior
- **Social service agency program involvement:** Child welfare system involvement (number and duration of foster home placements), residential treatment, informal out-of-home placements made by family or guardian
- **Leisure activities:** Hobbies, interests, presence in community of positive opportunities for participation in recreation, church activities, and organizations such as Big Brothers or Big Sisters.

One individual should take the lead in the process of assessment, primarily to gather, summarize, and interpret data. The designated lead assessor must often call or visit other agencies for information and must work carefully to resolve any "turf" issues between the court and the agency.

The TIP entitled *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents* recommends that the assessor be an appropriate professional trained in and experienced with adolescent AOD issues -- a psychologist or mental health professional, school counselor, social worker, nurse, physician, substance abuse counselor, or any
other individual with responsibility for young people. The assessor should have sufficient experience in evaluating youth with AOD abuse to be able to perform high-quality assessments. If no appropriately trained person is employed by the JJS, then the collaboration should develop a method for supplying this significant service, such as arranging for loaned staff or assessment teams or, when dollars are available, making a purchase-of-service agreement.

If a team of professionals performs different parts of the assessment, one individual should take the lead in the process, primarily to gather, summarize, and interpret the assessment data. The designated lead assessor often must call or visit other agencies for information about the juvenile's history.

Obtaining pertinent information from different people and agencies working with a young person is often difficult. The assessor must work carefully to resolve any "turf" issues while being persistent in gathering information.

The skill level of the assessor should be appropriate to the tasks required by the assessment process. The assessor should be trained in the use of and qualified to administer every instrument in use in his or her agency or office; he or she should participate in regular training updates and continuing education. An unlicensed but trained technician may be able to administer objective assessment instruments such as those described in Appendix E; however, the results may need interpretation and confirmation by a licensed clinician such as a psychologist, a psychiatrist, a certified substance abuse counselor, a psychiatric social worker, or a mental health counselor.

The information obtained via the use of objective assessment tools must be considered in the context of other information gathered during the assessment process to assure an adequate picture of the youth's and family's strengths, needs, and ability to participate in treatment.

The training, education, sensitivity, and skill level of the assessor can reflect directly on the depth and outcome of the assessment. An assessor who is not licensed to make mental health diagnoses should refer a youth in apparent need of a formal psychiatric workup to an appropriate mental health professional. Other professionals should be involved in the assessment process if assessors are not comfortable with or are not trained in particular issues (such as physical or sexual abuse, medical problems, sensitive family issues, or cultural concerns).

When possible, a summary of information gathered in the assessment process should be included in the juvenile court file with the youth's social records in order to make the information readily available to concerned parties and to avoid repeated assessments that delay intervention. The complex issues of confidentiality may require that a youth and/or his or her legal guardian consent to having assessment results included in the social records of the juvenile's case file. (See Exhibit 2-1, The Assessment Process.)
The results of the assessment of the individual youth (and, to the extent possible, of the youth's family) form the basis of the treatment plan or plan of corrective action. If there are gaps in the assessment, the treatment plan will not address important problems. Obviously, the entire process of assessment and AOD abuse treatment will be facilitated if the juvenile court has linkages with various local agencies and programs and can thus guarantee that the youth will be able to move through the whole process with the minimum number of barriers (waiting lists, lack of resources, and the like).

Many communities have limited access to comprehensive assessment services. If this is the case, the juvenile court judge or a juvenile court services staff member may work with other agencies to establish collaborative relationships resulting in purchase-of-service or similar agreements. In rural areas, a "circuit-riding" assessor may be shared by a number of jurisdictions. ★ TOP

**Ensuring Adequate Funding**

To divert AOD-abusing youth, adequate funding must exist to provide necessary services. The collaboration systems should establish a multiagency management team that includes individuals who are familiar with public and private funding streams. The management team can identify and investigate funding sources from Federal, State, local, and private sources. It is sometimes possible to make creative use of programs that are already funded. For example, a Native American youth who is an enrolled member of a federally recognized tribe may qualify for treatment services through the Indian Health Service at no cost to the diversion program; other youth may be eligible for Medicaid-supported AOD abuse treatment.

Some JJSs have been able to contract with a hospital or other healthcare provider for medical services. School districts may be a resource for all or part of the assessment process. It is hoped that by collaborating, the participating systems may develop creative ways to extend current or decreasing funding levels by clarifying service delivery functions, assessing the need for duplicate services when they exist, developing methods to increase staff productivity, unifying paperwork formats to reduce time and duplication of effort, and blurring program lines to allow for sharing of staff, facilities, or resources.

A variety of funding possibilities should be investigated; such an investigation also may be a way to help families and community groups assume financial responsibility. Revenue sources for funds could be derived from community fees, fines, levies, or forfeitures resulting from drug trafficking and other criminal offenses associated with AOD abuse.

Legislation can create special funds earmarked for or dedicated to AOD abuse treatment programs. The collaborating systems can facilitate access to a broader array of funds than any single group could provide. Representatives of various disciplines can pool their knowledge of resources to obtain funding for needed services. Further, the collaboration has a voice greater than that of a single entity in bringing about changes in current funding streams. ★ TOP
JJS Origins

Juvenile justice in the United States is largely a 20th century phenomenon. For most of the first half of the century, the JJS was envisioned as an informal system within which the youth "who had broken a law or an ordinance [was] to be taken by the hand by the State, not as an enemy but as a protector" (Rosenthal and Smith, 1982).

By the middle of this century, however, there was concern that the traditionally informal nature of juvenile justice could be misused to deny juveniles due process of law. For example, the juvenile courts could place youth in foster homes, assign them to probation, or lock them up in institutions without jury trial or even counsel.

This untenable situation led to a series of Supreme Court decisions that limited the traditional discretionary powers of the juvenile court by increasing a juvenile's rights to due process. The first of these was *Kent v. United States*, 383 U.S. 541 (1966), which stated, "There is evidence that the child receives the worst of two possible worlds: That he gets neither the protection accorded to adults nor the solicitous care and regenerative treatment postulated for children." *The Desktop Guide to Good Juvenile Probation Practice* contains a legal rights section that addresses many of these issues (see Appendix F).

Just as JJS personnel must be aware of current treatment philosophies and approaches to the treatment of youth with AOD abuse problems, so must AOD abuse treatment personnel understand the origins of workings of the JJS.

A series of important U.S. Supreme Court decisions followed *Kent* and clearly defined the parameters of due process afforded juvenile offenders:

- *Breed v. Jones*, 421 U.S. 519 (1975), addressed double jeopardy; juvenile adjudication was equated to criminal conviction.
- *Swisher v. Brady*, 438 U.S. 204 (1978), found no double jeopardy in cases involving a de novo hearing (a new hearing, as if the first hearing had never taken place) or supplemental findings by a judge after trial before a master.
- *Fare v. Michael C.*, 442 U.S. 707 (1979), declared that the presence of the probation officer was not required for continuation of police interrogation.
- *Schall v. Martin*, 467 U.S. 253 (1984), addressed preadjudication detention of juveniles and found that preventive detention served legitimate State objectives and that safeguards were required to assure that preadjudicative detention was not punitive in nature.

Stanford v. Kentucky, 492 U.S. 361 (1989), also addressed the death penalty: Execution of juveniles aged 16 or 17 did not constitute cruel and unusual punishment.

JJS Goals

The JJS has several basic goals:

- Balanced approach to juvenile court interventions
- Community protection
- Accountability
- Competency development
- Individualized assessment
- Due process protection for youth involved with the court
- Manageable caseloads
- Appropriate dispositions
- Involvement of the juvenile's family
- Community-based interventions
- Victim involvement
- Meeting the needs of youth from special population groups.

Methods for meeting these goals are discussed in the following eight subsections.

A Balanced Approach

Community protection, accountability, competency development, and individualized assessment are the basic values identified by (see Exhibit 2-2, Accountability Approach).

The challenge to juvenile courts over the years has been to reconcile these seemingly incompatible values in order to develop a strategy that will address the needs of the community, the juvenile courts, and the youth processed by the courts. Justice is best served when the community and the youth receive balanced attention and each gains a tangible outcome from interaction with the juvenile court.

The basic components of the balanced approach and some intervention options associated with them are

- **Community Protection and Public Safety**: The public has a right to a safe and secure community. Accordingly, a primary goal of the juvenile court system is to protect citizens from crime.
- **Youth Accountability**: Whenever a juvenile commits an offense, there must be a tangible and enforceable consequence for the misdeed. The juvenile must accept responsibility for the loss, damage, or injury suffered. Procedures and techniques
to enhance the youth's accountability for wrongdoing while maintaining a rehabilitation orientation must exist.

- **Competency Development:** Juvenile offenders who come within the jurisdiction of the court should leave the JJS more capable of living productively and responsibly within the community. Approaches to achieving this goal include traditional rehabilitation and treatment programs. More recently, efforts have focused on basic habilitative processes, including those that enable youth to develop social competency, parenting skills, and independent living skills, and to acquire vocational training and job skills.

- **Individualized Assessment:** Each young person entering the JJS is unique. Consequently, the youth's social and cultural surroundings, background, circumstances, talents, and deficiencies all need to be examined on an individual basis. Individualized assessment takes many forms, including 1) the placement of the youth in different legal categories, 2) the performance of diagnostic assessments to determine appropriate treatment response, 3) the development of differential caseload assignments based on risk of further offenses and danger to the community, and 4) the development of treatment case planning strategies based on a multitude of variables that address both risk and need.

The JJS is responsible for providing the accountability-based sanctions and supervision necessary to ensure that juvenile offenders are held accountable. To ensure the safety of the community, juvenile offenders who are a potential threat to the community should not be eligible for diversion to AOD abuse treatment. A range of supervisory options must be available within the community so that each juvenile can be monitored based on his or her level of risk to the community (Bazemore, 1992a).

Accountability is achieved when juveniles accept responsibility for their behavior. The JJS's response to the offense must make it clear to the juvenile that the act was dangerous and resulted in loss, damage, or injury and that the juvenile is expected to make restitution to the community. In turn, the community must be sensitive and responsive to the needs of juvenile offenders and their families.

Not all juveniles have the interpersonal and cognitive skills necessary to accept responsibility and be accountable for their behavior. Many youth also lack basic education and social skills such as anger management or conflict resolution. Diverted youth should be helped to develop the skills required to become productive members of society.

**Due Process for Juveniles**

Although the statutory rights of juveniles in the JJS vary from State to State, all juveniles' rights of due process must be protected. Although youth who commit drug-related crimes in some States have a right to referral for treatment, the fact that the agencies to which they are referred can actively deny them admission diminishes their right to treatment.
Juvenile offenders should not have an automatic right to diversion, but due process for these juveniles should include an objective, centralized assessment and clearly articulated eligibility criteria for placement in a diversion program. The offense should be just one of several criteria when the possibility of diversion is considered. Other criteria will be explored later in this document.

Juveniles should have a guardian *ad litem* (a guardian for the particular proceeding) or legal representative when they are being considered for diversion to treatment -- not only to protect their traditional due process rights but also to explain dispositional options and their consequences. For example, a youth being considered for diversion may have to choose between 6 months of probation with the juvenile court or a full year of treatment. Some programs require a juvenile who is charged with a drug offense to admit to the offense before being sent to a diversion program, and the juvenile in this situation needs a full explanation of the potential consequences of such an admission.

*In re Gault* 387 U.S. 187 (1963) underscored the importance of representation of juveniles by counsel. Now most States provide by statute for representation of juveniles by counsel in one form or another. Statutes vary. Some jurisdictions require that the guardian *ad litem* be an attorney, especially if the juvenile faces the possibility of commitment to a correctional institution. Other jurisdictions may allow the guardian *ad litem* to be someone who understands the JJS and acts in the best interest of the youth. The guardian *ad litem* must be mindful that the privilege against self-incrimination applies to juveniles. While his or her responsibility is to advocate for the youth's welfare, as well as to provide legal assistance, the guardian *ad litem* must have some discretion regarding the appropriate way to handle information that a juvenile volunteers about offending or criminal behavior unrelated to the offense for which the juvenile has been brought into the JJS. Furthermore, the guardian *ad litem* should be sensitive to cultural issues and have sufficient rapport with juveniles to allow him or her to establish and maintain their trust.

Accountability is achieved when juveniles accept responsibility for their behavior. In turn, the community must be sensitive and responsive to the needs of juvenile offenders and their families.

Prompt response by the JJS is extremely important to increasing the effectiveness of AOD abuse treatment. An AOD-abusing youth is most susceptible to successful intervention when he or she is in crisis, that is, immediately after being taken into custody and detention. A timely and systematic AOD screening and assessment is necessary. The AOD-abusing youth should be subject to immediate referral to appropriate AOD abuse treatment. Too often, delays in imposing interventions for juvenile offenders are protracted. Timely and effective resolution of cases involving AOD abuse is particularly critical if the AOD abuse treatment diversion program is to establish and maintain credibility in the community.

Due process implementation often varies according to who the offender is, where the offense occurred, and the type of offense. Clear and concise procedural guidelines should
be developed to incorporate due process rights for every juvenile. The existence of guidelines will facilitate the process and help keep JJS and AOD abuse treatment personnel aware that they must remain conscious of the juvenile's rights throughout the process.

Management of the Juvenile Justice Caseload

Productive case management by the JJS is one of the primary features of an effective system of justice for juveniles. Readers should note that both the AOD abuse treatment field and the JJS perform case management. The use of the term "case manager" can be confusing when the two work together. It is important to designate whether one is referring to case management of clients in AOD abuse treatment or to case management of offenders within the JJS.

Individualized assessment, classification, and case planning are cornerstones of effective JJS case management. Individualized assessment is necessary for effective case management: An assessment must be made of the juvenile's risks and needs and of available resources. Any causes or factors that influenced the youth toward high-risk behavior must be assessed as well as what factors can be used in a positive movement toward law-abiding behavior. The critical areas in the juvenile's life -- the family, the school, and the community as well as the social, interpersonal, and job skills necessary for those interactions -- must be assessed (National Institute for Juvenile Justice, 1993).

Case classification in the justice system is a management tool designed to assess a client's risk and needs and then to assign resources accordingly. Not all juvenile offenders exhibit the same risk factors or require the same level of supervision (Baird et al., 1984).

Whether the initial AOD assessment within the JJS is conducted formally or informally, the information gleaned during the assessment should be applied directly to a case plan for holding the juvenile accountable for his or her actions, ensuring the safety of the community, providing reparation to the victim, and identifying treatment objectives for the juvenile. Conferring with a designated representative of the AOD abuse treatment system will be a necessary step in identifying the AOD objectives for the case plan. (See Exhibit 2-1, The Assessment Process.)

The case plan should identify both long-range and short-range objectives. One well-known JJS case planning strategy assists the juvenile intake officer or counselor in selecting the most appropriate problems for immediate attention and involves the following components identified by Lerner et al. (1986):

1. Analysis/identification of the problem and the youth's strengths and weaknesses
2. Problem prioritization based upon strength (is the problem an important force in the juvenile's delinquency?), alterability (is the defined problem subject to modification?), and interdependence (will solving this problem help solve other problems?).
The caseload of a juvenile court services officer depends upon a variety of factors, including the number of youth referred to the juvenile court, the number of juvenile court services officers available to handle the cases adjudicated by the court, the officers' individual responsibilities, and their qualifications and areas of specialization. For example, some juvenile court services departments have units that handle only specialized cases such as youth with AOD problems or sex offenders.

In addition, some juveniles require intensive supervision or frequent drug screens and may be subject to daily contacts with juvenile court services officers. These officers, especially case managers in large rural geographical areas, may have to spend a significant amount of time traveling. Many juvenile court services officers are involved in preadjudicatory court activities in addition to their responsibility for managing cases of adjudicated delinquent juveniles.

As most JJS practitioners know, a single case manager is needed to coordinate activities and to answer any questions that arise concerning the juvenile's progress and behavior. A designee of the court, perhaps the juvenile court services officer, may be the most appropriate case manager; however, it is not required that the case manager be a designee of the court.

In fact, some people believe the case manager should not be a designee of either the juvenile court or of AOD abuse treatment services. The affiliation of the case manager selected to handle an AOD abuse case will depend on the resources available to the community and the agencies serving it. Regardless of the approach followed, it is important that representatives from all the groups involved in the collaboration agree on the designation of the case manager.

Ideally, a mechanism should be established for selecting staff to work with each youth. For example, the Norfolk Interagency Consortium (NIC) in Norfolk, Virginia, was created to establish a proactive interagency approach to the provision of intensive treatment services through a comprehensive collaborative system of individual care. The NIC's stated mission is To preserve the family and its individuals, by linking youth and their families with community-based resources to strengthen the family and to enhance the self-esteem and integrity of all family members.

To achieve this mission, the city of Norfolk has established a case management system that uses community assessment teams (CATs) to determine appropriate interventions for selected youth and to provide the most proactive, innovative services possible to the city's youth and families. The members of the CATs represent the following agencies: the Division of Social Services, mental health agencies, Juvenile Court Services, the Juvenile Services Bureau, the public school system, AOD abuse treatment providers, public health services, parents, and private service providers Exhibit 2-4, Norfolk's CAPES Program. It describes the Chemical Abuse Prevention Through Educational Services [CAPES] program of the City of Norfolk Community Services Board.)
The availability of alternative methods of supervision and support is also a factor affecting caseload management. In the Denver Juvenile Treatment Alternatives to Street Crime (TASC) project, for example, a community-based "tracker" may remain in contact with a juvenile who needs a lesser degree of supervision, stay informed of the juvenile's location, and ensure that the juvenile attends treatment sessions. This work leaves a certified addiction specialist affiliated with the Denver TASC free to work one on one with the more unresponsive juveniles.

**Appropriate Dispositions**

Diversion should not be viewed as a vehicle for the youthful offender to avoid responsibility. Accountability under the law is essential. The JJS is required to mandate sanctions and remedies for unlawful behavior and, in some cases, to provide treatment services to avert further offenses. Diversion should be viewed as an appropriate disposition, taking into full account a clearly defined problem requiring treatment. Clearly, the AOD-abusing youth must be held accountable for his or her conduct if rehabilitation is to be successful. The court's power and authority to mandate treatment for AOD abuse can be a significant asset to support the treatment process.

Accountability in juvenile court dispositions addresses the identified needs of the juvenile as well as the needs of the family and community. Those juvenile courts and court services making effective dispositions will recognize not only the risks associated with an intervention but also the strengths of the juvenile, family, and community. For example, it may be inappropriate to allow an adjudicated youth with an identified AOD abuse problem to remain in a community in which there is little bonding among the members and in which values and mores support AOD abuse. The youth may be better served in a community-based placement outside his or her home community.

It is best to make dispositional recommendations based on individual needs. The consensus panel recognized that, unfortunately, these recommendations are often made on the basis of the availability of services and resources. The community is the key to successful reduction of AOD abuse. Every community should develop and sustain comprehensive substance abuse prevention, treatment, and recovery programs for youth and families. The community is in the most effective position to develop and sustain accessible programs that over time will successfully prevent, treat, and control substance abuse. However, when the resources that the juvenile needs do not exist, it will be necessary to develop them or obtain them from other sources, including other jurisdictions. The community must set priorities and reach out to find or develop the resources. Providing treatment alternatives is a responsibility of society to its juveniles. Every community must define the extent and nature of juvenile AOD abuse to determine the precise nature of the problems it must confront in dealing with AOD-abusing juveniles.

In some cases, there are resources within the community, particularly in urban communities, but uncovering them takes considerable effort. The best resources are the parents, the relatives, the people, and the organizations (such as churches, schools, or
recreation programs) within the community. These people and organizations may be natural helpers, and obtaining assistance from them usually does not require additional funding.

**Family Involvement**

With a parent's natural right to control a child's upbringing comes the responsibility to discourage AOD abuse by the child. Family involvement is critical to effective juvenile court interventions. It is particularly critical in the treatment of court-involved youth who have AOD abuse problems (Geismar and Wood, 1986).

The traditional definition of a family is not necessarily applicable to the case of every juvenile. Alternative and functional family arrangements should be fairly and honestly considered during efforts to involve "family" in juvenile court interventions. For example, a stable family may consist of a grandmother and her grandchildren, a single mother living with her boyfriend who may be helping raise the children, or foster parents raising children from several different families. The National Association of Social Workers' Commission on Families defines the family as "two or more people who consider themselves family and who assume obligations, functions, and responsibilities generally essential to healthy family life." The functions of family life include child care, child socialization, income support, long-term care, and other types of caregiving.

The family is the most critical force for control, authority, and support in the lives of children and adolescents. When parental substance abuse is determined to be a factor contributing to familial dysfunction, the family is likely to need treatment services as well. In some States, treatment for families can be ordered by the court; however, it should be noted that these orders may not extend to individual parents.

Rather than relying only upon the authority of the court, diversion programs may find it necessary to identify other means of obtaining the participation of the family in treatment either for the juvenile or for themselves. For example, an explanation of how their involvement can help the juvenile may be required in order to garner the cooperation of family members. AOD abuse treatment providers should initially seek to engage parents or guardians as "members" of the treatment team. This role alleviates the sense of helplessness and feelings of guilt and anger many parents experience.

Resistance to treatment often comes from the fear that treatment will intensify undesirable feelings. Any court-ordered requirement and treatment expectation must be feasible for the family to meet. The flexibility to make and support accommodations—such as providing court time as well as treatment outside working hours, providing transportation assistance, and making bilingual or bicultural staff available to provide gender-specific treatment -- is essential for successful AOD abuse treatment of the youth.

Although the primary goal should be family preservation, it may not be possible (or even always advisable) to keep the family intact at all costs. Sometimes the family environment is abusive, and remaining in or returning to that environment is not in the
best interests of the youth -- return may not even be safe. If the juvenile's safety from physical, sexual, or severe emotional neglect or abuse cannot be guaranteed, alternative arrangements must be considered. If it is necessary to remove the juvenile from the home or community, the time that the juvenile remains away from the home should be as brief as possible. During this period, case managers should work with the family and the juvenile to prepare them both for the juvenile's return. Building on the family's strengths will promote family preservation.

Differences in cultures, values, family systems, and dynamics must be respected. No single measure of family functioning should be used to determine the "worth" of the family or the ability of the parent. The juvenile court must be guided by the balancing of three interests: the safety of the youth, the role of the parents, and the responsibility of the State.

Community-Based AOD Abuse Treatment in Least Restrictive Setting

AOD abuse treatment within the context of the community's needs should be a primary goal of juvenile justice interventions. Community-based AOD abuse treatment has the advantage of allowing the family access to treatment and providing continuity of care, as the same people work with the juvenile throughout the treatment process and establish a support system for the juvenile. This approach facilitates community responsibility to the juvenile and empowers the community. Furthermore, placement in the community can help make the juvenile more socially conscious and encourage him or her to make decisions appropriately and independently.

Juveniles should be placed in the least restrictive community environment during AOD abuse treatment; this placement requires a careful screening and assessment to ensure that the juvenile will not be a threat to the safety of the community. Therefore, some community-based treatment alternatives should exist that directly address these issues and that maintain public safety and hold the juvenile accountable without incarceration (placement in a secure facility). Such alternatives may include intensive treatment with electronic monitoring, as in the Clackamas Juvenile Justice Collaboration, or the use of a tracker, as in the Denver TASC project. If incarceration is necessary, it should be meaningful in the sense that its structure should help the juvenile increase his or her social competency, become more accountable, and return to the community as promptly as possible.

It is important to build upon the community's strengths. Programs that reflect positive community values and in which the community has demonstrated support should be considered prime candidates for funding. Referring AOD-abusing juveniles who have committed AOD-related or other offenses to such programs can reduce the problem of "labeling," because such referral prevents the identification of these juveniles as part of a special group.

Some community-based treatment alternatives should exist to ensure that the juvenile will not be a threat to the safety of the community.
Victim Involvement

An emerging shift in the JJS has established the victim of a crime as a "client," on an equal footing with both the community and the offender. Today, more and more people recognize that when a person commits an offense, he or she incurs an obligation to the victim. Accordingly, juvenile justice interventions should attempt to restore to the victim and to the affected communities that which has been lost as a result of the juvenile offender's actions. To accomplish this goal, victims must be empowered as active participants in the juvenile justice process. Victim reparation is accomplished through several well-established practices, such as restitution, community service, and victim-offender mediation. Victims can play an active role in providing input into the system, ensuring appropriate reparation, and making the offender aware of the damage for which he or she is responsible (Bazemore, 1992).

Furthermore, because one of the primary goals of the JJS is to return the juvenile offender to the community and because it is preferable for AOD abuse treatment to take place within the community, it is entirely possible that the juvenile will encounter the victim eventually. In some instances, a meeting between the juvenile and the victim, orchestrated by court services personnel, may help the juvenile realize the extent to which he or she has done something wrong. It makes the crime less impersonal and forces the juvenile to consider its consequences.

In some instances, as in the case of informal adjustments, it is appropriate to involve the victim in the disposition of the juvenile's case. In fact, the involvement of the victim may empower members of the community to care for their own. However, the potential involvement of the victim should not indicate either a bias in the system or a differential valuation of either the victim or the juvenile offender. For example, regardless of the individual characteristics of the victim, the sanction for the offense should be the same.

The type of offense is significant in determining the feasibility of victim involvement. When the offense is a property offense that may be settled through mediation, a meeting between the victim and the juvenile may be useful. In the case of an offense such as rape, however, such a meeting may be inadvisable. The background and maturity of the juvenile, as well as the degree of harm done to the victim, also influence whether the victim should be involved in the juvenile's case. Even when the victim does not meet with the juvenile offender and does not participate in the legal proceedings, the JJS should have a mechanism to inform the victim about the disposition of the case.

Needs of Juveniles from Special Populations

Youth involved in the JJS represent the full spectrum of socioeconomic, cultural, and ethnic categories, and physical ability. As a result, the services and interventions provided by the JJS must meet the cultural, spiritual, physical, mental health, language, and gender-specific needs of a wide range of juveniles (see Exhibit 2-6, Gender-Specific AOD Abuse Treatment).
Traditionally, it has been more difficult to obtain services for juveniles with special needs than for those without such needs. Some juveniles, as a result, have been excluded from the particular program that they need because of that program's narrow focus. The continuum of AOD abuse treatment services available to diverted youth should be matched to serve the spectrum of needs identified by the community collaboration. The collaboration should consider how best to serve youth

- Who have disabilities (such as learning disabilities, emotional disturbance, mental retardation, and physical impairment)
- Who have a coexisting mental disorder
- Who have been victims of abuse
- Who are living at a low socioeconomic level
- Who are homeless
- Who have educational deficit(s)
- Who are pregnant and/or parenting (including teen fathers)
- Who are gang members
- Who are latchkey children
- Who are gay, lesbian, or bisexual
- Who are not Caucasian
- Who are from cultures other than the dominant one(s) of the community
- Who are in the country illegally and/or whose parents are undocumented workers
- Whose parents are migrant workers
- Whose parents are mentally ill
- Whose parents are involved in the criminal justice system
- Whose parents abuse AODs.

It may be necessary to be imaginative and creative in order to develop the resources required to meet the needs of these special groups. For example, the primary (often the only) language of a substantial number of youth in the JJS is not English. AOD screening and assessment instruments may not be available and normed in the language of non-English-speaking populations (such as Spanish, Laotian, or Vietnamese). Involving community leaders and parents in the design of a screening tool may produce more sensitive instruments and bring the community more fully into the partnership. Many AOD screening and assessment tools, including those available in several languages, have not been normed for every cultural or ethnic group. Also, many tools are not translated in a manner that is culturally appropriate for certain groups.

Where no appropriate tools exist, a comprehensive interview by a bilingual or bicultural professional should be sufficient. The relevant research regarding the specific target populations should be reviewed before an instrument or method of treatment is selected. In addition to the screening and assessment instruments, the AOD abuse treatment modalities available must be culturally, ethnically, and spiritually relevant to all populations, including minorities. See Appendix G, *Multicultural Awareness: Developing Cultural Understanding of the Juvenile Justice System.*
Gay and lesbian youth are at high risk of AOD abuse, and some research has shown that their rates of alcoholism may be three times that of the general population (Feinleib, 1992). AOD abuse treatment service providers need to be aware of the special needs these youth bring into treatment. Staff members should be comfortable discussing sexual orientation issues and conscious of the conflicts that may arise in mixed treatment settings. Homophobic behavior occurs frequently in the greater society and could easily exclude gay or lesbian youths from the potential benefits of AOD abuse treatment.

**Adolescent Treatment Goals**

AOD abuse treatment for youth was covered by the CSAT consensus panel that developed the TIP *Guidelines for the Treatment of Alcohol- and Other Drug- Abusing Adolescents*. That panel was charged with producing guidelines to be used by States for the establishment, funding, operation, monitoring, and evaluation of treatment programs for AOD-abusing adolescents. An additional effort was made to define treatment approaches to meet the specific needs of AOD-abusing adolescents involved with the juvenile and criminal justice systems.

The fundamental assumptions underlying the TIP included

- Adolescent clients require different core treatment services from adult AOD abusers. Services must focus on age-appropriate skill development.
- Among these needed services are screening, assessment, and diagnosis; matching the client with the appropriate type and intensity of treatment, which should include a variety of behavioral, cognitive, and family therapies; preventing relapse; providing continuing care; and developing skills that are necessary to a successful, independent life.
- Ancillary services for AOD abusers should be tailored to meet the specific needs of adolescents. Services include specialized education, preemployment training, health maintenance, transportation, leisure activities, and mentoring.

**Adolescent AOD Abuse Assessment Criteria**

If the brief screening suggests the existence of a problem, then assessment for AOD abuse is necessary (see Exhibit 2-7). Many States, including Oregon, Iowa, and Washington, have developed AOD abuse treatment system "levels of care," and others have adopted the Patient Placement Criteria of the American Society of Addiction Medicine (ASAM). These systems help practitioners determine the need for a specific intensity of treatment for each individual through the use of identifiable markers relating to the need for detoxification, treatment resistance, coexisting emotional and behavioral problems, and relapse potential. Such patient placement criteria provide greater consistency of treatment recommendations among assessors, whose clinical judgment, rather than personal relationships or the influence of good marketing, should dictate treatment recommendations. (See the CSAT TIP *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders.*) The criteria make it
possible to place youth in AOD abuse treatment programs that provide the intensity of services they need.

Ideally, a full continuum of AOD abuse treatment services should exist in each community (see Exhibit 2-8, Continuum of Services). Rarely, however, is this the case. The full continuum ranges from low intensity services for youth in the initial stages of AOD abuse problems to high-intensity services for those with severe problems. It is the task of the collaboration to identify service gaps, to assist the AOD abuse treatment provider group in reorganizing parts of the existing system, and to obtain additional funding to fill in the gaps identified. Many juveniles in the diversion program will have had previous AOD abuse treatment experiences, and some may have a significant history of delinquent behavior. To ensure positive treatment outcomes, sophisticated programming must be developed that can confront the thinking errors and treatment jargon that juveniles may have learned.

Each service level encompasses many types of prevention or treatment settings. Prevention can range from neighborhood protection efforts to peer helper programs in schools. Outpatient treatment can be located in a school or community center or can function as a free-standing agency.

The science and technology of AOD abuse treatment is constantly moving toward a clearer understanding of which forms of treatment work for which parts of the population. The collaboration should undertake a review of the pertinent treatment literature when considering the local service continuum.

The current body of research findings is too large to review adequately in this document. Access to this information has been greatly enhanced by the availability of computer network links to online databases. Many university systems have developed rural networks to ensure access to information and technology.

The consensus panel felt that successful treatment of AOD-abusing juveniles required families and the community to be dynamic parts of the treatment. No matter how conflicted family relationships appear, juveniles are still part of the family units, and AOD abuse treatment needs to focus on these units, not just on individual juveniles. The concept of adolescent AOD abuse treatment should be expanded from informational lectures and self-help. It should focus in addition on each juvenile and his or her family and peer group. Family treatment can be provided in many ways:

- **In-home intensive intervention such as providing information about family preservation models.** This type of intervention seeks to increase the parents' skill in managing house rules, communication, and consistency in consequences.
- **A multifamily education and treatment group designed to empower parents.** This type of intervention seeks to help parents resolve issues and to share successful interventions and skills.
- **Family network therapy.** This type of intervention engages the extended family and close social support in developing solutions to the identified problems.
- All forms of individualized family therapy techniques.
- Family AOD education.

A family's involvement may be hampered by parents' fears that treatment professionals will blame them for their children's problems. Family members should participate in identifying problems and planning treatment. Providers should actively attempt to involve the family even if the youth is not currently living at home, except in cases where the family presents a clear risk of physical, sexual, or emotional abuse. Involvement can be as minimal as phone contact regarding progress in treatment. However, this minimal level of involvement should serve as a fallback strategy only after the family has refused more intensive participation.

Using only a single family intervention model may not be helpful. Many family therapy models are based on concepts of how a functional family is structured and how roles are determined in order to maintain the structure. For many segments of the population, these therapies may not support the cultural family structure or may be viewed as overly intrusive.

Peer groups can be affected through school- or community-based interventions as well as through more traditional group therapies. Adolescent group therapy offers the opportunity for the development of new social, problem-solving, and anger management skills. Furthermore, it allows juveniles to interact in an arena in which they can receive feedback on how they relate to other adolescents. Group therapy also allows for the introduction of information regarding alcohol, tobacco and other drugs, human immunodeficiency virus (HIV), tuberculosis (TB), and other health concerns.

Adolescent AOD abuse treatment should also include individual therapy. This modality allows for continued assessment of coexisting mental health issues, privacy for the adult therapist to provide feedback regarding inappropriate behaviors, and a forum in which youth can bring up issues that they feel the group may not understand, such as specific fears, gender issues, details of sexual or physical abuse, or health issues. This relationship is often the bond the youth needs to feel safe in treatment.

Many youths enter AOD abuse treatment with physical problems, such as untreated injuries, pregnancies, and acute illnesses. Forming linkages will facilitate referrals for medical care. The medical providers with whom linkages are formed should have a history of successfully treating adolescents.

**Criteria for Admission to AOD Abuse Treatment Diversion Programs**

Substance-using juvenile offenders who qualify should be diverted into AOD abuse treatment at the earliest possible point. Clear and concise guidelines must exist to determine who is eligible for diversion programs and to ensure equitable treatment no matter who the juvenile is and no matter where the juvenile is in the justice system. These guidelines must incorporate and protect the juvenile's due process rights.
While meeting the requirements of providing for community safety, AOD abuse treatment diversion programs should be designed to include only minimal barriers to admission. Thus, the goal should be to channel as many youth as possible into treatment rather than to screen out as many as possible. AOD screening and assessment are critical to determining which youth are appropriate for diversion to AOD abuse treatment.

*Adolescent AOD Abuse Treatment*

Adolescents constitute a diverse group. AOD abuse treatment programs that are able to meet their full spectrum of needs are rare. Healthcare reform and other external influences are shifting the emphasis in AOD abuse treatment placement decisions. Matching clients' individual clinical and other problems with the most appropriate level of AOD abuse treatment is emphasized, rather than providing accountability sanctions or long-term child welfare services.

Because relapse, while expected, places the juvenile in jeopardy, it is wise to hold an initial case conference that includes the juvenile, the parent(s), the AOD abuse treatment providers, and representatives of the JJS early in the treatment process. Such a meeting provides an invaluable opportunity to assess the juvenile's progress and to redefine the consequences that will be imposed if the youth relapses.

*Continuing Care*

To prevent the juvenile from reentering the JJS after successful treatment for AOD abuse and release from court-ordered sanctions, continuing care (also referred to as aftercare) must be a strong component of any treatment program for diverted juveniles. Effective continuing-care programs will increase the likelihood that youths will remain AOD-free and will not return to the juvenile court on new charges. An effective continuing-care program should

- Support sobriety by emphasizing relapse prevention and recovery planning
- Facilitate effective reintegration into the community and positive activities
- Facilitate and ensure continuity and application of competencies gained during treatment
- Reduce recidivism among offenders released from residential facilities
- Decrease the number of juveniles who build lengthy delinquent careers and move on into criminal careers as adults (Altshuler and Armstrong, 1990).

The case manager should make clear that, should they need further treatment, the juveniles who have been in AOD abuse treatment because of illegal behavior may seek treatment directly and need not wait until they are referred to treatment through the JJS. The agencies participating in the management of the juvenile's case should agree upon the actions that each will take should any recurring or additional problems occur at any time during AOD abuse treatment, continuing care, or followup.
Closure of diversion occurs whenever the juvenile completes the AOD abuse treatment plan that was implemented by court services or that was court ordered. The discharge plan, like the assessment and treatment plans, should be multidisciplinary and should be based at least in part on input from the youth and his or her family. Many jurisdictions have found graduation ceremonies or some other formal acknowledgment to have positive effects in increasing the juvenile's self-esteem and reducing the risk of relapse.

Relapse Prevention

Relapse episodes are to be expected during treatment and recovery. All involved parties, particularly case managers, must have some training in the prevention of relapse in adolescents. Relapse should not be seen as synonymous with failure. Although relapse is no longer perceived as a totally negative event but rather as part of the recovery process, the AOD-abusing juvenile should understand that even one lapse will have immediate consequences.

Zero tolerance of AOD use must be the officially stated policy in any system supporting AOD abuse treatment, but the consequences for failure should be somewhat flexible. If the juvenile is clearly making some effort and is progressing, the consequences may be minimal; however, a continuum of consequences, depending on the individual circumstances of the juvenile, may exist. For example, the juvenile may face loss of privileges (earlier curfew, increased community service hours, more frequent urine drug screens, or weekend detention). Whatever the consequences, they must be clearly articulated, accepted by both the JJS and AOD abuse treatment systems, explained when juveniles enter the program, and applied consistently.

Public Health System Goals

Typically, juveniles involved in the JJS are medically underserved. They often come from families that cannot afford primary healthcare or are unable to gain access to the available healthcare system, or whose lifestyle does not support participation in ongoing treatment. The medical profession must mobilize to assess the needs of and provide services to juveniles who have committed AOD-related offenses. This is the first step toward ensuring access to healthcare and preventive services and toward ensuring a continuity of care for medically underserved juveniles. Medical intervention will benefit the individual youth and the public health interest as well. The public health system's goals include case-finding, disease prevention, and health promotion.

It is essential to mobilize the medical profession to join the effort to assess and provide services to meet the healthcare needs of juveniles involved in AOD-related offenses.

Medical Assessment
The purpose of medical assessment is threefold: 1) to identify acute illnesses or chronic medical conditions, 2) to identify communicable diseases, and 3) to identify health-compromising risk factors. Obtaining a detailed medical and behavioral history, focusing on common problems found in adolescence, followed by a complete physical examination and appropriate screening tests, will contribute to an effective intervention plan for the individual youth. Providing an extensive listing of medical problems and methods of assessment is beyond the scope of this document; interested readers are referred to textbooks on adolescent medicine.

Common or often unrecognized medical problems among youth at risk include asymptomatic communicable diseases that may result in late complications in the individual; these diseases include hepatitis, tuberculosis, and sexually transmitted diseases (STDs) such as gonorrhea, chlamydia infection, syphilis, trichomoniasis, or HIV. Chronic medical problems may be accompanied by no symptoms or mild or intermittent symptoms, yet associated with grave consequences if left untreated. These problems include hypertension, seizure disorders, reactive airway diseases, diabetes, nutritional deficiency, rheumatic carditis, or conditions related to inadequately treated injury, such as chronic osteomyelitis.

Nutritional deficiency in adolescents may stem from poor dietary intake, eating disorders, AOD abuse, or chronic illness. Every AOD abuse treatment program must develop a system for referring patients to such community-based health services as health maintenance, immunization, continued care of chronic medical conditions, and other basic services.

More than 70 percent of boys and more than 50 percent of girls in the United States become sexually active by the 12th grade. Youth involved in the JJS, as well as AOD abusers, tend to engage in high-risk sexual activities such as not using condoms, having multiple at-risk sex partners, or engaging in sexual activity while under the influence of AODs. Screening for and management of high-risk sexual activity, STDs and HIV infection, and pregnancy are some of the priority areas in medical assessment of these youth. Chlamydia and gonorrhea infections (urethritis or cervicitis) are among the most common STDs in both male and female adolescents. Syphilis and hepatitis rates are also higher among AOD-using adolescents and young adults than among those not using AODs. Although infectious, a majority of STDs are asymptomatic and therefore remain undiagnosed and untreated until late complications occur—unless a screening program is in place.

Screening for treatable STDs should result in an assessment of behavioral risk, treatment of juveniles who test positive and of their sex partners, and education to reduce the risk of reinfection. Consequences of untreated or unrecognized lower genital tract infections are much greater for girls than for boys. Complications of untreated STDs in girls can include infertility, ectopic pregnancy, pelvic inflammatory disease, and transmission of the disease to their babies in utero or intranatally. Risk assessment and screening for sexually transmissible viral infection, particularly HIV, is desirable and should be offered with assurance of confidentiality, appropriate counseling, and referral resources. The
screening and management of STDs and HIV infection among populations at high risk of exposure, such as AOD-using juveniles, have significant public health implications as well. However, screening for HIV infection in the absence of strict confidentiality and appropriate counseling is not advisable.

Patients who are pregnant must receive medical attention and supervision, and preventive/early screening for gynecologic healthcare problems. Early referral of pregnant AOD users to prenatal care is especially critical.

Provision of Health Information and Education

Most juveniles lack critical information about risk reduction, immunization (because they have never had primary preventive care), pregnancy and family planning, steroid use, nutrition, and eating disorders. Staff members of diversion programs need this information not only to educate the juveniles in their care, but also to reinforce prevention efforts, make appropriate referrals, use appropriate precautions to minimize their own risk of exposure to disease, and help prevent juveniles in need of treatment from being excluded on the basis of their ignorance or misperceptions regarding medical conditions. Thus, staff training is a critical component of any educational effort.

Adolescent illness and death are largely preventable, and when they do occur, they are usually attributable to intentional or unintentional injury or high-risk behavior. Prevention through health education, including abstinence, and the promotion of healthy lifestyle must be goals of the public health system. Reproductive health education, including abstinence and family planning for both female and male adolescents, prevention of STD/HIV infection, and promotion of physical fitness must be integrated into all diversion programs for juveniles.

The preventive training may be delivered in group sessions or in individual sessions using curriculums that are developmentally appropriate for youth. The effectiveness of education programs may be enhanced by involvement of peer counselors and implementation of programs that are sensitive to the gender and cultural needs of the target youth.

Violence-Related Injury Prevention

Violence is one of the leading causes of death among adolescents and young adults in the United States, and it is the number one cause of mortality among male youth living in some urban areas of the United States. AOD-abusing youth in the JJS often are the victims of child abuse or neglect, or they are witnesses to domestic violence. Studies have shown that violence is a learned behavior. Primary prevention and early intervention are critical if this deadly public health problem is to be controlled. When assessment reveals that the juvenile has a history of exposure to violence as a victim or bystander, or has a propensity for violent behaviors, assessment should be followed by intervention in the form of appropriately focused therapy or participation in violence prevention programs.
These interventions must be available to all youth in the diversion programs. A long-term, sustained intervention may be necessary for success in violence prevention.

The staff of AOD abuse treatment diversion programs should be knowledgeable about the origins of violence, interpersonal conflict resolution skills, and nonviolent anger management. Participation in a violence prevention and conflict resolution workshop is desirable for training staff in the JJS and in the diversion programs because a propensity for violent behavior is common among AOD-abusing juveniles.

**Mental Health**

Many juveniles have coexisting AOD and mental health problems, such as posttraumatic stress disorder, depression, bipolar disorder, or schizophrenia. Many mental disorders have such a direct and significant impact on a juvenile's behavior or ability to perform daily cognitive tasks that AOD abuse treatment would be ineffective without concurrent mental health treatment. Early assessment, diagnosis, and treatment of both AOD abuse and coexisting mental health problems are necessary for diversion to be successful.

The collaboration should develop linkages and establish a process to meet both the AOD abuse and the mental health needs of the juveniles in its community. Many AOD abuse treatment programs are part of a larger community mental health center, so this tandem treatment process should not be overly difficult to achieve. Where the two treatment systems are separated, turf issues—such as professional versus paraprofessional credentials, who "owns" the youth, or whether psychiatry addresses AOD issues properly -- must be resolved before agreement can be reached.

The strengths of both systems should be the basis for the linkage. Both treatment systems share the youth- and family-centered view. AOD abuse treatment has long sought to place the recovery process with the client. Community mental health centers have great expertise with emergency situations such as suicide attempts, and many have extensive "wraparound" services that would further support a youth in treatment. Some of the services are therapeutic foster care, in-home therapy, sexual abuse recovery programs, outreach, and medication management. Both treatment systems should share the goal of developing a single comprehensive treatment plan. *The burden of coordination should be on the providers, not on the youth or the family.*

**Conclusion**

This chapter has addressed the basic goals of AOD abuse treatment diversion programs for youth involved in the JJS. Specifically, it has attempted to address the goals of the four human service systems that will be most likely to participate in a consortium program to divert youth safely from the JJS to AOD abuse treatment. The four systems are the JJS, the AOD abuse treatment system, social services, and the physical and mental health systems in the community. In addition to providing information about the specific systems, the discussion has illustrated the common ground shared by these systems with respect to youth with AOD abuse problems.
The next chapter provides guidelines for planning a collaborative approach to an AOD abuse treatment diversion program. The key to a collaborative approach is to effectively divert youth with substance abuse problems from further penetration into the JJS and into AOD abuse treatment. This type of collaboration will allow youth to receive the "best of both worlds." They receive treatment for their AOD abuse problems with the full support and authority of the juvenile court.

Chapter 3—Collaborating on a Diversion Program

Planning and implementing an alcohol and other drug (AOD) abuse treatment diversion program is not a simple task. Many issues must be considered before comprehensive planning for a system to divert youth from the juvenile court system to appropriate AOD abuse treatment can begin. Complex decisions must be made by a collaborative group that is formed to plan and to get the program started. Collaborators will be most effective if they agree to use a consensus-building decisionmaking process. This process encourages dialogue, and members will have to find common ground upon which they can agree. Consensus builds ownership and does not require absolute agreement on every point.

The decisions can be made most effectively if members of the collaborative planning committee take a simple systems view of the development process and the diversion program being designed. For planning purposes, the juvenile justice system (JJS), AOD abuse treatment, physical and mental health services, and social services should be considered essential system components that together with other community collaborators, such as the education system, make up the juvenile AOD diversion program. Each system component is a partner in the planning and implementation process. The collaborators must be sure that the purposes and needs of each system are considered as they design a diversion program. Likewise, they need to put into place an effective management system. This management system can be considered another system component, as illustrated in Figure 3-1.

The Functions of the Collaborating Committee

The collaborating committee will deal with wide-ranging issues. For example, after the creation of the committee, one of the most critical steps is for its members to reach consensus on the definition of diversion. This definition forms the basic construct of the system under design, and it sets the stage for consideration of issues that range from the identification of juvenile offenders appropriate for treatment and what types of treatment shall be available to them, on the one hand, to the identification of funding sources on the other.

The collaboration is most likely to be effective if the participants agree to use a consensus-building decisionmaking process. This process encourages dialogue, and participants will have to find enough common ground on which to agree. Consensus builds ownership.
Five major types of decisions confront the collaborating committee:

- Juvenile justice decisions
- AOD abuse treatment decisions
- Physical and mental health decisions
- Social services decisions
- Management system decisions.

While some of the core decisions within each system can be made only by members of that system, collaborators from the other groups may be involved in decisionmaking by becoming informed, raising questions, and then working toward the goal of building a unified system that will continue to receive input from the major system components.

The many decisions to be made by the committee are reviewed in this chapter, which has been written to help collaborators prepare for the work they will perform.

**Identifying the Stakeholders To Be Involved in the Planning Process**

Ideally, every community will recognize and acknowledge that AOD abuse presents a challenge that must be confronted for the best interests of its children and families. The planning effort must be guided by people who accept this premise.

People from all strata of the organizational hierarchy of the JJS and local officials should be included on the planning team, including court services staff, supervisors, administrators, community volunteers, physicians, AOD abuse treatment and community health providers and agencies, and local officials or their designees. The team must include decisionmakers who have knowledge of the juvenile justice and AOD abuse treatment issues involved.

When planning an AOD abuse treatment diversion program or system, it is necessary to have two types of people as members: 1) those who understand and have an interest in the broad and specific problems of community welfare, juvenile justice, AOD abuse, and health and social services and 2) community leaders who can ensure that productive change occurs. They may represent public, private, or business and industrial organizations, or they may be community volunteers.

**Community Decisions**

- Identifying the stakeholders and leaders to be involved in the planning process
- Agreeing on community accountability
- Planning for the presence of urban, suburban, and rural differences
- Defining the roles and expectations of families
- Planning the focus and influences of community diversity

**JJS Decisions**
• Developing the diversion concept
• Identifying the points in the justice process at which diversion can occur
• Devising effective education and training programs for judges and court services personnel so that they know and understand the treatment resources available, and so that the most effective treatment approach can be implemented for each juvenile
• Helping treatment providers and public health officials understand the JJS
• Establishing procedures for judicial responses to AOD abuse treatment issues
• Defining appropriate target populations within the JJS's jurisdiction
• Defining noncompliance and completion of AOD abuse treatment
• Identifying the types of information required to measure outcomes needed for decisionmaking
• Developing the ability to supervise AOD-abusing juvenile offenders and monitor treatment progress

While some of the core decisions within each system can be made only by members of that system, collaborators from the other groups can be involved in decisionmaking by becoming informed, raising questions, and then working toward the goal of building a unified system.

**AOD Abuse Treatment Decisions**

• Defining the needed continuum of services
• Identifying needed treatment modalities
• Defining treatment expectations
• Defining and locating services
• Establishing uniform eligibility and acceptance criteria
• Developing a screening and assessment process for placement in AOD abuse treatment
• Defining the supervision roles of AOD abuse treatment providers
• Planning to deal with issues of culture, gender, and ethnicity

**Ethical and Legal Decisions**

• Deciding what information is appropriate to exchange
• Deciding who is appropriate to receive information
• Protecting confidential electronic data
• Reporting in accordance with local, State, and Federal guidelines
• Defining the scope of confidentiality rules

**Decisions Regarding Physical and Mental Health Services and Social Services**
• Defining what physical and mental health services and social services need to be available to youth and families
• Establishing linkages with the AOD abuse treatment system to integrate services for youth into the diversion program

Management Decisions

• Resolving funding and cost considerations
• Ensuring confidentiality and adequate communication among all parties
• Identifying program management capabilities
• Encouraging interagency cooperation and collaboration (which includes written documentation)
• Developing preimplementation training and public education
• Conducting system oversight
• Defining the evaluation process
• Conducting feedback analysis and reporting on outcomes
• Defining the need for ongoing research
• Defining ongoing data and demographic requirements

Since funding is a critical issue, it is important to include in the first group people who are knowledgeable of funding streams, who are potential funders, or who have ties to funding organizations. Often, commitment to productive change is more important than a person's position or field of work. Planners from these groups are not likely to be directly involved in the implementation of the program, although some collaborating groups may designate some to be involved. Elected officials should be included on the collaborating committee if possible or appropriate. Often the single State agency (SSA) has the power to reprioritize funds based on identified local need.

The responsibilities of planning team members and possibly the team's composition may shift as planning progresses. For example, planning will require the participation of people with the ability to communicate problems and solutions, and it will necessitate support and commitment from people representing a variety of organizations in the community. Some members should be able to clearly explain the process of juvenile diversion and what it means for the JJS, the AOD abuse treatment field, and the community. As planning moves toward implementation, the judge and agency and department heads will need to assert leadership so that the program being planned can be activated. As planning moves to implementation and expands into ongoing programming, this committee leadership can be vital to sustaining the diversion program.

Each community that is planning a diversion program for AOD-abusing youth should evaluate the extent and nature of its AOD problems and develop a response that reflects the local challenges of AOD use and the unique characteristics of the community. Accordingly, the planning team membership should also reflect the community's social characteristics.
Because an evaluation plan is critical to developing the diversion program, members of the team should include people with appropriate research or project evaluation backgrounds. If this expertise is missing within the community, linkage with a college or university may be appropriate. The committee should take advantage of research findings and plan to document its efforts for future evaluation, feedback, and development. Selection of an individual with the ability to develop and operate a management information system (MIS) is necessary to ensure that appropriate data collection systems are in place.

Often, commitment to productive change is more important than a person's position or field of work.

Representatives of the Collaborating Groups

The specific members of each system component will vary from community to community. The representative membership of a hypothetical collaborating group might include individuals from the following groups.

Representing the JJS

- **Juvenile courts:** This group should include the juvenile court judge or the referee, master, or designee, as well as probation and parole officers and other representatives of juvenile court.
- **Prosecutors:** Some prosecutors are accustomed to working with a more limited concept of diversion than the definition proposed in this TIP. Involving them in the planning process can avoid any constraint on buy-in.
- **Public Defender's Office:** Included with representatives from the public defender's office may be those attorneys identified by or contracted with the jurisdiction to represent delinquent or status-offending youth.
- **Law enforcement:** Although official involvement with juveniles usually ends once the juvenile has been charged, police can serve as valuable mentors or community resources. Police also may want feedback about case disposition, particularly in community policing models. Some communities incorporate police officers into school systems as resource officers, an interactive arrangement in which police build trust with children and youth.

Representing AOD Abuse Treatment Providers

- **Youth AOD abuse treatment providers:** Include both public and private providers that specialize in adolescent AOD abuse treatment.
- **Community-based resources relevant to treatment:** In some parts of the country, continuing care and relapse prevention may be provided by physical and mental health services, social services, or other organizations.
Representing Physical and Mental Health and Social Services Providers

- **Community school professionals:** This group can include staff from the mainstream public and private schools as well as from alternative education environments. If the number of schools is too large to incorporate, a member from a representative teachers' organization may be selected.

- **Healthcare professionals:** These professionals may be private practitioners or representatives of public and private providers, as well as providers focusing on prevention or representatives of professional organizations such as the National Association of Social Workers. They should include representatives from community mental health centers (most States have a well-developed network of community mental health centers or child guidance programs) and from the public health department. The public health system ensures that general medical services (preventive health care, infectious disease screening and treatment, and reproductive healthcare) are incorporated as appropriate in treatment programs.

- **Social services professionals:** This group can include professionals from public and private social welfare agencies, child protective services, child welfare organizations, and family service programs (for example, the Salvation Army, Jewish community services, and city and county human services organizations).

Representing the Community

- **Support groups:** This category includes such groups as Alcoholic Anonymous (AA), Narcotics Anonymous (NA), and Rational Recovery (RR). If AA, NA, and RR have no meetings for youth, perhaps adult members can participate in the implementation effort by initiating them. Since AA, NA, and RR have no official representatives, participants from these groups will be active, interested private individuals with a special interest in assisting youth.

- **Victim advocacy groups:** These groups have different names in different localities but will be known to most professionals in child and juvenile welfare organizations.

- **Business community:** Members of the business community who are involved in decisions about healthcare coverage and who also have an interest in youth as future members of the workforce should be included. Planning committee members from businesses can provide assistance by establishing youth advocacy efforts, offering incentives such as job training and other opportunities for recovering youth, supporting drug testing as a condition of employment, and making facilities available for use as meeting space by the planning committee.

- **Parent groups:** Parents who have experience with juvenile justice and AOD abuse treatment should be included but not parents whose children are currently in these systems.

- **Teenage peers:** Youth recovering from AOD abuse problems should be included.

- **Clergy:** Clergy and members of the religious community have the resources and ability to make decisions that have a positive impact. They may offer cultural or ethnic perspectives on the diversion program, as well as support the program.
They also can educate their congregations about the AOD abuse treatment diversion program.

- **Community elders:** Elders who can provide guidance and practical perspectives often are available to volunteer. Diversion is not a new concept, and many times the community elders have particularly salient views on why past efforts have succeeded or failed.

- **Funders:** Representatives of both private and public funding sources should be included, as well as lawmakers who develop legislation for programs and who are responsible for the appropriation of funds.

- **Local officials:** Representatives from the mayor's office, the city council, the county board, and local representatives to the legislature should be included.

- **Volunteer organizations:** Examples include community youth service organizations such as Boys and Girls Clubs, Big Brothers/Big Sisters, YMCAs and YWCAs, police youth clubs, service sororities and fraternities, Civitan clubs, and other youth organizations such as church groups or entrepreneurship development programs.

The length of this list suggests that a large group might be created, so large that it could outnumber the target population of AOD-abusing youth. In a large city, the collaborating group might be even larger. It is more likely, however, that a much smaller group would participate with representatives from a few key organizations interested in juvenile welfare and community safety.

The following chapter describes some of the major decision points facing the collaborating committee. They are provided to assist local groups in planning and developing their AOD abuse treatment diversion program for appropriate juveniles involved in the JJS.