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Juvenile Drug Treatment Court

David M. Ledgerwood[(1)], **Phillippe B. Cunningham**[(2)]

[(1)]Department of Psychiatry and Behavioral Neurosciences, Wayne State University, Detroit, MI

[(2)]Department of Psychiatry and Behavioral Sciences, Division of Global and Community health, Family Services Research Center, Medical University of South Carolina, Charleston, SC.

Summary

Delinquency and substance use by juvenile offenders exacts a tremendous cost on society. Juvenile drug treatment courts (JDTCs) were established in the 1990s to reduce the cycle of crime, drug use, and delinquency among youthful offenders. Currently there are over 400 JDTCs operating in the United States. In this chapter we describe JDTCs including the principles and guidelines underlying JDTCs, the roles of their multidisciplinary team members, and the procedures common to JDTCs operating across the country. A review of the research literature reveals that youth served by JDTCs are overwhelmingly male, frequently identify as racial or ethnic minorities, come from impoverished backgrounds, and experience significant psychiatric co-morbidity. Recent meta-analyses have revealed the effectiveness of JDTCs to be mixed with regard to reducing substance use and recidivism. In this chapter we review the small number of clinical trials that have examined adjunctive treatments utilizing mostly family-based and individual behavioral treatment approaches designed to improve the overall efficacy of JDTCs. Additional considerations for future research on JDTCs are described.

Keywords

Juvenile Drug Treatment Court; Adolescent; substance use; cannabis; caregivers; parents; therapeutic jurisprudence

Introduction

Substance abusing and delinquent adolescents involved in the juvenile justice system represent a large and underserved population that is at high risk for significant deleterious outcomes and long-term costs for themselves, their families, their community, and society. Furthermore, without effective interventions substance abusing and delinquent adolescents are likely to continue to abuse substances and maintain their criminal activity well into adulthood (Godley, Godley, & Dennis, 2001; Henggeler, Clingempeel et al., 2002; Liberman, 2008). The costs of substance abuse and crime to society (e.g., criminal justice expenditures, fear of crime, pain and suffering) are quite staggering, with annual estimates

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ranging from $820 billion (see National Institute on Drug Abuse Trends and Statistics, 2018) to $3.4 trillion (Government Accountability Office, 2017). This chapter begins by describing Juvenile Drug Treatment Courts (JDTCs), their theoretical underpinnings, common elements and goals, and research-based and practice-informed federal guidelines. The remainder of the chapter describes how JDTCs operate and summarizes the latest outcome research on their effectiveness.

What are JDTCs and what are their Common Elements?

Beginning in the mid-1990s, JDTCs emerged as a promising juvenile justice program model in response to the perceived need to intervene more effectively in reducing the cycle of drug use, crime, and delinquency among youthful offenders. Modeled after the success of adult drug courts in reducing recidivism, a JDTC is a specialized docket within juvenile courts for cases involving youth identified as having problems with alcohol and/or other drugs (AOD) severe enough to require treatment. A basic assumption of any JDTC is that youth (and their families) entering court have a complex array of needs that vary considerably from defendant to defendant based on their level of maturation. This assumption is congruent with the theoretical underpinnings of JDTCs, which is the theory of therapeutic jurisprudence (TJ).

TJ asserts that the law and court are social agents for positive therapeutic change (Wexler, 2000). Judicial goals, and the design, operation, procedures and court personnel (judges, lawyers, probation staff; who value the psychological well-being of its participants), can positively affect criminologic and psychosocial outcomes (Gilbert, Grimm, & Parnham, 2001; Shaffer, 2011). An essential component of JDTC, derived from the TJ perspective, is a clear focus on developing treatment and rehabilitative services that can address the unique needs of each youth and his/her family (Grimm et al., 2001). Consistent with a TJ conceptualization, JDTCs are expected to extend intervention beyond just the youth's substance use and criminal behavior, into his/her mental health (e.g., traumatic history, learning disabilities) and that of his/her family (e.g., parental mental health, substance abuse, unemployment, parenting practices, practical needs). That is, from the TJ lens JDTCs are family-focused and expected to play an important role in connecting youth and their families with services needed to address the myriad social and practical factors (e.g., poor parenting practices, inadequate housing, limited employment and vocational activities, lack of social support) that contribute directly or indirectly to a youth's substance use and criminal offending.

Although JDTCs may differ across jurisdictions, they all share several common therapeutic elements and goals. At their core, JDTCs provide substance abusing youth offenders with specialized treatment and rehabilitative services that require effective partnering with a youth's family to address substance use and prevent legal problems (Shaffer, 2011). To establish effective relationships with families requires JDTCs to maintain a creative problem solving stance built upon the principles of collaboration, case management, and a balance between treatment and accountability (van Wormer & Lutze, 2011), with a clear focus to maximize therapeutic benefits while recognizing and maintaining legal safeguards (due process, community safety) (Rottman & Casey, 1999; Winick, 2003). Other common

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therapeutic elements of JDTCs include immediate intervention and continuous supervision of the youth/family (parent or guardian); treatment and rehabilitative services to address the unique needs of each youth/family; judicial oversight and coordination of services (treatment, education, social services) to promote accountability across systems (youth, family, treatment providers, probation staff, etc.); and immediate judicial response to youth/ family noncompliance with treatment or court requirements (Grimm et al., 2001).

These common elements have been codified by leading drug treatment court organizations (National Drug Court Institute, a division of the National Association of Drug Court Professionals, and the National Council of Juvenile and Family Court Judges) into five goals for JDTC programs. As suggested by these organizations the goals of any JDTC are to: 1. provide immediate intervention and treatment for offenders through ongoing oversight and monitoring by the court; 2. Improve an offender's psychosocial functioning across each domain of functional impairments (e.g., social, familial, academic) contributing to his/her drug use/criminal offending; 3. Provide offenders with the necessary skills to lead productive substance and crime free lives; 4. Help strengthen the offender's family functioning to improve their capacity to provide the necessary structure to effectively monitor and guide their child; and, 5. Promote accountability by all involved systems (e.g., family, school, probation, treatment and rehabilitative service providers) (National Association of Drug Court Professionals, 2004).

JDTC Guidelines

Between December of 2003 and June of 2013 JDTCs grew from 268 to 476 courts. As of June 2015, there were an estimated 409 JDCs operating in the United States (National Institute of Justice, 2015). As JDTCs proliferated, mixed evidence of their effectiveness began to emerge in the scientific literature. In the mid-2000's several reviews and meta-analyses reported only modest effect sizes and slight reductions in recidivism among program participants (e.g., Aos, Miller, & Drake, 2006; Latimer, Morton-Bourgon, & Chretien, 2006; Shafer, 2006; Wilson, Mitchell, & MacKenzie, 2006). In response to these mixed findings and to increase the effectiveness of JDTCs, the Office of Juvenile Justice and Delinquency Prevention (OJJDP), in partnership with the scientific community, conducted a systematic review of the extant literature. The goal was to synthesize the available evidence from JDTCs to identify implementation components associated with the most positive outcomes to create research-based and practice-informed guidelines for JDTCs (Wilson, Olaghere, & Kimbrell, 2016). This review also included research from the fields of drug treatment, juvenile justice, and effective interventions in child welfare, public health, and education. This effort resulted in OJJDP publishing Juvenile Drug Treatment Court Guidelines (see Table 1) that can be found at https://www.ojjdp.gov/Juvenile-Drug-Treatment-Court-Guidelines.html.

Ultimately, the focus of these guidelines is to ensure improved JDTC outcomes by making sure these courts promote adolescent development, reduce substance use, and reduce delinquency (OJJDP Juvenile Drug Treatment Court Guidelines, 2016). Concerning healthy adolescent development, implicit in these guidelines is a realization that courts must inculcate a developmental perspective that understands the importance of improving family

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functioning, personal well-being, healthy family and peer relationships, and educational/ vocational functioning (OJJDP Juvenile Drug Treatment Court Guidelines, 2016).

According to the federal eligibility guidelines, JDTCs should only serve those youth who meet eligibility criteria. These eligibility criteria include the following: Youth with a substance use disorder based on assessments from validated risk and needs instruments (e.g., urinalysis, GAIN); youth 14 to 17.5 years; and youth with moderate to high risk of reoffending (e.g., non-violent, first time offenders). In most jurisdictions youth adjudicated for a violent or sexual oriented offense are ineligible for a JDTC.

How do JDTCs Operate?

JDTCs take a multidisciplinary team approach in addressing the unique needs of each participant. As such, a multidisciplinary team of professionals, who take a non-adversarial team approach, coordinates the day-to-day operations of the court and provides a wide range of complementary services germane to healthy child development and public safety. JDTC teams include a judge, court coordinator/supervisor, district or prosecuting attorney, defense attorney or public defender, case manager or probation officer, and a substance abuse treatment provider (roles of each member of the JDTC team are summarized in Table 2). Teams may also include a school representative, as well as representatives from child welfare, social services, and adult counseling services (e.g., parents who may require their own mental health services or educational/vocational counseling). Each member of the team reviews a participant's progress since the last status hearing, and makes legal or treatment recommendations based on the results of their respective assessments. The latter occurs during weekly team meetings designed to provide the judge with information to inform his/her decision during the upcoming status hearing.

JDTC status hearings (legal proceedings) typically occur every 1–4 weeks where the judge has an opportunity to review each participant's progress (e.g., treatment, school, home, community). During the hearing, a participant is called before the judge with his or her caregiver and accompanied by their defense attorney or PD. The judge may ask the adolescent participant to give him/her an update on how well (or not) the youth has been doing since the last hearing. Caregivers are also asked to provide their own independent evaluation of the youth's progress. The judge then directs members of the team to provide their assessment of the youth's progress, and results from the most recent urine drug screen (UDS). Once the review is complete, the judge makes a decision to provide an incentive (i.e., reward) for compliance or sanction for noncompliance (i.e., not meeting program requirements) (Festinger et al., 2002).

Consistent with operant learning principles, the judge selects from a wide range of available incentives for program compliance (e.g., abstinence, school/treatment attendance) and sanctions for noncompliance (e.g., positive UDS, failure to attend treatment, truancy), to help youth progress through program phases (see below). Successful progression through each Phase (individual courts may have three to five phases) can last anywhere from six to 12 months. Phase progression is facilitated by immediate and contingent consequences designed to reinforce or modify the behavior of the participant and his/her family (Gatowski,

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Miller, Rubin, Thorne, & Barnes, 2016). Incentives for program compliance may include praise and encouragement from the judge, gifts (e.g., movie passes, tokens, gift cards, tickets to sporting events), less frequent court appearances and/or UDSs, and ultimately, graduation. Sanctions for non-compliance or non-compliant events (NCE) (e.g., drug relapse, law violations, unexcused absence from treatment, court, or school, inappropriate dress, inappropriate behavior in court) may range from a verbal warning to brief detention (hours to days/weekends) in a juvenile facility. Sanctions may also include community service or a writing assignment. A major law violation (e.g., felony) often results in immediate termination from JDTC.

Each phase has a specific focus and requirements designed to hold participants accountable and to track their progress in areas pertinent to adolescent development, relapse prevention, and aftercare. The team tracks and reviews drug abstinence (results from the most recent UDS), school attendance, grades, and behavior at home (e.g., compliance with caregiver behavioral expectations, curfew compliance). In Phase 1, the focus is often on participant stabilization with the following requirements: weekly status hearing (i.e., drug court attendance), drug treatment and random UDS, regular school attendance, weekly contact with the assigned JPO, and obeying the law. With a continued focus on school and treatment attendance, Phase 2 adds a primary focus on drug abstinence, and begins aftercare planning. In the final Phase 3, the primary focus is transitioning to aftercare and JDTC graduation. A major benefit for graduation from a JDTC, in addition to reducing or eliminating drug use, is that an offender's criminal record is sealed or expunged by the court.

Characteristics of those who participate

Youth who participate in JDTCs vary based on the demographics and policies of the various jurisdictions, but there are some commonalities. Several studies have found that male youth make up over 80% of JDTC enrollees (e.g., Dakof et al., 2015; Henggeler et al., 2006; Henggeler, McCart, Cunningham, & Chapman, 2012; Liddle, Dakof, Henderson, & Rowe, 2011; Sloan, Smykla, & Rush, 2004). Racial and ethnic minorities are also overrepresented among JDTCs. For example, an early investigation in the Orange County JDTC revealed that just over half of the youth were white and 35% were African American (AA; Applegate & Santana, 2000). In a large clinical trial by Henggeler et al. (2006) conducted in a JDTC in South Carolina, 67% of youth were AA, 31% white and 2% biracial. Similarly, a study conducted in Birmingham, Alabama recruited 71% AA youth (Sloan et al., 2004). Dakof et al. (2015) also found high proportions of AA (33–39%) and Hispanic (56–62%) youth in their clinical trial conducted in Miami-Dade Florida.

Families of JDTC participants are often characterized by single-parenthood and poverty. Henggeler et al. (2006) found that most (52%) JDTC youth lived with a single biological or adoptive parent, and only 21% lived with both biological parents. Furthermore, primary caregivers had a median 12th grade education and a median family income ranging from $10,000–15,000, with 38% of families receiving public assistance. Similarly, Henggeler et al. (2012) found that 53% lived with a single biological parent, median household income was in the $20,000–30,000 range, and 47% were receiving assistance. Sloan et al. (2004) reported that about 67% of JDTC participants lived in a single-parent home. Dakof et al.

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(2015) found that over 50% of participants lived in a single parent home, with a median family income around $20,000 or less. Other studies have found similar rates of single-parent households and low family income (e.g., Liddle et al., 2011). Liddle et al. (2011) also found that 75% of teens had a parent with criminal justice system involvement.

Cannabis use was the most frequently used illicit substance across JDTC studies, with rates as high as 98% (Applegate & Santana, 2000; Dakof et al., 2015; Henggeler et al., 2006; Henggeler et al., 2012; Liddle et al., 2011). These studies also showed alcohol abuse and dependence to be quite prevalent, whereas use of other substances (e.g., cocaine, opioids) was relatively uncommon. In many cases, drug-related offenses were the most common crimes that resulted in JDTC referral (Applegate & Santana, 2000; Sloan et al., 2004).

Psychiatric co-morbidity is prevalent among youth attending JDTCs. High rates of externalizing disorders (e.g., conduct disorder, oppositional defiant disorder, attention deficit disorder) have been reported in several studies (e.g., Dakof et al., 2015; Henggeler et al.; 2006; Henggeler et al., 2012). These studies also found elevated rates of internalizing disorders (e.g., anxiety disorders, major depression, obsessive-compulsive disorder).

Overall, JDTC studies reveal that a majority of teens experience several disadvantages. Many identify as AA or Hispanic, and come from socioeconomically disadvantaged homes often headed by a single caregiver. A large majority use marijuana, but other drugs of abuse are also present. Finally, many experience significant internalizing and externalizing psychiatric disorders that have the potential to interfere with the drug court process.

Drug Court Effectiveness

Recent research examining the effectiveness of JDTCs has provided mixed results. One meta-analysis of 46 evaluation studies, for example, revealed that JDTCs were no more or less effective than usual court proceedings (Tanner-Smith, Lipsey, & Wilson, 2016). However, the authors note a great deal of variability in study findings, and criticize the research literature as using mostly poor methodology and lacking randomized trials. Another meta-analysis found that JDTCs had a modest positive effect on recidivism, but that the effects tended to be less pronounced among the more rigorous clinical trials (Mitchell, Wilson, Eggers, & MacKenzie, 2011).

Individually, several studies have provided evidence for the effectiveness of JDTCs. In one of the most rigorous studies to date, Henggeler and colleagues (2006) revealed that JDTC resulted in decreased alcohol and polysubstance use, and fewer criminal offenses during the follow-up period compared with family court. In another study, a retrospective examination comparing 24-month post-drug court reincarceration rates found that JDTC was comparable to a more intensive intervention that incorporated continuation of pre-adjudicatory probation, dropping charges upon program completion, drug education and treatment, parenting classes, and urinalysis monitoring (Sloan, et al., 2004).

Cost effectiveness analyses have shown JDTCs to have some advantages over family courts. For example, Sheidow et al. (2012) found that although JDTC was more than three times the

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cost of family court, it was still more cost effective for reducing criminal behavior. Cost effectiveness was similar between the two court types for substance abuse outcomes.

Other studies have revealed specific youth characteristics that may predict success in JDTC. For example, a secondary analysis of data from Henggeler et al. (2006) examined youth-based (pre-treatment marijuana use, arrests, anxiety/depression), family-level (caregiver illegal substance use, family legal problems, parental supervision), and extra-familial (peer drug activities, school status, treatment condition) variables (Halliday-Boykins et al., 2010). Only one variable, parental illegal substance use, predicted treatment non-response as measured by continued cannabis use. Thus, it may be important to consider and encourage treatment for caregiver substance use problems for teens who are engaged in JDTCs.

Community collaboration is viewed as an essential way to improve drug court services. In a qualitative study of drug court representatives, Korchmaros, Thompson-Dyck, and Haring (2017) found that community collaboration, engaging of families and improved service matching are key features that would enhance JDTC effectiveness. However, there are barriers in each of these areas. For example, engaging families in their teens' JDTC process is difficult in part because families may be unable or unwilling to participate. Thus, strategies to reduce such barriers are viewed as essential for improving effectiveness.

Efforts to improve drug court using evidence-based treatments (EBT)

Given the mixed findings to date with regard to JDTC, there has been an effort to improve outcomes by incorporating EBT, and conducting clinical trials to examine whether these adjunctive therapies might improve primarily substance use or criminal recidivism outcomes. To date, most of the studies that have explored the use of EBTs have used individual behavioral interventions such as contingency management (CM) treatment, and/or family-based interventions such as multisystemic therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009).

Henggeler et al. (2006) conducted a randomized clinical trial to examine the relative efficacy of four treatment conditions: 1) family court; 2) JDTC alone; 3) JDTC plus MST; or 4) MST plus a CM intervention where teens could receive reinforcement for target behaviors related to drug abstinence (MST+CM). As already noted above, participants who received JDTC had better outcomes than did those who attended family court. This study also found that teens randomly assigned to MST and MST+CM conditions experienced significantly greater drug abstinence than those assigned to JDTC alone, as measured by UDS. JDTC conditions demonstrated improvements in recidivism measures relative to family court, but addition of MST and/or CM did not improve rates further. Results of this study showed that the addition of an EBT (in this case MST and CM) significantly improved the cost effectiveness of JDTC (Sheidow et al., 2012).

In a second trial by this group, Henggeler et al. (2012) randomly assigned six JDTCs to provide a treatment that included either family engagement and contingency management interventions (CM-FAM) or to continue to provide treatment as usual (TAU). In total, 104 juvenile offenders received treatment over an 18-month period. Participants in the CM-FAM

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condition exhibited significant reductions in marijuana use as measured by UDS data (but not self-report) compared with the TAU condition. CM-FAM participants also experienced significantly greater decreases in general delinquency, offenses against persons and property offenses compared with usual care.

Another clinical trial by Dakof et al. (2015) randomized JDTC participants to an EBT, multidimensional family therapy (MDFT) or adolescent group therapy (AGT; which is somewhat more consistent with treatments typically provided in JDTC). Both groups experienced significantly reduced offending and substance abuse at 6-month follow-up, and improvements in self-reported delinquency at 24-months. Over the longer term, substance use and re-arrest rates tended to worsen, but did not reach baseline levels. MDFT was associated with fewer felony arrests and less substance use at 24-month follow-up compared to AGT. Clearly, adding an evidence-based family therapy resulted in significantly better long-term outcomes than a more traditional treatment approach.

Taken together, these studies demonstrate that the addition of EBTs to JDTC may enhance the efficacy of these interventions. However, it is important to note that there are relatively few studies that have tested the incorporation of evidence-based treatments into the JDTC model.

Summary/Discussion

JDTCs are one of the few promising juvenile justice interventions that help substance abusing offenders turn their lives around by providing specialized treatment services and intensive judicial supervision as an alternative to incarceration. Overall, JDTCs provide an opportunity for justice-involved youth to receive help for substance abuse and mental health problems rather than confinement in juvenile detention. However, the results of research conducted thus far have demonstrated that JDTCs are not universally effective at reducing recidivism and substance use. Further, there are relatively few trials designed to test adjunctive treatment to JDTCs, but those that have been conducted demonstrate that addition EBTs can be used to bolster its effectiveness. Recommended future directions include assessment of factors that affect JDTC effectiveness, and development and testing of adjunct treatments that may help to engage families into the JDTC process.

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Key Points

1. Juvenile Drug Treatment Courts (JDTCs) were established in the 1990s to reduce the cycle of crime, drug use, and delinquency among youthful offenders.
2. JDTCs are made up of multidisciplinary teams including a judge, district attorneys, public defenders, juvenile probation officers, and drug treatment providers who collaborate to address the unique needs of each participant, guided by the principle of therapeutic jurisprudence.
3. The effectiveness of JDTC has been mixed. Several efforts have been made to improve its effectiveness through further development of its most efficacious components, development of adjunctive treatments designed to improve outcomes, utilization of community resources, and encouragement of family participation.

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Table 1.

OJJDP Juvenile Treatment Court Guidelines

Objectives	Guideline
1	Focus the JDTC Philosophy and Practice on Effectively Addressing Substance Use and Criminogenic Needs To Decrease Future Offending and Substance Use and To Increase Positive Outcomes
2	Ensure Equitable Treatment for All Youth by Adhering to Eligibility Criteria and Conducting an Initial Screening
3	Provide a JDTC Process That Engages the Full Team and Follows Procedures Fairly
4	Conduct Comprehensive Needs Assessments That Inform Individualized Case Management
5	Implement Contingency Management, Case Management, and Community Supervision Strategies Effectively
6	Refer Participants to Evidence-Based Substance Use Treatment, To Other Services, and for Prosocial Connections
7	Monitor and Track Program Completion and Termination

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Table 2.

Roles and responsibilities of juvenile drug treatment court team members.

Team Member	Roles and Responsibilities
Judge	• Presides over court proceedings and makes all final decisions regarding a youth participant's involvement including treatment, incentives, and sanctions • Reviews weekly status reports for each adolescent (usually during a team meeting where members provide updates on each participant), which detail their compliance with treatment and the treatment provider, drug testing, progress at home and school, and progress towards abstinence and obeying the law. • Administers a system of graduated sanctions and rewards during hearings to increase each participant's accountability and to enhance the likelihood of abstinence.
District Attorney (DA)	• Takes a non-adversarial stance and balances role of prosecutor (i.e., maintaining public safety) with the rehabilitative needs of the participant • Collaborates with the treatment team in monitoring youth's progress, and makes recommendations regarding sanctions and treatment recommendations • Attends weekly status and other court hearings (e.g., detention, probation violations, revocations, and any other special hearings associated with a JDTC participant) • Reviews weekly progress reports of each case, and if a youth is rearrested, reviews each new charge and assesses the appropriateness of youth's continued participation in JDTC
Public Defender (PD)	• Attorney who works for a public offender's office, which is a government-funded agency that represents indigent criminal defendants • Responsible for ensuring participant's legal and constitutional rights are not violated in court proceedings • Promotes participant health and wellbeing • Attends weekly status hearings, appears at all court hearings/proceedings, reviews weekly progress reports, and takes a non-adversarial stance with the court • Negotiates legal and treatment recommendations consistent with participant needs
Juvenile Probation Officer (JPO)	• Assigned to JDTCs by the Department of Probation and provides quality assurance for each youth's participation in the program • Responsible for the direct supervision of each participant's compliance with court mandates (e.g., sanctions, recommendations) • Oversees implementation of appropriate level of supervision in the community, serving as a liaison with relevant agencies (e.g., Department of Health and Human Services, adolescent treatment providers, school), and monitoring the day-to-day activities and home environment of each participant
Drug Treatment Provider (DTP)	• Participates in the weekly status hearings • Makes treatment recommendations to the court based on the specific needs of each youth and family (e.g., mental health, social services, etc.) and provides weekly updates as needed • DTP provides the multidisciplinary team with information regarding the adolescent's attendance and participation in treatment (substance abuse, mental health) • Levels of care available to JDTC usually includes outpatient treatment, intensive outpatient treatment, hospital based detoxification, and short-term (30-day) and long-term (60–90 days) residential treatment