Addressing the Needs of Youth with Co-occurring Disorders in Juvenile Drug Treatment Courts

Robert Kinscherff, J.D., Ph.D.

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Presenter Disclosures

Robert Kinscherff, J.D., Ph.D.

The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

No relationships to disclose
Behavioral health disorders – mental illness and/or substance abuse – are a serious public health concern.

Youth with behavioral health disorders experience higher rates of:
- impaired academic, family, and social functioning
- suicide attempts
- court involvement and recidivism (Hawkins, 2009)

Unrecognized, or left untreated, the presence of behavioral health disorders in youth may lead to involvement in the juvenile justice system.
**Prevalence of Behavioral Health Disorders among Youth in the Juvenile Justice System**

<table>
<thead>
<tr>
<th>Study</th>
<th>Prevalence</th>
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<tbody>
<tr>
<td>Teplin et al. (2013)</td>
<td>74.0%</td>
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<tr>
<td>NCMHJJ (2006)</td>
<td>70.4%</td>
</tr>
<tr>
<td>Wasserman et al. (2010)</td>
<td>65.0%</td>
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About 27% of justice-involved youth have disorders serious enough to require immediate and significant treatment.
In the 1990’s and early 2000’s, one response was the formation of Juvenile Drug Courts (JDC) to

• respond to youth with alcohol and other drug problems
• promote accountability of juvenile offenders
• promote accountability of those who provide services to them
443 Juvenile Drug Courts Around the Country

(Retrieved from nadcp.org)
JDC Effectiveness

Evaluation results continue to be mixed:

- **The Good:**

- **The Bad:**
  - Hartmann & Rhineberger (2003); Wright and Clymer (2001); Anspach et al., (2003); Latessa (2014)

- **Meta-Analysis:**
  - Null-findings for both Wilson et al. (2006); Shaffer (2006)
Why Aren’t They Effective?

Lack of...

- Reliance on evidence-based practices
- Fidelity to the 16 Strategies
- Attention to the presence of co-occurring mental and substance use disorders – those that exist simultaneously – among youth in the juvenile justice system
Why Focus on Youth with Co-occurring Disorders?

Youth with co-occurring disorders are more likely to:
- relapse following treatment
- be hospitalized
- be labeled as "treatment resistant"
- fail to meet terms of probation
- drop out of school
- engage in self-destructive or violent behavior
- become homeless
- die prematurely

Build Capacity in Juvenile Drug Courts

- Establishing Eligibility and Exclusion Criteria
- Screening and Assessment
- Youth and Family Involvement
- Integrated Treatment Services
- Violations, Sanctions, and Rewards
- Graduation Expectations
Establishing Eligibility and Exclusion Criteria

- Criteria broadly excluding youth with mental disorders should be changed to permit *inclusion of youth with mental disorders*

- Avoid using criteria exclusively based upon *specific diagnosis* and focus instead upon *degree of functional impairment* arising from the mental and substance use disorders
Screening and Assessment

- Screening of all potentially eligible youth for *both mental and substance use disorders* using *consistent protocols* and empirically *validated tools* for screening

- Refer youth screened “positive” for individualized assessments:
  - Administered by clinicians *trained in co-occurring assessment* methods
  - Attentive to *trauma-informed assessment*
  - Geared toward *case-specific* plans, “*treatment “matching”*
  - Focused upon *effective, integrated treatment*
Youth and Family Involvement

- Better outcomes with higher level of family engagement

- Consider requiring family participation in screening, assessment, and treatment by at least one “family” member (not necessarily a parent)

- Family-Friendly practices including
  - Scheduling when working parents can attend
  - Assisting with transportation, child care
  - Being sensitive to cultural issues
  - Recognizing family members who support recovery
  - Recruiting parents with “lived experience” as supports
  - Inviting parents with “lived experience” as JDC team members
  - Inviting former youth participants (graduates) as JDC team members
Integrated Treatment Services

- Better outcomes with integrated EBP treatment
- Avoid settling for what is available if inadequate
- “Something is better than nothing” = FALSE

- Work with community-based clinical services providers to *develop capacity for evidence-based integrated treatment*
  - Bring insurers and other funders into the conversation
  - Consider incentivizing a provider with sole referrals
  - Access technical support and consultation
  - Avoid “parallel” or “serial” treatment approaches
Violations, Sanctions, and Rewards

- Just as substance use recovery is characterized by relapse along the way to recovery, mental disorders may have a waxing and waning course of symptoms despite participation in treatment (especially in early phases of treatment).

- Violations and sanctions should focus on treatment engagement, not solely fluctuations of symptoms

- Violations, sanctions, rewards should consider:
  - Treatment attendance and participation
  - Degree of progress in substance use recovery
  - Indications of functioning at home, school, community
Graduation Expectations

- Ordinarily hold **youth with co-occurring disorders to same criteria as those with just mental or substance use disorders**

- Consider whether failure to achieve some expectations (e.g., school attendance) reflects **functional impact of active mental disorder** beyond the ready control of the youth

- Focus upon **ultimate markers of success** which include
  - Active participation in integrated treatment
  - Evidence of substance use recovery over time
  - Improved functional capacities, reduce impairment
  - Reduced re-arrest and violations of JDC expectations
Emerging Models

- Are promising but still developing
- Require key modifications in JDC policies
- Should provide access to integrated treatment for co-occurring mental and substance use disorders
Contact Information

Robert Kinscherff, J.D., Ph.D.
Senior Associate
National Center for Mental Health and Juvenile Justice
rkinscherff@prainc.com

Karli J Keator, M.P.H.
Division Director, Juvenile Justice
National Center for Mental Health and Juvenile Justice
kkeator@prainc.com