What Juvenile Courts Need to Know about Providing Effective Services for Youth with Co-occurring Disorders

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Timeline of Juvenile Drug Courts

1990s  Increasing Recognition of SUD in Criminal Court and then Juvenile Court Populations

2000s  Expansion of Juvenile Drug Courts
  - 2003 Juvenile Drug Courts: Strategies in Practice

Now  Increased recognition of COD
  Focus on evidence-based treatment
  Emergence of Integrated Treatment Models
Disproportionate Presence of Youth with Behavioral Health Disorders in Juvenile Justice

<table>
<thead>
<tr>
<th>Prevalence of Mental Disorders - Findings From Recent Studies</th>
<th>Positive Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCMHJJ (2006)</td>
<td>70.4%</td>
</tr>
<tr>
<td>Teplin et al. (2002)</td>
<td>69.0%</td>
</tr>
<tr>
<td>Wasserman et al. (2002)</td>
<td>68.5%</td>
</tr>
<tr>
<td>Wasserman, Ko, McReynolds (2004)</td>
<td>67.2%</td>
</tr>
</tbody>
</table>
Multiple and Complex Disorders are the Norm

- ~ 60 percent of youth with MHD also had SUD (NCMHJJ, 2006)

- Among youth who have received mental health treatment, estimates of lifetime co-occurring substance abuse range from 24% to 50%

- Among youth who have received substance abuse treatment, estimates of lifetime co-occurring mental health disorders range from 59% to 87%

- About 27% of justice-involved youth have disorders serious enough to require immediate and significant treatment
Key Decisions in Building COD Capacity

- Identifying Key Stakeholders and Partners
- Establish Eligibility and Exclusion Criteria
- Establish Policies: Termination, Sanction, Graduation
- Articulation of Roles and Responsibilities
- Policies regarding Exchanges of Information
- Protocol for Evidence-Based Screening for MHD, SUD
- Procedures for Integrated Assessment of MHD, SUD
- Referral for Evidence-Based Integrated Treatment
- Data Collection, Evaluation and Outcome Analysis
Why Integrated Treatment?

- Unrecognized/untreated mental health disorders reduce likelihood for achieving successful outcomes (reduced engagement & retention)

- Integrated treatment for co-occurring disorders is more effective – both problems are treated at the same time

- Few integrated treatment options available for youth with COD until recently
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INTEGRATED CO-OCCURRING TREATMENT MODEL OVERVIEW

NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS 21ST ANNUAL TRAINING CONFERENCE

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July 28, 2015
Problems are Multiple and Complex

- Among youth who have received substance abuse treatment, estimates of lifetime co-occurring psychiatric disorder range from 59% to 87%; 62% (Hussey); 67% (Dennis)
- Treatment and research on this population are not commensurate with the high prevalence
- Multiple problems (5+) are the norm (Dennis, 2005)
- Trauma and victimization in 62 to 80% of youth (Dennis; Hussey)
- Most youth have multiple system involvement and problems (juvenile justice (81%)
- Treatment engagement and retention are difficult, and intervention outcomes tend to be poor, (Hawkins, 2009, p.206).”
- Chronic relapsing disorder, requiring multiple treatment attempts over time (White and Dennis)
Influence, Interaction, and Manifestation of Multiple Occurring Conditions

- Contexts (Home, School, Peers, Community, etc.)
- Substance Use Disorder
- Mental Health Disorder
- Trauma Factors
- Risk & Resiliency Factors
- Developmental Factors
- Safety Concerns
- Youth
- Family

Salient Behavior/Symptom
Core Assumptions

1. Youth with COD often present as complex sets of externalizing, internalizing & substance use symptom patterns and vary in their nature, onset, presentation, interaction and severity; even among youth with similar diagnoses

2. The onset, progression & trajectory of co-occurring disorders is influenced by developmental variables including youth resiliency & risk and protective factors

3. Symptoms and behaviors manifest in, and are influenced by, multiple cultural contexts including home, school and community factors

4. Traumatic stress experiences contribute to impaired emotional and behavioral functioning and to the adoption of risk behaviors, which in turn may lead to further exposure to victimization, violence, and trauma experiences.

5. The stressors associated with co-occurring disorders have a dramatic impact on a youth and family’s resources (emotional, interpersonal, material)

6. Safety concerns and risk behaviors are elevated and need to be actively managed.
Weighing the Costs

“The question is not whether we can afford to invest in every child; it is whether we can afford not to.” Mariann Wright Edelman

- Estimate the present value of saving a 14-year-old high risk juvenile from a life of crime to range from $2.6 to $5.3 million

From: New Evidence on the Monetary Value of Saving a High Risk Youth (Cohen & Piquero, 2008; p. 25)
<table>
<thead>
<tr>
<th>Placement Type</th>
<th>Average Cost Per Diem</th>
<th>Annualized Cost</th>
<th>System(s) Impacted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Care  Level IV</td>
<td>$123.90</td>
<td>$45,224</td>
<td>Child Welfare</td>
</tr>
<tr>
<td>Group Home</td>
<td>$125</td>
<td>$45,625</td>
<td>Child Welfare; Juvenile Courts</td>
</tr>
<tr>
<td>Residential Treatment (non-secure)</td>
<td>$200.56</td>
<td>$73,204</td>
<td>Child Welfare; Juvenile Courts; School Systems; Mental Health; Substance Abuse</td>
</tr>
<tr>
<td>Residential Treatment (secure)</td>
<td>$335</td>
<td>$122,275</td>
<td>Child Welfare; Juvenile Courts; School Systems; Mental Health; Substance Abuse</td>
</tr>
<tr>
<td>Juvenile Commitment</td>
<td>$338</td>
<td>$122,356 (11.9 months)</td>
<td>ODYS; Local Juvenile Courts</td>
</tr>
<tr>
<td>ICT (average cost per treatment episode)</td>
<td>$7,500- 9,000</td>
<td></td>
<td>All</td>
</tr>
</tbody>
</table>
Negatives Aspects of Placement

- Youth may learn additional negative, sometimes more destructive behaviors
- Detrimental to child and family bonds
- Family not normally a part of treatment
- Transitional delays in receiving services (medication)
- Lost education time
- Research does not support effectiveness
- Financial cost to community
It takes a community ....

- Shared burden - shared risk
- No single system can manage the multiple issues of at-risk youth and their families alone
- Mutual responsibilities: we all play a role
  - Youth and family
  - Providers
  - Child-Serving Systems
  - Community (supports)
# Service to Science Development

## Phase One

| Initial Model Development: U. of Akron, 1999 |
| Naturalistic progression based on community need. Expert panel; focus groups; youth and family |

## Phase Two

| Pilot Implementation: 2001-2005 |
| Model refinement; small comparison study. High family and community saliency. |

## Phase Three

| Multiple Site Implementation: 2005-Present |
| Initial research study: 2005-2008 Model refinement |

## Phase Four: Develop Increasing Research Support
Integrated Co-Occurring Treatment

ICT utilizes an integrated treatment approach, embedded in an intensive home-based service delivery model, to provide both mental health and substance abuse treatment services to youth with co-occurring disorders of substance use and serious emotional disability and their families. Services are provided in the home, school and community where the youth lives, with the goal of safely maintaining the youth in the least restrictive, most normative environment.

Main Purpose:
- Placement prevention
- Reunification
- Stabilization and safety
ICT Model Components

- Intensive Home-Based Service Delivery Modality
- Systemic Engagement and Change
- Multidimensional and Integrated Assessment and Conceptualization
- Comprehensive and Integrated Treatment Array Matched to Needs and Strengths

System of Care Principles

Resiliency-Oriented Developmental Perspective
<table>
<thead>
<tr>
<th>Location of Service</th>
<th>Home and Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensity</td>
<td>Frequency: 2 to 5 sessions per week</td>
</tr>
<tr>
<td></td>
<td>Duration: 4 to 8 hours per week</td>
</tr>
<tr>
<td>Crisis response &amp; availability;</td>
<td>24/7</td>
</tr>
<tr>
<td>active safety planning and</td>
<td></td>
</tr>
<tr>
<td>monitoring</td>
<td></td>
</tr>
<tr>
<td>Active safety planning &amp; monitoring</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Small caseloads</td>
<td>4 to 6 families per FTE; 8 to 12 for team of two</td>
</tr>
<tr>
<td>Flexible scheduling</td>
<td>Convenient to family</td>
</tr>
<tr>
<td>Treatment duration</td>
<td>3 to 6 months</td>
</tr>
<tr>
<td>Systemic engagement and community</td>
<td>Child and family teaming; skillful advocacy;</td>
</tr>
<tr>
<td>teaming</td>
<td>family partnering; culturally mindful</td>
</tr>
<tr>
<td></td>
<td>engagement</td>
</tr>
<tr>
<td>Active clinical supervision &amp;</td>
<td>24/7 availability; field support; individual &amp; group</td>
</tr>
<tr>
<td>oversight</td>
<td></td>
</tr>
<tr>
<td>Program structure and credentials</td>
<td>Licensed BSW and above; MA preferred</td>
</tr>
<tr>
<td></td>
<td>Program size: 4 to 8; .5 to 1 FTE IHBT Supervisor</td>
</tr>
<tr>
<td>Comprehensive service array</td>
<td>Crisis stabilization, safety planning, skill</td>
</tr>
<tr>
<td></td>
<td>building, trauma-focused, family-focused;</td>
</tr>
<tr>
<td></td>
<td>resiliency &amp; support-building interventions;</td>
</tr>
<tr>
<td></td>
<td>cognitive interventions</td>
</tr>
</tbody>
</table>
I. **Symptom Patterns and Diagnoses:** youth who meet the criteria for both Mental Health and Substance Use diagnoses

II. **Contextual Functioning:** Degree of functional impairment per life domain

III. **Developmental and Cognitive Functioning:** (cognitive functioning, emotional, & behavioral maturity)

IV. **Risk and Recovery Environments:** Environmental risk and recovery conditions (e.g. trauma, safety, negative influences, family conflict, poverty)

The youth’s functioning and COD patterns are determined by integrating these areas in context of the other and as a collective whole.
ICT Treatment Foci

- Build Protective Factors: Pro-Social Recovery Environments, Asset Building; Supports
- Establish Positive Connections & Functional Success through Relational Supports and Strategic Accommodations
- Solidify Structure, Supervision, & Monitoring
- Build Adaptive Skills & Emotional Coping Across Settings; Psycho-education
- Engagement; Readiness to Change
- Safety, Stabilization, Risk & Symptom Reduction

Resiliency & Recovery

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Integrated and Comprehensive Treatment Matched to Need

Youth and Family Need Hierarchy (Shepler, 1991, 1999)
Integrated Contextual Functional Analysis

Contextual & Relational Dynamics: Family, Peers, School, Community

Dispositional Factors

De-stabilizing Event or Trigger

Trauma Filter

Youth

SU Disorder

MH Disorder

Risks Factors, Skills, Resources, and Supports

Salient Behavior/Symptom

Exacerbating Response

Escalation Cycle

Safety Issue

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Center for Innovative Practices
Target Outcomes

Increase functioning in major life contexts so that the youth is:

- Living at home or in a permanent home setting
- Attending and achieving at school/work
- Reduced involvement in the JJ system
- Reduced use/no use of substances
- Participating in positive family, peer, and community life
- Improved family recovery environment
- Accessing resources and natural supports as needed to maintain gains and prevent recidivism
Integrated Co-Occurring Treatment

Logistics

- Dually certified agency; dually licensed supervisor
- 2 to 4 FTE clinical staff either dually licensed or dually trained, with mix of SU and MH expertise on the team
- Consultation, training, and technical support:
  - Provide initial and booster trainings
  - Provide regular consultation and coaching of ICT Team
- Years 3+:
  - ICT Supervisor Monitors Fidelity
  - Consultation negotiated based on need
  - Yearly fidelity review
Funding Intensive Home Based Programs

- ICT is typically funded through a combination of Medicaid, insurance, and cross-system funding.
- Unique aspects of intensive home-based service delivery models that are more costly
  - Extensive supervision and consultation time involved;
  - Small caseloads;
  - Travel time required to deliver the service in the natural environment; and
  - On-call coverage;
- All of which decrease the amount of time in a week for billable services.
Results of ICT Study (2001-2002)

<table>
<thead>
<tr>
<th>ICT Youth</th>
<th>Usual Services Comparison Group</th>
<th>Size of Difference in commitment and/or recidivism rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>o 56 youth</td>
<td>o 19 Youth</td>
<td>Chi Square (1, 19): 3.338</td>
</tr>
<tr>
<td>o 25% recidivism</td>
<td>o 47% commitment rate</td>
<td>Level of significance: (p one-tailed = .034)</td>
</tr>
</tbody>
</table>
Recent ICT Study

- Real world study: Utilized naturally occurring comparison groups from a specialized co-occurring court
  - Due to ethical concerns, randomization into groups was not allowed
- All youth received the co-occurring court’s intensive probation program
- Compared ICT to traditional non-integrated services (TAU)
- ICT group had significantly more problems at admission than TAU group
- Randomized controlled study with follow-up needed to confirm results
## Positive Results: Improvement Over Time

<table>
<thead>
<tr>
<th>All Youth Considered Together</th>
<th>ICT Did Better than TSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Substance use variables (GRAD; Drug Screens)</td>
<td>- Substance Use Variables (GRAD; Drug Screens)</td>
</tr>
<tr>
<td>- Mental health variables: (Ohio Scales; GRAD)</td>
<td>- Mental Health Problem Severity: (GRAD only)</td>
</tr>
<tr>
<td>- Family/Parenting (GRAD)</td>
<td>- Pro-Social Activities (GRAD)</td>
</tr>
<tr>
<td>- Pro-Social Activities (GRAD)</td>
<td>- Pro-Social Peers (GRAD-Parent Rating)</td>
</tr>
<tr>
<td>- Educational Functioning (GRAD)</td>
<td>- Family/Parenting (GRAD-Youth Rating)</td>
</tr>
</tbody>
</table>
ICT showed a significant decrease in substance use, as measured by the GRAD Substance Use/Abuse Scale, as compared to TSS (p < 0.001)
ICT showed a significant decrease in mental health problem severity, as measured by the GRAD Personality/Behavior Scale, compared to TSS \( (p < 0.014) \)
Realistic Outcomes and Expectations

- Think trajectory of wellness not cure
- Youth living with mental health and substance use disorders often have ongoing treatment and/or support needs
- Substance use is a chronic relapsing disorder (Dennis)
  - Completion rates low/High rate of treatment drop-out.
  - About half of adolescents treated report no use after treatment
- Measure what you do: risk reduction across life domains
  - Track multiple outcomes
- Conversation with key stakeholders about realistic outcome expectations (increased functioning; decreased level of care needs; etc.)
National Recognition

- **SAMHSA’s 2010 Science and Service Award**: A national program that recognizes community-based organizations and coalitions that have shown exemplary implementation of evidence-based mental health and substance abuse interventions. Given to McHenry County for its implementation of ICT for their SAMHSA SOC grant.

- **NIATx iAward (2010)** given by the State Association of Addiction Services and NIATx: Family Service and Community Mental Health Center located in McHenry County, Illinois received a 2010 iAward for Innovation in Behavioral Healthcare Services for its successful implementation of Integrated Co-Occurring Treatment (ICT).

- **Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile**: One of the programs chosen by the National Center for Mental Health and Juvenile Justice to be highlighted as a promising practice in this OJJDP supported monograph.
<table>
<thead>
<tr>
<th>Current ICT Sites</th>
<th>Federal Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summit County, Ohio</td>
<td>Byrne; JAIBG 2001-2004</td>
</tr>
<tr>
<td>McHenry County, Illinois</td>
<td>SAMHSA System of Care: 2008-2012</td>
</tr>
<tr>
<td>Franklin County, Ohio</td>
<td>Re-Entry: 2011-2012;</td>
</tr>
<tr>
<td>Kalamazoo County, Michigan</td>
<td>SAMHSA System of Care: 2006-2009</td>
</tr>
<tr>
<td>Montana (Helena and Missoula)</td>
<td>SAT-ED 2013- current</td>
</tr>
</tbody>
</table>
What we have learned

- Engagement and motivation to change is slower
- Optimal effects are more likely to be achieved using interventions that impact youth behaviors, family systems, peer relationships, and school functioning.
- Focus on risk reduction and symptom stabilization across life domains
- Intensive clinical supports are needed to help manage risk and safety (active safety planning and monitoring, and have 24-hour on-call availability to the youth and family)
- Look for treatment programs that offer both substance use and mental health approaches delivered in home and community environments such as ICT, Multisystemic Therapy (MST), Functional Family Therapy-CMT (FFT-CMT), Multidimensional Family Therapy (MDFT).
- Traditional adult-oriented programs, such as twelve step programs, may not be developmentally appropriate for youth with co-occurring disorders. Try recovery mentors.
Intersection of Treatment and Court

- Leveraging the influence of the court in combination with effective treatments leads to better outcomes
- Managing risk and safety issues of high-risk youth in the community requires active collaboration and coordination between service providers, the family, and the court (consider utilizing Wraparound process format)
  - Community service coordination planning can be incorporated into court orders.
  - Coordinated teaming efforts increases community accountability to a unified plan for the youth.
  - Clinically-informed judicial decision making: Can utilize the clinical information provided to make informed decisions about youth
  - Utilize regularly scheduled staffing/teaming between service providers and juvenile justice team for purpose of problem-solving and developing creative solutions
- Resolve infrastructure issues prior to implementing new programs (integrated funding and paperwork requirements)
Limitations of Communication

☐ Be cognizant that federal law 42CFR Part 2 is the most restrictive confidentiality law for treatment professionals and limits what treatment professionals can say about a client’s substance use without appropriate releases or unless court ordered.
Effective **intervention practices** and programs

+ 

Effective **implementation practices**

= **Good outcomes for children and their families**

No other combination of factors reliably produces desired outcomes for children, families, and caregivers

NIRN


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