

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

Prevalence of Mental Disorders- Findings From Recent Studies	Positive Diagnosis
NCMHJJ (2006)	70.4%
Teplin et al. (2002)	69.0%
Wasserman et al. (2002)	68.5%
Wasserman, Ko, McReynolds (2004)	67.2%

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 20TH ANNUAL TRAINING
CONFERENCE

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Prevalence of co-occurring mental health and substance abuse disorders: Clinical Samples

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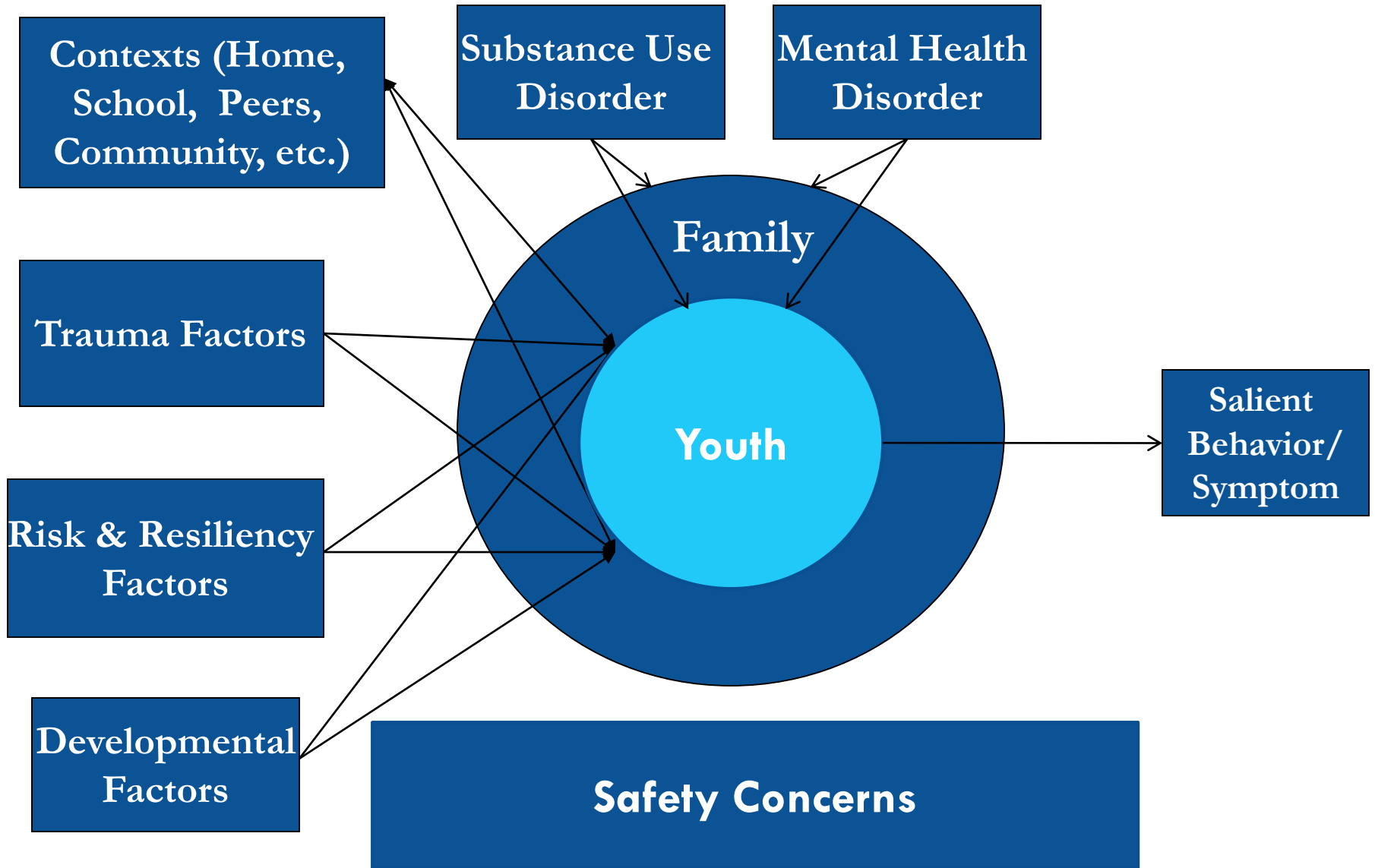
- Among mental health treatment samples, estimates of lifetime co-morbid substance abuse samples range from 24% to 50%
- Among youth who have received substance abuse treatment, estimates of lifetime co-occurring psychiatric disorder range from 59% to 87%; 62% (Hussey); 67% (Dennis)
- 45 to 49% of youth treated for substance use disorders also have co-occurring psychiatric disorders (Tenn Care)
- Treatment and research on this population are not commensurate with the high prevalence

Problems are Multiple and Complex

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- ❑ 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%); schools; family; peers)
- ❑ 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)
- ❑ Is Multiple-Occurring Conditions a better frame?

Influence, Interaction, and Manifestation of Multiple Occurring Conditions



Core Assumptions

1. Youth with COD present with multiple and complex symptom patterns and behaviors, which adversely affects their functioning in developmentally important life domains.
2. Sustained recovery often takes multiple treatment attempts over time.
3. COD presentation in youth is affected by brain development; and conversely, brain development is impacted by substance use.
4. Contextual factors (peers, family, school, neighborhood, and the risk and protective factors associated with them) play a mediating role in youth behaviors, use patterns, and recovery trajectory.
5. The stressors associated with co-occurring disorders negatively strain family emotional, interpersonal, and material resources.

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)

Fiscal Impact for System Stakeholders (2008 Ohio Data)

Placement Type	Average Cost Per Diem	Annualized Cost	System(s) Impacted
Foster Care Level IV	\$123.90	\$45,224	Child Welfare
Group Home	\$125	\$45,625	Child Welfare; Juvenile Courts
Residential Treatment (non-secure)	\$200.56	\$73,204	Child Welfare; Juvenile Courts; School Systems; Mental Health; Substance Abuse
Residential Treatment (secure)	\$335	\$122,275	Child Welfare; Juvenile Courts; School Systems; Mental Health; Substance Abuse
Juvenile Commitment	\$338	\$122,356 (11.9 months)	ODYS; Local Juvenile Courts
ICT (average cost per treatment episode)		\$7,500- 9,000	All

Negative Aspects of Placement

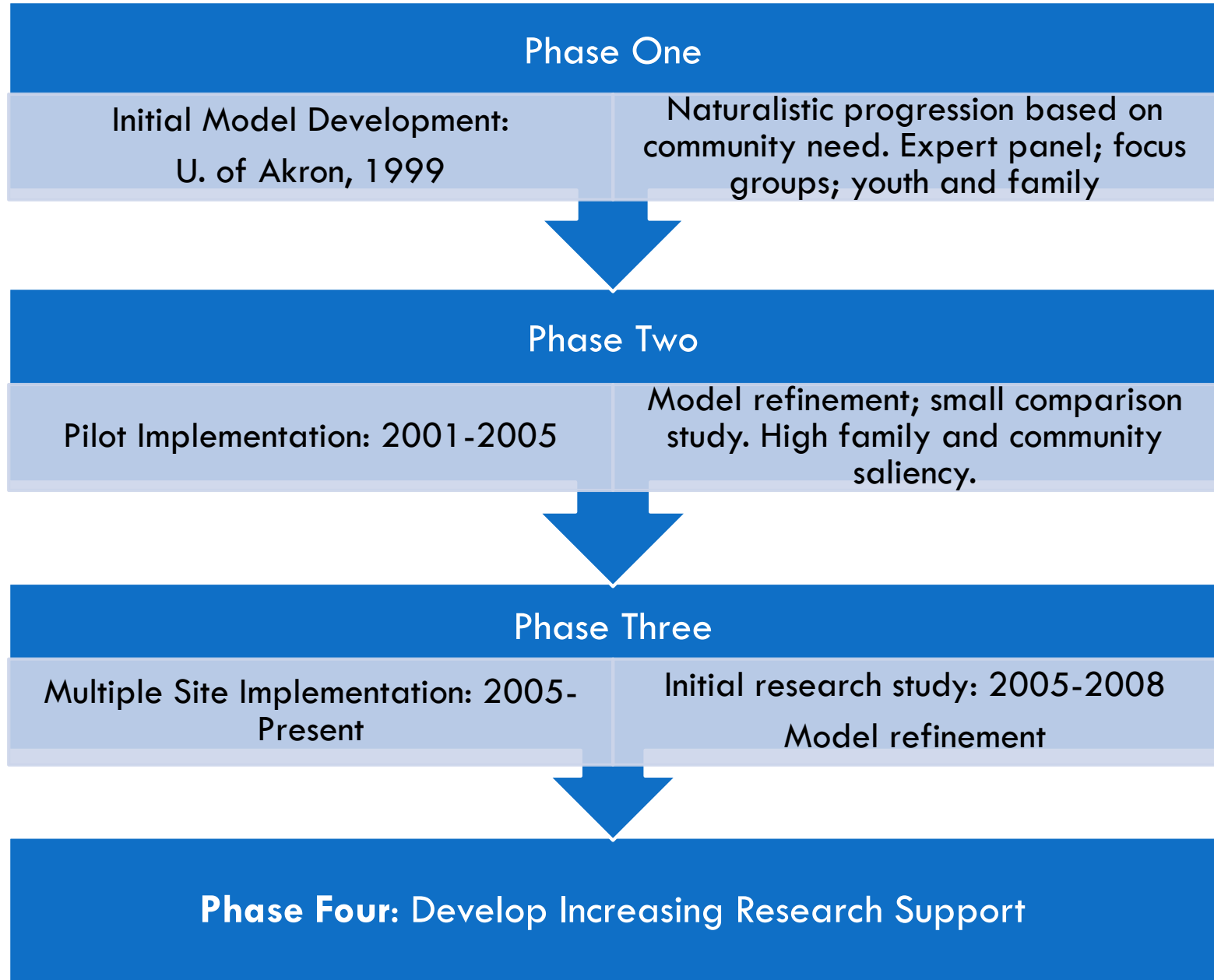
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- ❑ Youth may learn additional negative, sometimes more destructive behaviors
- ❑ Detrimental to child and family bonds
- ❑ Family not normally a part of treatment
- ❑ Transitional delays in receiving services (medication)
- ❑ Lost education time
- ❑ 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



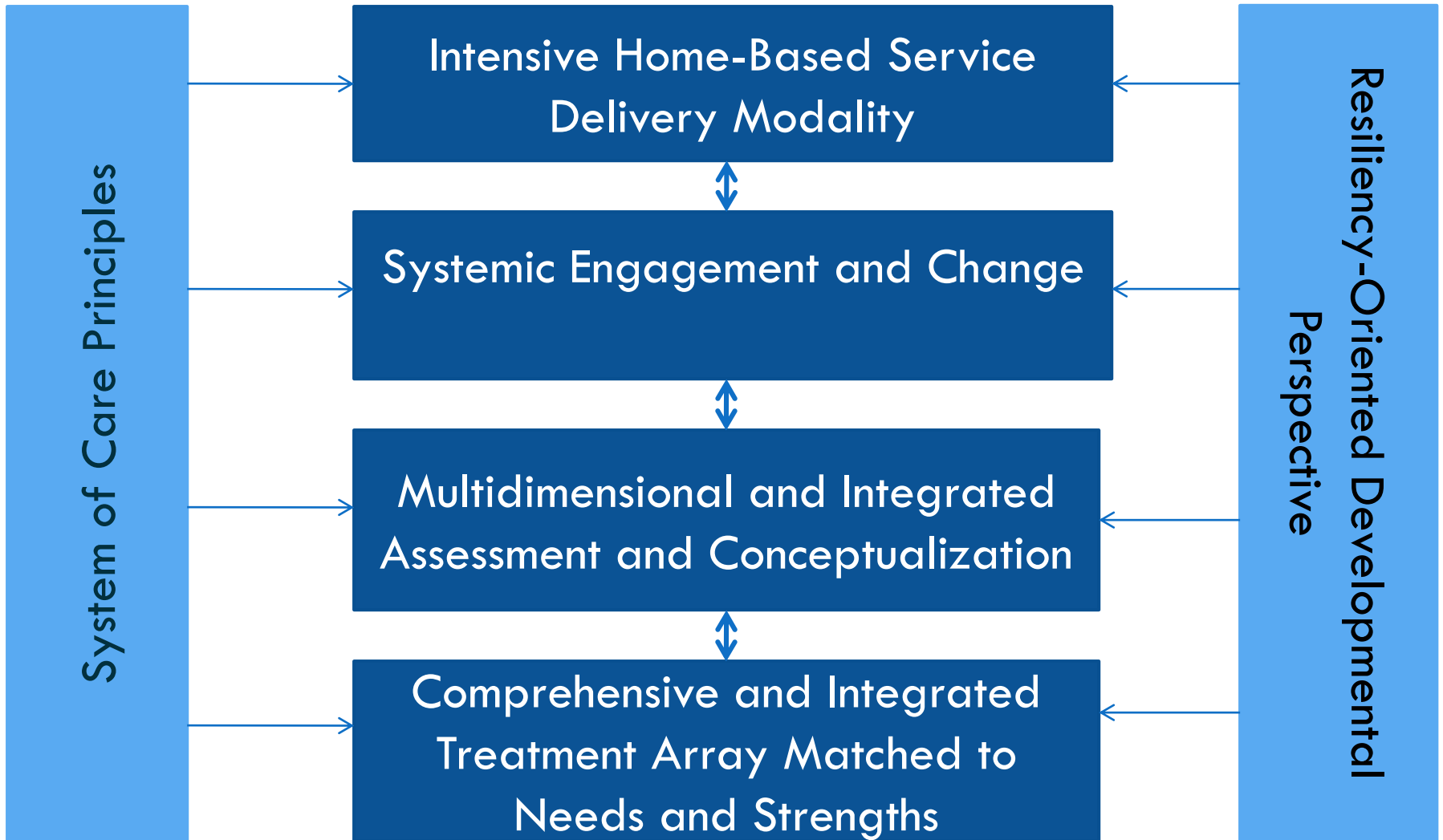
Integrated Co-Occurring Treatment

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- 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 Model

Location of Service	Home and Community
Intensity	Frequency: 2 to 5 sessions per week Duration: 4 to 8 hours per week
Crisis response & availability; active safety planning and monitoring	24/7
Active safety planning & monitoring	Ongoing
Small caseloads	4 to 6 families per FTE; 8 to 12 for team of two
Flexible scheduling	Convenient to family
Treatment duration	3 to 6 months
Systemic engagement and community teaming	Child and family teaming; skillful advocacy; family partnering; culturally mindful engagement
Active clinical supervision & oversight	24/7 availability; field support; individual & group
Program structure and credentials	Licensed BSW and above; MA preferred Program size: 4 to 8; .5 to 1 FTE IHBT Supervisor
Comprehensive service array	Crisis stabilization, safety planning, skill building, trauma-focused, family-focused; resiliency & support-building interventions; cognitive interventions

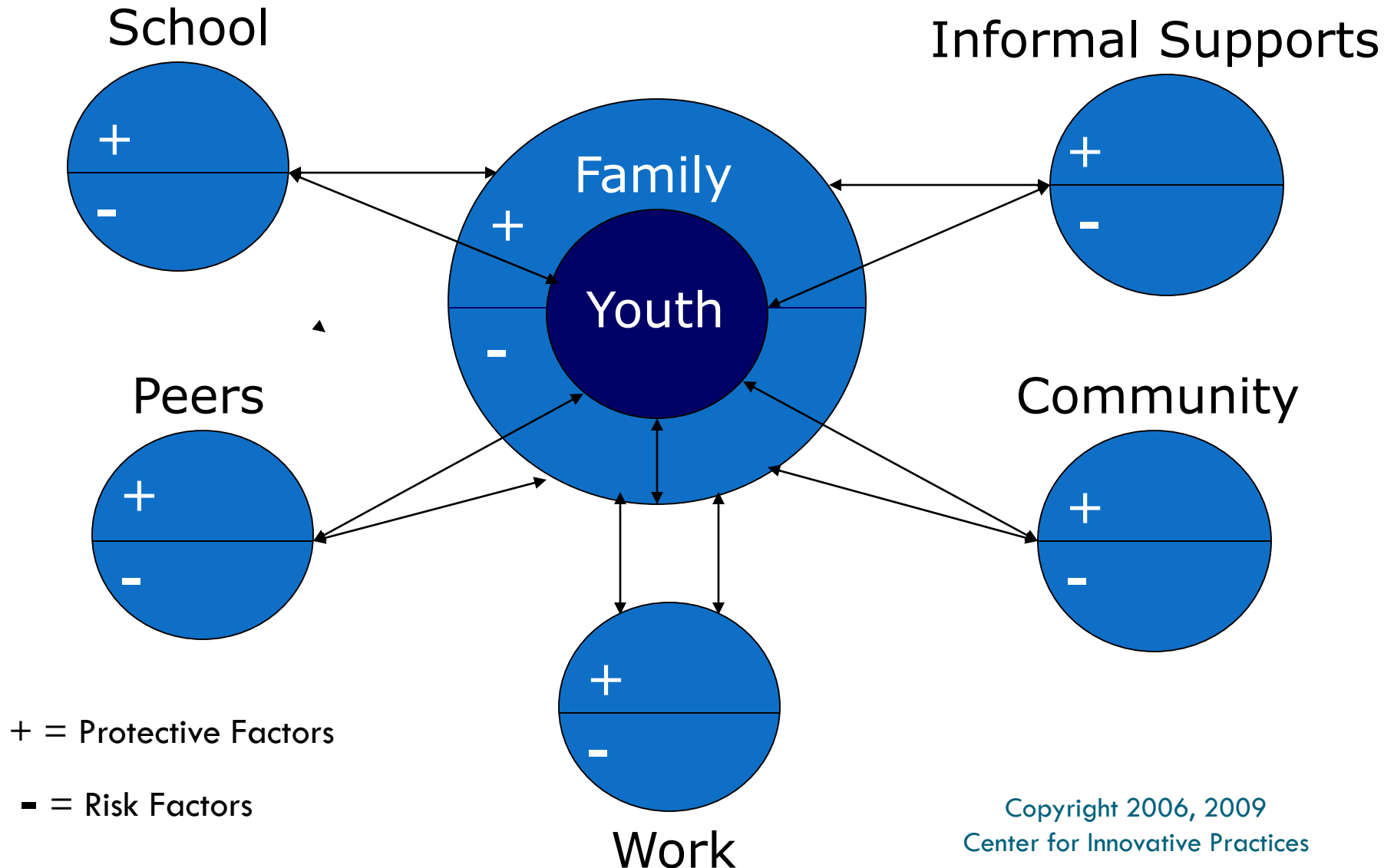
Multidimensional and Integrated Contextual Assessment

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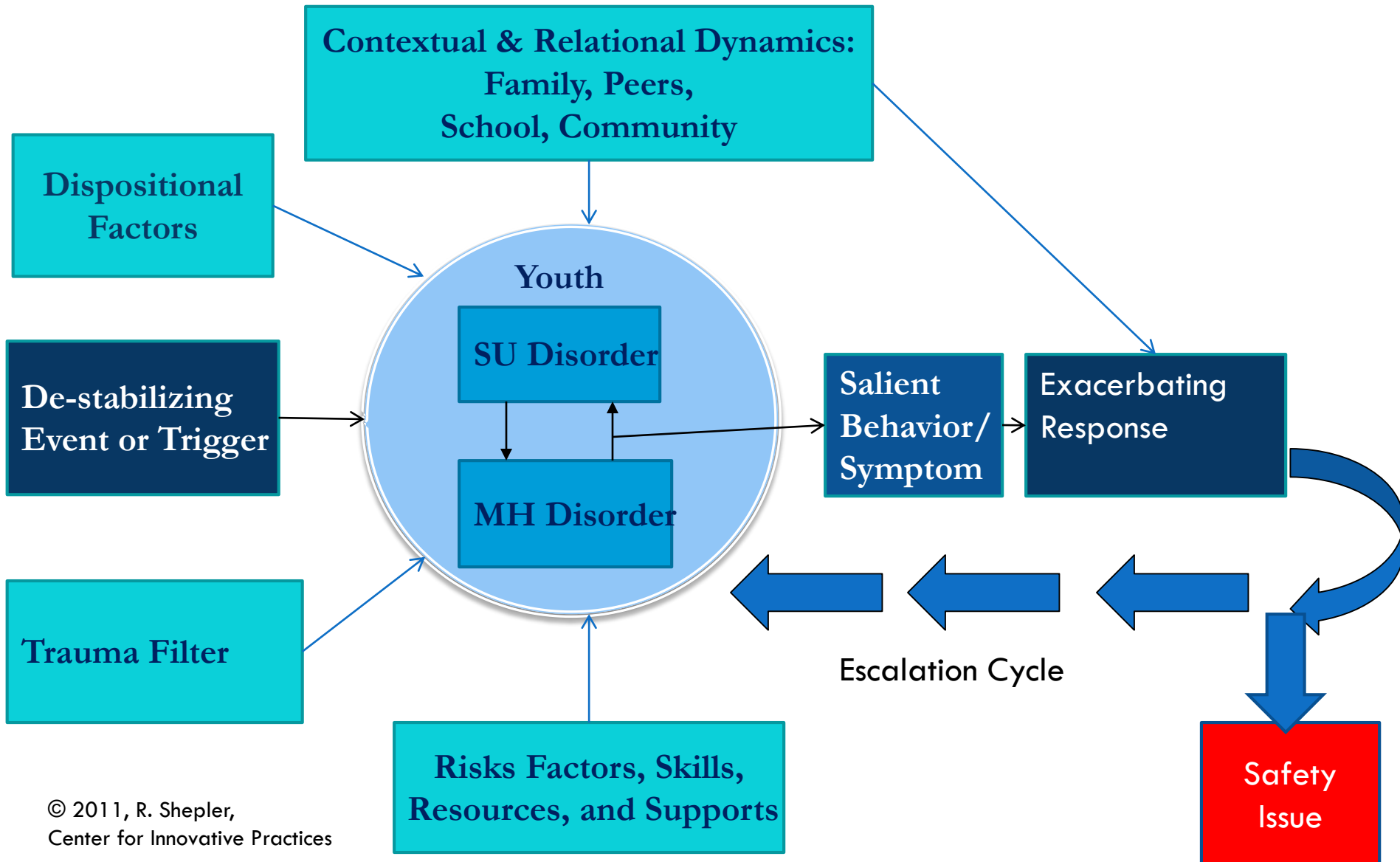
- I. **Symptom Patterns and Diagnoses:** youth who meet the criteria for both Mental Health and Substance Use diagnoses
- II. **Contextual Functioning:** Degree of functional impairment per life domain
- III. **Developmental and Cognitive Functioning:** (cognitive functioning, emotional, & behavioral 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.

Contextual Assessment



Integrated Contextual Functional Analysis



ICT Core Services

- Crisis Intervention and Stabilization
- Case management-oriented activities to meet basic needs
- Individually-Focused Interventions
- Family-Focused Interventions
- Cross-System Interventions
- Resource and support building activities

Integrated and Comprehensive Treatment Matched to Need

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Youth and Family Need Hierarchy (Shepler, 1991, 1999)

Target Outcomes

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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.

ICT RESEARCH

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

Current ICT Sites	Federal Funding
Summit County, Ohio	Byrne; JAIBG 2001-2004
Cuyahoga County, Ohio	SAMHSA System of Care (2006-2008) & SCY: 2006-2007
McHenry County, Illinois	SAMHSA System of Care: 2008-2012
Franklin County, Ohio	Re-Entry: 2011-2012;
Kalamazoo County, Michigan	SAMHSA System of Care: 2006- 2009
Montana (Helena and Missoula)	SAT-ED 2013- current

Results of ICT Study (2001-2002)

ICT Youth	Usual Services Comparison Group	Size of Difference in commitment and/or recidivism rates
<ul style="list-style-type: none">○ 56 youth○ 25% recidivism rate	<ul style="list-style-type: none">○ 19 Youth○ 47% commitment rate	Chi Square (1, 19): 3.338 Level of significance: (p one-tailed = .034)

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

All Youth Considered Together

- ❑ Substance use variables (GRAD; Drug Screens)
- ❑ Mental health variables: (Ohio Scales; GRAD)
- ❑ Family/Parenting (GRAD)
- ❑ Pro-Social Activities (GRAD)
- ❑ Educational Functioning (GRAD)

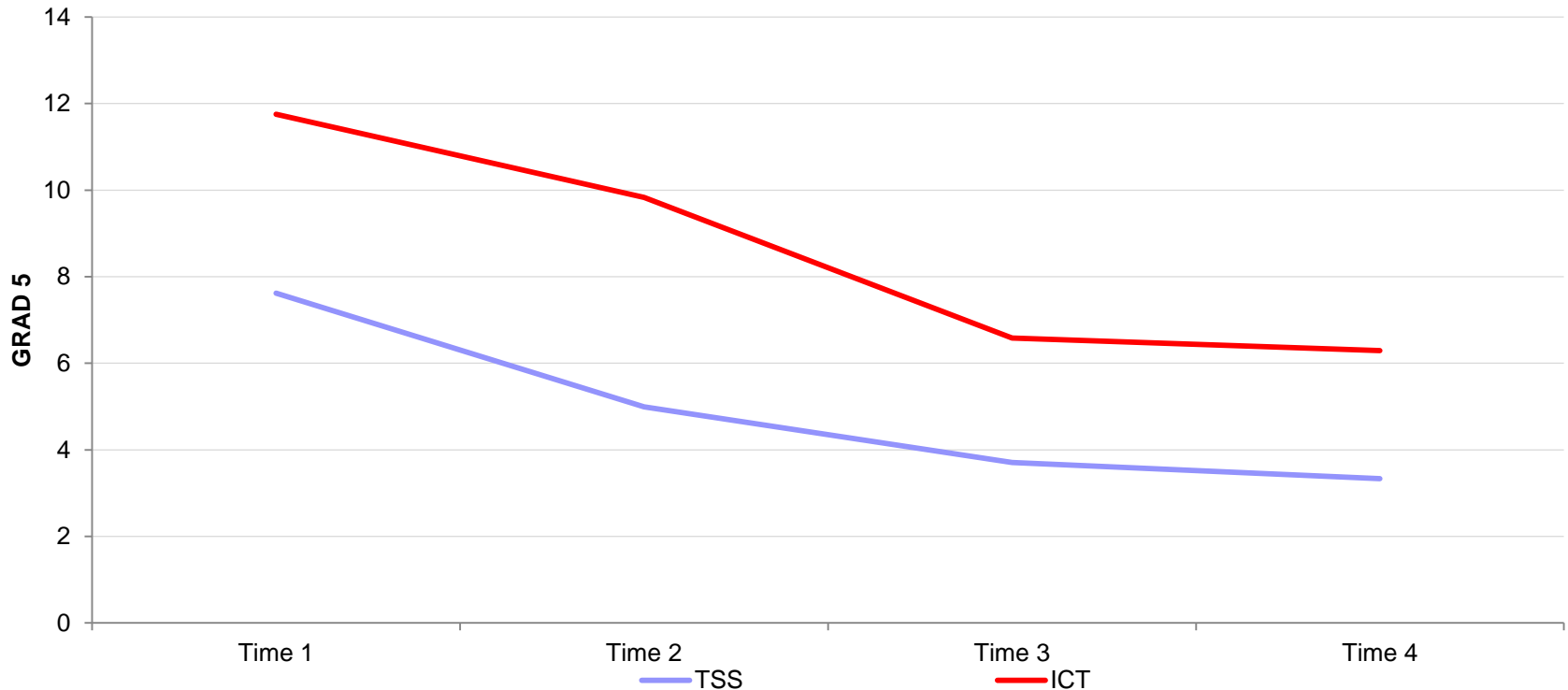
ICT Did Better than TSS

- ❑ Substance Use Variables (GRAD; Drug Screens)
- ❑ Mental Health Problem Severity: (GRAD only)
- ❑ Pro-Social Activities (GRAD)
- ❑ Pro-Social Peers (GRAD-Parent Rating)
- ❑ Family/Parenting (GRAD-Youth Rating)

ICT showed a significant decrease in substance use, as measured by the GRAD Substance Use/Abuse Scale, as compared to TSS ($p < 0.001$)

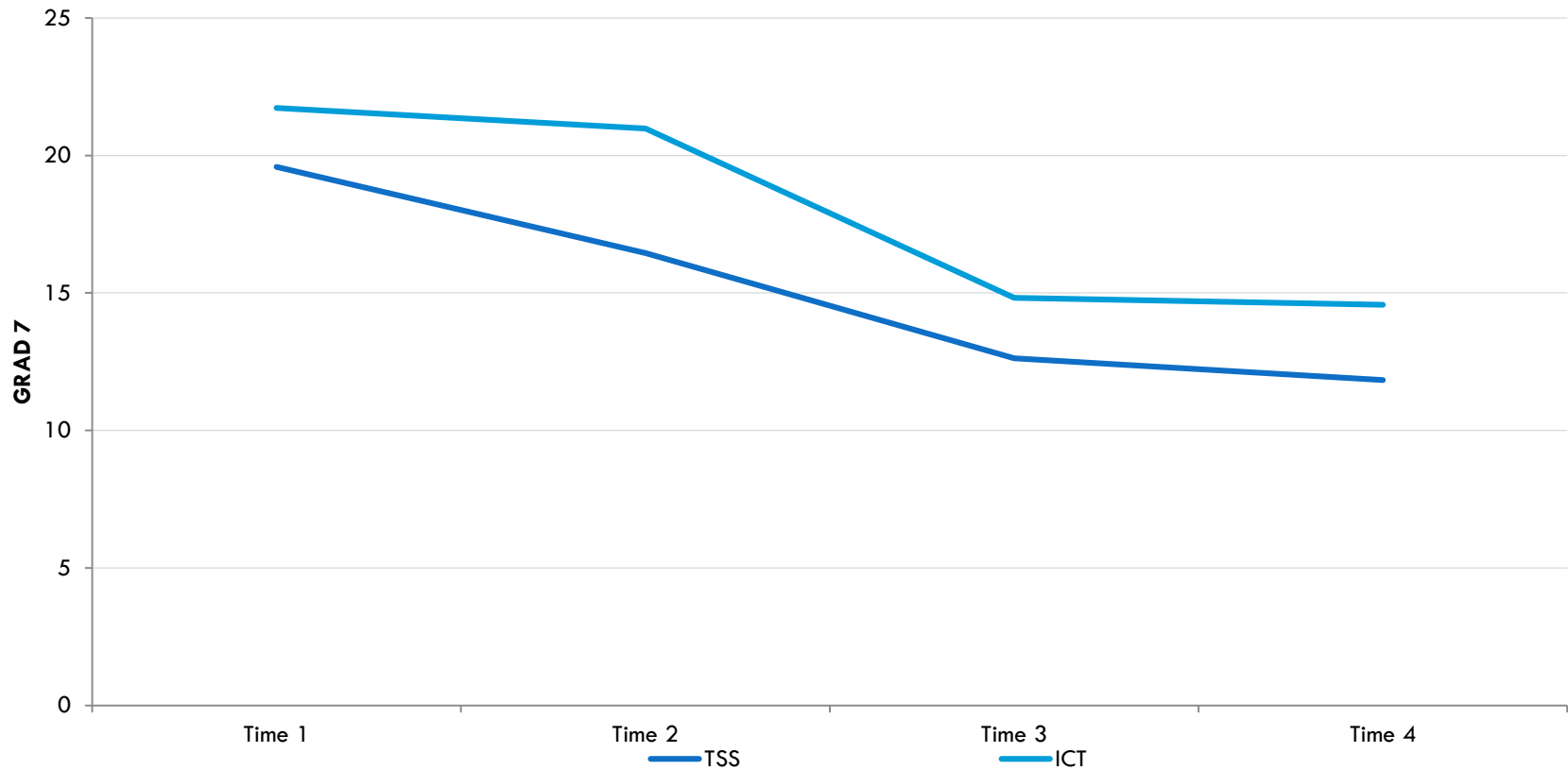
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Substance Use as Measured by GRAD Substance Use/Abuse Scale Across Treatment and Time



ICT showed a significant decrease in mental health problem severity, as measured by the GRAD Personality/Behavior Scale, compared to TSS ($p < 0.014$)

GRAD 7 Across Treatment and Time



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.)

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.

Proven Formula

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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