



Effective  
^

# Developing Policies for Addressing the Needs of Court-Involved Youth with Co-occurring Disorders

## Advancing Juvenile Drug Treatment Courts: Policy and Program Briefs

Robert Kinscherff, Ph.D., J.D.<sup>1</sup>, and Joseph J. Cocozza, Ph.D.<sup>2</sup>

The presence of co-occurring mental disorders among court-involved youth with substance use disorders creates unique challenges for juvenile drug treatment courts. Research consistently finds that these youth present with the greatest impairment in individual and academic functioning, have elevated risk of suicide, and consistently have the poorest treatment outcomes. Policy and practice changes are necessary to successfully address youth with co-occurring disorders in juvenile drug treatment courts.

Given the growing recognition that most youth who come in contact with the juvenile justice system have both substance use and mental disorders, the National Center for Mental Health and Juvenile Justice and the National Council for Juvenile and Family Court Judges have developed a series of three briefs that

- outline policies that should be reviewed and modified,
- describe emerging program models with demonstrated evidence of effectiveness, and
- identify treatment practices that increase the likelihood of achieving positive outcomes for these youth.

This brief focuses on modifications to policy and practice that juvenile drug courts should consider if youth with co-occurring disorders are to be effectively served.

<sup>1</sup> Senior Associate at the National Center for Mental Health and Juvenile Justice, Policy Research Associates, Inc.

<sup>2</sup> Director of the National Center for Mental Health and Juvenile Justice, Policy Research Associates, Inc.

*When a person experiences both mental and substance use disorders, he or she is said to have co-occurring disorders. Although these disorders may exist independently of each other, one often exacerbates the other.*

## Introduction

Recognizing that fragmented services systems impede efforts to respond effectively to youth with alcohol and other drug problems, innovative juvenile courts have developed specialized dockets for these youth and their families. These courts not only promote accountability of youthful offenders but also of those who provide services to them. By 2012, some 458 juvenile drug treatment courts were established or being planned (National Institute of Justice, 2012). Although initial evaluation results are mixed, recent findings indicate positive outcomes for youth, especially when courts are guided by the 16 strategies set forth by the Bureau of Justice Assistance (2003) and adhere to evidence-based and best practices (Henggeler, McCart, Cunningham, & Chapman, 2012; Stein, Deberard, & Homan, 2013).

Common practices in juvenile drug treatment courts include heightened judicial oversight, cross-systems communication and collaboration, coordination of model court practices with evidence-based treatments, use of family and youth engagement strategies, recognition and rewards for successful “graduation” from the program, and meaningful accountability of youth and service providers (Bureau of Justice Assistance, 2003). Policy and practice reflect highly localized responses based on judicial leadership, level of buy-in and collaboration among key partners, community needs and resources, and other characteristics of the court and community.

Cooper (2001, p. 7), observes that successful juvenile drug treatment courts develop practices and procedures that reliably achieve five strategic goals:

1. Provide immediate intervention, treatment, and structure in the lives of juveniles who use drugs through ongoing, active oversight and monitoring by the drug court judge
2. Improve the level of functioning of youth in their environment, address problems that may contribute to their use of drugs, and develop and strengthen their ability to lead crime- and drug-free lives
3. Provide juveniles with skills that aid them in leading productive, drug free and crime free lives — including skills that relate to their educational development, self-worth, and capacity to develop positive relationships in the community

4. Strengthen families of drug-involved youth by improving the capacity of families to provide structure and guidance to their children
5. Improve system capacity to promote accountability for both juvenile offenders and the services they are provided

## Emerging Focus on Co-occurring Disorders among Court-Involved Youth

Research consistently demonstrates that between 60 and 90 percent of youth in contact with the juvenile justice system meet criteria for at least one behavioral health disorder (Shufelt & Cocozza, 2006; Teplin, et al., 2013; Wasserman, et al., 2010). These high rates remain constant even when diagnoses of Conduct Disorder and Oppositional Defiant Disorder are excluded (Karnik et al., 2009). Karnik and colleagues' (2009) study of 790 incarcerated youth finds 88 percent of males and 92 percent females had at least one psychiatric disorder (including substance use disorders), and that 86 percent of males and 85 percent of females meet criteria for *three or more* disorders. Not surprisingly, Henggler and colleagues (2012) find a high prevalence of co-occurring mental and substance use disorders among youth participating in juvenile drug treatment courts.

The high rates of co-occurring disorders among justice-involved youth are especially concerning since research consistently finds that these youth present with the greatest impairment in individual and academic functioning, have elevated risk of suicide, and consistently have the poorest treatment outcomes (Bender, Kim, & Springer, 2007; Dausey & Desai 2003; Hawkins, 2009). Increased recognition of the prevalence of mental and substance use disorders among court-involved youth has led to varied responses for best addressing their needs. Some communities have developed specialized juvenile mental health courts to parallel juvenile drug courts (Callahan, Cocozza, Steadman, & Tillman, 2012). Others have adapted or blended these models to meet the needs of youth with co-occurring disorders, a strategy that responds to both the high prevalence of co-occurring disorders and research findings that treatment outcomes for youth with co-occurring disorders are

better when evidence-based clinical treatments simultaneously target both disorders in an integrated approach.

## Adapting Policy to Better Address the Needs of Youth with Co-occurring Disorders

---

---

*The high rates of co-occurring disorders are especially concerning since research consistently finds that these youth present with the greatest impairment in individual and academic functioning, have elevated risk of suicide, and consistently have the poorest treatment outcomes.*

---

---

Juvenile drug treatment courts that seek to better address the needs of youth with co-occurring disorders should continue to be guided by the 16 strategies (Bureau of Justice Assistance, 2003); however, modifications to policy and practice are required if youth with co-occurring mental disorders are to be effectively served on the drug court docket. Shifting practice in an established juvenile drug treatment court or establishing a new specialized docket to address the needs of these youth requires attention to many of the policies that guide operations.

Critical domains of the juvenile drug treatment court model that require modifications to address the needs of youth with co-occurring disorders include

- **Eligibility Criteria.** Eligibility criteria that exclude youth with mental disorders must be changed. Most important is to avoid relying exclusively on *specific diagnoses* but rather focus on the *degree of functional impairment* arising from the mental disorder and associated substance use disorder.
- **Screening and Assessment.** All youth potentially eligible for the juvenile drug court program must be screened for both mental and substance use disorders using consistent protocols and empirically validated screening tools (Substance Abuse and Mental Health Services Administration, 2011). Youth who screen “positive” must be referred for individualized assessments by clinical professionals trained to identify mental and substance use disorders and provide case-specific plans for effective, integrated treatment for youth with co-occurring disorders. Optimally, given the disproportionately high rates of childhood adversity and trauma among court-involved youth, clinicians providing assessments should have clinical competencies assessing the contributions of adverse childhood experiences and trauma to the mental and substance use disorders in each case (Kinscherff, 2012).

- **Program Supervision.** Youth with co-occurring disorders require the intensive oversight characteristic of juvenile drug treatment courts, including alcohol and other drug screenings and relatively frequent hearings. In addition, supervision should include monitoring of participation in treatment; assessments of youth and family engagement in treatment; and assessments of medication compliance, if the youth is prescribed psychiatric medications. Furthermore, steps should be taken to protect confidentiality and any relevant privileges (e.g., psychotherapist-client, psychiatrist-patient, and attorney-client) by delimiting the confidentiality of information exchanges or legal privileges as part of obtaining informed consent for the youth’s participation in the juvenile drug treatment court (Wiig, Tuell, Rosado, & Shah, 2008).
- **Youth and Family Involvement.** Clinical interventions that involve family members in both assessment and treatment have better outcomes than those that focus primarily or exclusively on the youth (Larsen-Rife & Brooks, 2009; McKay & Bannon, 2004). Family members are able to provide history and information about the youth that can substantively improve assessment results and treatment outcomes. Policies and practices that focus on family involvement include requiring family participation in assessment and treatment as a condition of program eligibility, scheduling hearings at times convenient for working parents, being sensitive to cultural differences, assisting with transportation and child care, recruiting parents with “lived experience” of parenting a child with co-occurring disorders as volunteers or peer support staff on the juvenile drug treatment court team, and recognizing parents and other family members who support the youth’s active engagement in treatment and recovery.
- **Access Integrated Treatment Services.** Insisting upon collaboration with services providers who provide integrated treatment of co-occurring disorders permits the juvenile drug treatment court to structure communications about youth in treatment with one rather than two (or more) clinical services providers. Many jurisdictions have community-based treatment providers who self-identify as skilled in providing treatment of either mental or substance use disorders.

---

---

*Developing local capacity for integrated treatment may present as a challenge, but this capacity is essential if positive outcomes for youth with co-occurring disorders are to be achieved.*

---

---

However, most acknowledge that they do not provide *integrated* treatment interventions for youth with co-occurring disorders. Juvenile drug treatment courts need to identify and collaborate with clinical service providers who offer, or are willing to offer, promising or evidence-based integrated treatment for youth with co-occurring disorders. It is not the case that “something is better than nothing.” Juvenile drug treatment courts that want to provide interventions for these youth are strongly cautioned to avoid accepting inadequate clinical services just because that is what is currently available. Developing local capacity for integrated treatment may present as a challenge, but this capacity is essential if positive outcomes for youth with co-occurring disorders are to be achieved.

- **Treatment Participation Expectations.** Consistency of attending therapy sessions or meetings related to treatment is crucial to supporting a positive outcome. Closely related to consistent attendance in treatment are expectations regarding treatment participation. Participation refers to the extent to which the youth actively makes use of the opportunities for learning and skill-building that occur as part of treatment, practices and uses those skills in the community, and modifies his or her behavior and attitudes over time in a manner consistent with treatment goals. Juvenile drug treatment courts serving youth with co-occurring disorders must communicate clear expectations to youth and families regarding both attendance and active participation in treatment and the link to observable positive outcomes (e.g., presenting with “clean” drug screens, symptom reduction of mental disorders, increased participation and success in school and other community-based activities, no new arrests).
- **Violations and Sanctions.** Recognizing that relapse is part of the path to recovery, juvenile drug treatment courts have developed policies that take this reality into account. Similarly, depending upon the natural course of their mental disorder and the degree to which it affects functioning, youth may experience a natural waxing or waning of symptoms even when they are actively participating in treatment. For this reason, decisions regarding violation and sanction should not turn solely upon fluctuations of symptoms of a mental disorder but

also take into consideration treatment attendance and participation; whether the youth are demonstrating substance use relapse; and indications of functioning at home, at school, and in community activities.

- **Graduation Expectations.** Youth with co-occurring mental disorders should ordinarily be held to the same criteria for graduation as are youth with only a substance use disorder. Juvenile drug treatment courts are familiar with marking progress with clean screens for drug and alcohol use, regular school or vocational program attendance, and participation in substance abuse treatment. While markers of participation or engagement in treatment (e.g., attending sessions, medication compliance) are important to track, the ultimate markers of success for youth with co-occurring disorders are active participation in integrated treatment, improved functional capacities and decreased impairments relevant to both mental health and substance use, and reduced rates of re-arrest or violations of conditions of program participation or probation. Individualized determinations should be made as to whether ongoing participation in treatment is warranted as a condition for graduation.

## Conclusion

Adapting the juvenile drug treatment court model to address the needs of court-involved youth with co-occurring disorders is a pragmatic recognition that many—if not most—court-involved youth appear with both mental and substance use disorders. In many communities, a key challenge is to develop a local capacity for integrated treatment. However, making the necessary modifications in program eligibility determinations, screening and assessment, family and youth engagement, and other features of traditional operations would be hollow if the result is referral of a youth to inappropriate clinical services. Emerging models of adapting juvenile drug treatment court programs to better address the needs of youth with co-occurring disorders are promising, but their effectiveness will depend heavily on fidelity to the sixteen strategies, the five strategic goals, and timely access to a continuum of community-based services that are informed by evidence and provided in an integrated care model.

## References

- Bender, K., Kim, J. S., & Springer, D. W. (2007). Effectiveness of interventions for dually-diagnosed adolescents: Implications for juvenile offenders. In D. W. Springer & A. R. Roberts (Eds.), *Handbook of forensic mental health with victims and offenders: Assessment, treatment, and research* (pp. 173-203). New York, NY: Springer Publishing Company.
- Bureau of Justice Assistance. (2003). *Juvenile drug courts: Strategies in Practice*. Washington, DC: US Department of Justice, Bureau of Justice Assistance, NCJ 197866.
- Callahan, L., Coccozza, J., Steadman, H. J., & Tillman, S. (2012). A national survey of U.S. juvenile mental health courts. *Psychiatric Services, 63*(2), 130-134.
- Cooper, C. S. (2001). *Juvenile drug court programs* (NCJ 184744). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Dausey, D. J. & Desai, R. A. (2003). Psychiatric comorbidity and the prevalence of HIV infection in a sample of patients in treatment for substance abuse. *Journal of Nervous and Mental Disease, 191*(1), 10-17.
- Hawkins, E. H. (2009). A tale of two systems: Co-occurring mental health and substance abuse disorders treatment for adolescents. *Annual Review of Psychology, 60*, 197-227.
- Henggeler, S. W., McCart, M. R., Cunningham, P. B., & Chapman, J. E. (2012). Enhancing the effectiveness of juvenile drug courts by integrating evidence-based practices. *Journal of consulting and clinical psychology, 80*(2), 264.
- Karnik, N., Soller, M., Redlich, A., Silverman, M., Kraemer, H., Haapanen, R., & Steiner, H. (2009). Prevalence of and gender differences in psychiatric disorders among juvenile delinquents incarcerated for nine months. *Psychiatric Services, 60*(6), 838-841.
- Kinscherff, R. (2012). *A Primer for Mental Health Practitioners Working With Youth Involved in the Juvenile Justice System*. Washington, DC: American Institute for Research, Technical Assistance Partnership for Child and Family Mental Health.
- Larsen-Rife, D., & Brooks, S. (2009). *The importance of family engagement in child welfare services*. Report, UC Davis Human Services Northern California Training Academy, UC Davis, Davis, CA.
- McKay, M.M. & Bannon, W.M. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of North America, 13*(4), 905-921.
- National Institute of Justice. (2012, May 15). *Drug courts*. Retrieved from <http://www.nij.gov/topics/courts/drug-courts/Pages/welcome.aspx>.
- Substance Abuse and Mental Health Services Administration. (2011). *Identifying mental health and substance use problems of children and adolescents: A guide for child-serving organizations* (HHS Publication No. SMA 12-4670). Rockville, MD: Author.
- Shufelt, J. L. & Coccozza, J. J. (2006). *Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study*. Delmar, NY: National Center for Mental Health and Juvenile Justice.
- Stein, D. M., Deberard, S., & Horman, K. (2013). Predicting success and failure in juvenile drug treatment court: A meta-analytic review. *Journal of Substance Abuse Treatment, 44*(2), 159-168.
- Teplin, L. A., Abram, K. M., Washburn, J. J., Welty, L. J., Hershfield, J. A., & Dulcan, M. K. (2013). *The Northwestern Juvenile Project: Overview*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Wasserman, G. A., McReynolds, L. S., Schwalbe, C. S., Keating, J. M., & Jones, S. A. (2010). Psychiatric disorder, comorbidity, and suicidal behavior in juvenile justice youth. *Criminal Justice and Behavior, 37*(12), 1361-1376.
- Wiig, J. K., Tuell, J. A., Rosado, L. M., & Shah, R. S. (2008). *Models for Change Information Sharing Tool Kit*. Chicago, IL: John D. and Catherine T. MacArthur Foundation.

---

*This project was supported by Grant No. 2011-DC-BX-K001 awarded by the Bureau of Justice Assistance and the Office of Juvenile Justice and Delinquency Prevention. The Bureau of Justice Assistance and the Office of Juvenile Justice and Delinquency Prevention are a component of the Office of Justice Programs which also includes the Bureau of Justice Statistics, the National Institute of Justice, and the Office for Victims of Crime. Points of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Justice or the National Council of Juvenile and Family Court Judges.*

---