



Effectively

New Directions to Address Co-occurring Mental Disorders

Advancing Juvenile Drug Treatment Courts: Policy and Program Briefs

Holly Hills, Ph.D.,¹ and Karli J. Keator, M.P.H.²

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 outlines program modifications for juvenile drug courts to consider and describes two models that have successfully served youth with co-occurring disorders.

¹ Associate Professor in the Department of Mental Health Law and Policy at the Louis de la Parte Florida Mental Health Institute, in the College of Behavioral and Community Sciences at the University of South Florida

² Division Director of the National Center for Mental Health and Juvenile Justice, Policy Research Associates, Inc.

Introduction

Juvenile drug treatment courts are specialized court docket programs designed for juvenile offenders with substance abuse and dependency problems. These courts seek to reduce substance use and recidivism through judicial interaction, assessment of risks and needs, ongoing monitoring and supervision, engagement in treatment and rehabilitation, and application of sanctions and incentives. Although variation in structure and population target exists across jurisdictions, juvenile drug treatment courts typically operate according to the 16 strategies set forth in *Juvenile Drug Treatment Courts: Strategies in Practice* by the Bureau of Justice Assistance.

The relationship-building inherent in these strategies is a core feature of juvenile drug treatment courts. The first strategy calls for the collaboration of a multidisciplinary team of judges, prosecutors, defense attorneys, treatment professionals, and community corrections staff. These stakeholders work together to create a coordinated, systemic approach to working with youth and their families. Other strategies call for frequent judicial reviews and a system for program monitoring – both of which can help youth and their families connect to the multidisciplinary team working with them. As youth move successfully through the program, they may be rewarded with suspended sentences or dropped charges (Stein, Deberard, & Homan, 2013).

Emergence of Juvenile Mental Health Courts

Juvenile drug treatment courts began to emerge in the mid-1990s as a natural extension of the adult drug court movement that began in 1989. A further development in the offering of specialized dockets for subgroups of juvenile offenders was the initiation of juvenile mental health courts, beginning with Santa Clara County, California, in 2001. Since then, dozens of juvenile mental health courts have been created to address the “increasingly obvious problem” of the presence of significant mental disorders in youth under the courts’ purview (Office of Juvenile Justice and Delinquency Prevention, undated). Modeled on drug courts, juvenile mental health courts focus on therapeutic jurisprudence: engaging youth in a non-adversarial, treatment-oriented approach to the adjudication process. The development of this additional specialty focus has been met with concern by some who question whether splintering of dockets will actually provide added value to the juvenile justice system.

Prevalence of Youth with Co-occurring Disorders

Skepticism aside, research regarding the prevalence of mental disorders among youth in the juvenile justice system is clear. When compared to youth in the community, youth in the juvenile justice system experience significantly higher rates of mental illness (Shufelt & Coccozza, 2006; Teplin et al., 2002). Approximately 70 percent of justice-involved youth met criteria for at least one mental disorder, 27 percent of whom were thought to have a disorder serious enough to impact their ability to function (Shufelt & Coccozza, 2006).

Some investigators have found even higher rates of mental disorders among incarcerated youth. Karnik and colleagues (2009) reported that 90 percent of youth in their sample had a psychiatric disorder – even with Conduct Disorder and Oppositional Defiant Disorder removed. This study evaluated youth who had been incarcerated for at least nine months in the California Department of Juvenile Justice system. It found that 86 percent of females and 85 percent of males met criteria for *three or more* disorders. Among youth with a substance use disorder, it is estimated that 50-75 percent also experience a co-occurring mental disorder (Armstrong & Costello, 2002; Chan, Dennis & Funk, 2008; Hawkins, 2009).

As epidemiological and clinical evidence has demonstrated, youth coming into contact with juvenile courts are likely to present with both mental and substance use disorders (i.e., co-occurring disorders) (Hussey et al., 2008; Skowrya & Coccozza, 2006; Teplin et al., 2002). Other research suggests that as youth are more deeply involved in the juvenile justice system, even higher rates of co-occurring disorders are likely (Teplin et al., 2013; Abrantes et al., 2005; Golzari et al., 2006; Timmon-Mitchell et al., 1997; Robertson et al., 2004; Wasserman et al., 2010). Conclusions from multiple studies have found that youth with co-occurring disorders have greater impairment in role functioning, academic abilities, and number of suicide attempts, than their peers without co-occurring disorders (Roberts, Roberts & Xing, 2007).

History of Program Modification

In response to the emerging awareness that many of the youth appearing in juvenile drug treatment courts meet criteria for co-occurring disorders, some programs around the country are making modifications to ensure that youth

Skepticism aside, research regarding the prevalence of mental disorders among youth in the juvenile justice system is clear: when compared to youth in the community, youth in the juvenile justice system experience significantly higher rates of mental illness.

In modifying their programs to address youth with co-occurring disorders, many have added to their standardized screening and assessment protocol to capture a broader range of mental disorder symptoms.

receive individualized and comprehensive services. These court teams have had to undertake the following:

- reevaluating services available in their local communities and establish relationships to create a service continuum that meets the needs of the youth in their care
- reconsidering and altering program policies and criteria to allow for specific inclusion (and exclusion, where necessary) of youth with co-occurring disorders
- modifying the content and coverage of screening and assessment tools, as well as the range and type of treatment services

Most screening and assessment processes in juvenile drug treatment courts have historically focused on identifying the severity of a youth's substance use problem, performing a risk assessment, and evaluating the willingness and ability of the youth and his or her family to participate in the court programs. To address youth with co-occurring disorders, many jurisdictions have modified their standardized screening and assessment protocol to capture a broader range of mental disorder symptoms. As most screening measures have been developed to capture either mental or substance use disorders, this typically involves adding an additional brief screen to the initial process and ensuring that assessment instruments have the breadth required to capture symptoms associated with both mental and substance use disorders.

Other steps toward program modification have occurred over the past decade, but not without challenges prompted by providers' philosophical orientation, historical missions, funding sources, and personnel resources. Early in this evolutionary process, many service providers offered parallel care, where one agency delivered mental health and psychopharmacological services and another delivered substance abuse treatment. This created an unnecessary burden for youth and their families who were now required to see multiple treatment providers – providers who may not even communicate or collaborate with one another. In some areas, this is still the norm due to insurance plans that do not offer access to providers who have developed integrated care models, or because community providers are still in the process of modifying their service offerings. Fortunately, some providers are moving toward integrated care, offering single-site treatment delivered by a multidisciplinary staff to address both mental and substance use disorders (Shepler et al., 2013).

Modifications to Court Programs: Case Examples

As noted, some juvenile courts have modified their programs to explicitly acknowledge the needs of youth with co-occurring disorders. Program expectations have been revised to confirm their achievement by youth with co-occurring disorders and to expand access to services consistent with the range of challenges experienced by these youth. Described below are two programs that have modified eligibility and program requirements consistent with the common presentation of youth with co-occurring disorders who are appearing before their courts.

Summit County, Ohio: The Crossroads Program

What started in 1999 as a juvenile drug treatment court in Summit County, Ohio, became one of the first diversion programs in the country to specifically target youth with co-occurring disorders. In 2002, a 40-member advisory board planned and implemented the Crossroads Program. Approximately 70 youth, aged 12-17, are annually referred to the program, post-adjudication. If they successfully complete the program, the admitting charge and any probation violations will be expunged from their record. Youth with more severe forms of mental disorders in addition to co-occurring substance use disorders, are the focus of this docket. Youth with a history of serious felonies (including aggravated murder, manslaughter, rape, or drug trafficking) or gang involvement are not eligible for the program.

Youth in this program are assessed by the court with the Survey of Psychodevelopmental Influences, developed by the court's psychologist, which generates a mental disorder diagnosis. Substance use screening is conducted by a chemical dependency counselor using the Substance Abuse Subtle Screening Inventory (SASSI). Youth are in the Crossroads Program for approximately one year. Program participants and their families move through four phases of contact with the court (from weekly to monthly).

Family members are required to participate in the court programs and in the development of a case plan. A network of community agencies deliver the services to the youth and their families, which include substance abuse and mental health treatment in family and individual formats, as well as educational, vocational, and employment services. Though families can choose their service provider(s) in the local community, most are treated by a community-based treatment provider delivering integrated care. Caseloads are low, and youth receive 3-5 hours of direct contact with their counselor per week.

Probation officers receive training in Motivational Interviewing (MI) and cognitive behavioral therapy techniques. They meet with youth under their supervision two or three times per week. The court can impose sanctions on youth who are unable to meet program expectations. These sanctions may include changes in their curfew, electronic monitoring, suspension of their driver's license, or detention. Similarly, youth may be rewarded for their successful phase movement efforts. Youth can graduate from the program if they abstain from substance use for a minimum of 3 months, have had no new charges, and have completed a substance-abuse focused intervention. They must be compliant with their medication, if prescribed, and be considered stable in their mental health treatment. They must also be involved in some form of prosocial activity (organized sports, volunteer activities). Youth must apply in letter form to be released from probation when they consider these conditions to have been met.

Ouachita Parish, Louisiana: 4th Judicial District Juvenile Drug Treatment Court

Operating since 2005, the juvenile drug treatment court in Ouachita Parish, Louisiana, has broadened its service offerings through collaboration with the University of Louisiana-Monroe to more comprehensively serve youth who are referred to the court. Youth, age 10-17, initially undergo a clinical eligibility screening to determine their level of substance use, mental health status, and ability to comply with the demands of court participation. Measures used for this screening include the Massachusetts Youth Screening Instrument-2, the Adolescent SASSI-A2, and the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble); in addition, academic and family history and demographics are reviewed. Only youth with significant cognitive limitations, or those who are actively psychotic, are excluded from participation. Based on this initial evaluation, the court team determines whether a youth is appropriate for this program. In the next phase of their participation, youth in the program undergo a more comprehensive assessment, which includes the Comprehensive Adolescent Severity Inventory, the Inventory of Drug Taking Situations, and the Stages of Change Readiness and Treatment Eagerness Scale. The findings from this evaluation form the basis for their treatment plan.

This juvenile drug treatment court program offers two different tracks of court involvement that vary in length and content of service offerings. Most youth with co-occurring disorders are served in the program's "Track Two." Youth in this program progress through four phases of program requirements, and finish with

an aftercare phase. In the first phase of their intervention, youth participate in Cannabis Youth Treatment groups, which incorporate Motivational Interviewing techniques. In a later phase, Solution-Focused Brief Therapy is offered in individual and family formats. In the aftercare phase, a family member or guardian must develop a Family Action Plan for sustaining progress when involvement with the court ends. Youth in Track Two are engaged in the program for approximately 36 weeks.

Throughout their involvement in the program, youth are in close contact with their case manager, who helps them address any problems in program compliance that may arise. In their initial phase of court involvement, youth have two contacts with their case manager and probation officer per week, occurring in their home, at school, or in the team member's office. This contact is reduced as youth progress through the program's phases.

Throughout their involvement in the court, youth may receive incentives or sanctions related to their performance in the program. Examples of incentives include gift certificates to local restaurants, tickets to sporting events, extended curfews, or reduction of time in a program phase. Sanctions include earlier curfews, writing assignments related to the violation, movement to an earlier phase, electronic monitoring, increased frequency in court attendance, or possible detention. To graduate, youth have to have achieved 8 weeks with no positive drug screen and been an active and compliant participant in their individual, group, and family interventions.

Conclusion

Epidemiological and clinical research has revealed the prevalence of co-occurring mental and substance use disorders. To adequately address co-occurring disorders, juvenile drug treatment court programs must modify their program missions, broaden their screening and assessment domains, promote access to integrated care models, and review outcome measures to ensure that youth are able to achieve their treatment goals, successfully meet the court's requirements, and graduate from the program.

References

- Abrantes, A.M., Hoffmann, N.G., & Anton, R. (2005). Prevalence of co-occurring disorders among juveniles committed to detention centers. *International Journal of Offender Therapy and Comparative Criminology*, 49: 179-192.

- Armstrong, T.D., & Costello, E.J. (2002). Community studies on adolescent substance use, abuse, or dependence and psychiatric comorbidity. *Journal of Consulting and Clinical Psychology, 70*(6): 1224-1239.
- Chan, Y.F., Dennis, M.I., & Funk, R.L. (2008). Prevalence and comorbidity of major internalizing and externalizing problems among adolescents and adults presenting to substance abuse treatment. *Journal of Substance Abuse Treatment, 34*(1), 14-24.
- Golzari M., Hunt S.J., & Anoshiravani, A. (2006). The health status of youth in juvenile detention facilities. *Journal of Adolescent Health, 38*: 776-782.
- Hawkins H.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.
- Hussey, D. L., Drinkard, A.M., Falletta, L., & Flannery, D.J. (2008). Understanding clinical complexity in delinquent youth: Comorbidities, service utilization, cost, and outcomes. *Journal of Psychoactive Drugs, 40*(1): 85-95.
- 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.
- Roberts, R., Roberts, C., & Xing, Y. (2007). Comorbidity of substance use disorders and other psychiatric disorders among adolescents: Evidence from an epidemiological survey. *Drug and Alcohol Dependence, 88S, S4-S13*
- Robertson A.A., Dill P.L., Hussain, J., & Undesser C. (2004). Prevalence of mental illness and substance abuse disorders among incarcerated juvenile offenders in Mississippi. *Child Psychiatry and Human Development, 35*(1): 55-74.
- Shepler, R., Newman, D., Cleminshaw, H., Webb, T., & Baltrinic., E. (2013). A comparison study of treatment programs for youth offenders with co-occurring disorders. *Behavioral Health in Ohio: Current Research Trends, 1*(2): 7-17. Ohio Department of Mental Health: Columbus, Ohio.
- Shufelt, J., & Cocozza, J. (2006). *Youth with mental disorders in the juvenile justice system: Results from a multi-state prevalence study*. Delmar, NY: National Center for Mental Health and Juvenile Justice.
- Skowrya, K., & Cocozza, J. (2006). *A blueprint for change: Improving the system response to youth with mental health needs involved with the juvenile justice system*. Delmar, NY: National Center for Mental Health and Juvenile Justice.
- Stein, D.M., Deberard, S., & Homan, K. (2013). Predicting success and failure in juvenile drug treatment court: a meta-analytic review. *Journal of Substance Abuse Treatment, 44*: 159-168.
- Teplin, L., Abram, K., McClelland, G., Dulcan, M., & Mericle, A. (2002). Multiple substance use disorders in juvenile detainees. *Archives of General Psychiatry, 59*: 1133-1143.
- Teplin, L., Abram, K., Washburn, J., Welty, L., Hershfield, J., & Dulcan, M. (2013, February). The northwest juvenile project: Overview. *OJJDP Juvenile Justice Bulletin*. Retrieved from <http://www.ojjdp.gov/pubs/234522.pdf>
- Timmon-Mitchell, J., Brown, C., Shulz, C., Webster, S.E., Underwood, L.A., & Semple, W.E. (1997). Comparing the mental health needs of female and male incarcerated juvenile delinquents. *Behavioral Sciences and the Law, 15*, 195-202.
- U.S. Department of Justice, Office of Juvenile Justice Delinquency Prevention. (April 2013). *Drug courts*. Publication No.: NCJ 238527. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/238527.pdf>
- U.S. Department of Justice, Office of Juvenile Justice Delinquency Prevention. (Undated). *Mental health courts*. Retrieved from http://www.ojjdp.gov/mpg/litreviews/Mental_Health_Courts.pdf
- 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.

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.
