Juvenile Mental Health and Substance Abuse

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Overview

‣ Overview of the Risk-Needs-Responsivity approach to assessment and rehabilitation and its interface with substance use and mental health treatment

‣ Adolescent Substance Use and Mental Health Disorders

• Co-occurring Disorders

‣ Obtaining Services for Juvenile Justice – Involved Youth
  ◦ Publicly-funded health services
  ◦ Juvenile Justice Behavioral Health teams (JJBH/JJSAMHP)
  ◦ Juvenile Justice- and Juvenile Crime Prevention Council-funded programs and services

What Works in Reducing Recidivism

‣ **RISK PRINCIPLE**: Who you target, and how intensely

‣ **NEED PRINCIPLE**: Make sure you're addressing the right things.

‣ **RESPONSIVITY PRINCIPLE**: Don't forget that everybody is different; address things first that might prevent someone from benefiting from services or programs targeting crimineogenic needs.
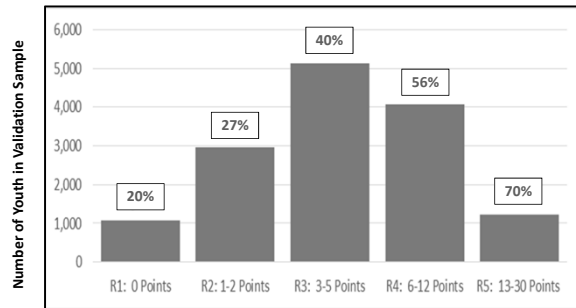
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The Risk Principle

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Three-year Recidivism by Risk Score

Bar chart — Number of Youth in Validation Sample by risk category:
- R1: 0 Points — 20%
- R2: 1-2 Points — 27%
- R3: 3-5 Points — 40%
- R4: 6-12 Points — 56%
- R5: 13-30 Points — 70%

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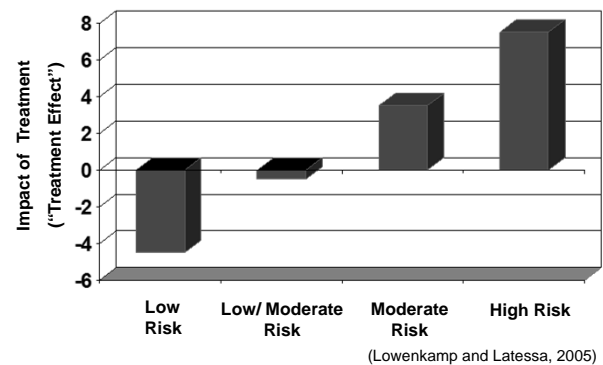## What Makes Youth High Risk?

They have many risk factors.

➢ Static criminogenic risks (set factors)
- Age of first offense
- Number of prior offenses
- Family history of involvement in criminal activity

➢ Criminogenic needs (*dynamic* factors)
- Thinking, attitudes, and beliefs
- Delinquent peers
- Family factors
- Substance use
- etc.

Matching Intensity of Services to Risk Level

	Intensive Supervision	No Intensive Supervision
High Risk	31.6	51.1
Low Risk	32.3	14.5
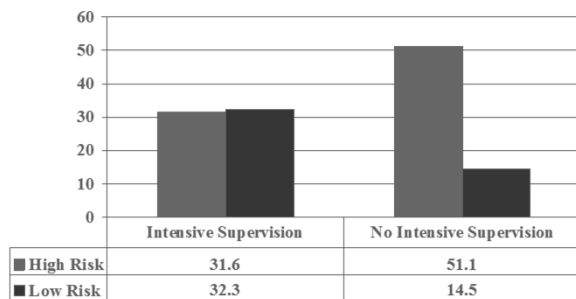
Bonta, J et al., 2000. A Quasi-Experimental Evaluation of an Intensive Rehabilitation Supervision Program. Vol. 27 No 3:312-329. *Criminal Justice and Behavior.*

The Impact of Incarceration Varies by Risk Level.

Impact of Treatment ("Treatment Effect") by risk level:
- Low Risk
- Low/ Moderate Risk
- Moderate Risk
- High Risk

(Lowenkamp and Latessa, 2005)

Violating the Risk Principle

‣ Low risk juveniles being *over*- supervised and *over*-treated
  ◦ at BEST no reductions in recidivism
  ◦ at WORST causing harm

‣ Why?
  ◦ Disrupt the very things that make the youth low risk

Violating the Risk Principle

‣ High risk juveniles being *under*-supervised and *under*-treated
  ◦ High risk youth with a substance use disorder being assigned to AA/NA
  ◦ Increased risk of recidivating

‣ Why?
  ◦ Does not provide enough supervision/control to reduce recidivism
  ◦ Does not provide enough intensity of programming to disrupt risk factors

The Risk Principle and Service Planning

‣ High risk juveniles should receive more intensive services for a longer period of time
  ◦ Intensity = more groups, services, supervisory check-ins more often

‣ Low risk juveniles have fewer problems and more pro-social supports.
  ◦ They usually do not require intensive interventions/supervision.

The Need Principle

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The Need Principle

- Assess and target the needs/problems related to criminal behavior that have potential for change.

- Criminogenic needs = dynamic risk factors
  - Attitudes, peers, substance abuse, lack of empathy, family issues, impulsivity, low educational achievement, anger, egocentric

- Non-criminogenic needs = problems not related to criminal behavior
  - Medical issues, low self-esteem or mental health issues, artistic or musical ability and/or skills, physical ability

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Top Four Risk Factors	Other Risk Factors	Non-Criminogenic
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
		5.

Family circumstances (lack of healthy support or accountability)

Self-esteem (low)

Substance abuse

Personal distress (anxiety, etc.)

Personality/behavior (e.g., poor impulse control, poor problem solving)

Leisure/recreation (lack of appropriate recreational outlets)

Learning disability

Employment (lack of success at work; little desire to work)

Education (lack of success at school; little desire for education)

Health issues (poor physical health)

Mental health (poor mental health and/or mental illness)

Peer relations (hanging around peers who are negative influence)

Thinking/beliefs (cognitions that support irresponsibility)

Andrews, D.A., Bonta, J., & Wormith, S. (2006). The Recent Past and Near Future of Risk and/or Need Assessment. Crime & Delinquency; 52(1); 7-27.

Top Four Risk Factors	Other Risk Factors	Non-Criminogenic
1. Thinking/beliefs	1.	1.
2. Personality/behavior	2.	2.
3. Peer relations	3.	3.
4. Family circumstances	4.	4.
		5.

Family circumstances (lack of healthy support or accountability)

Self-esteem (low)

Substance abuse

Personal distress (anxiety, etc.)

Personality/behavior (e.g., poor impulse control, poor problem solving)

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1. Thinking/beliefs	1. Substance abuse	1.
2. Personality/behavior	2. Education	2.
3. Peer relations	3. Employment	3.
4. Family circumstances	4. Leisure/recreation	4.
		5.

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2. Personality/behavior	2. Education	2. Personal distress
3. Peer relations	3. Employment	3. Learning disability
4. Family circumstances	4. Leisure/recreation	4. Health issues
		5. Mental health
Family circumstances (lack of healthy support or accountability)	**Leisure/recreation (lack of appropriate recreational outlets)**	**Health issues (poor physical health)**
Self-esteem (low)	**Learning disability**	**Mental health (poor mental health and/or mental illness)**
Substance abuse	**Employment (lack of success at work; little desire to work)**	**Peer relations (hanging around peers who are negative influence)**
Personal distress (anxiety, etc.)	**Education (lack of success at school; little desire for education)**	**Thinking/beliefs (cognitions that support irresponsibility)**
Personality/behavior (e.g., poor impulse control, poor problem solving)		

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Need Principle: Why Target Criminogenic Domains?

‣ Research shows a 38% reduction in recidivism when case plans contained interventions matched to assessed criminogenic needs for high risk youth. (Luong, D., & Wormith, J.S. (2011).

‣ The absence of interventions to address a domain that was ranked medium risk or higher was associated with an 82% increase in likelihood of recidivism. (Luong, D., & Wormith, J.S. (2011).

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Sample Risky Attitudes

➢ Negative expressions about the law

➢ Negative expressions about conventional institutions, values, rules, & procedures, including authority

➢ Negative expressions about self-management of behavior, including problem solving ability

➢ Negative attitudes toward self and one's ability to achieve through conventional means

➢ Lack of empathy and sensitivity toward others

Neutralizations and Minimizations

Self-talk that serves to justify or support criminal activity.

◦ Denial of Responsibility: Criminal acts are due to factors beyond the control of the individual; thus, the individual is free to act, without guilt.

◦ Denial of Injury: Admits responsibility for the act, but minimizes the extent of harm or denies any harm

◦ Denial of the Victim: Reverses the role of offender & victim & blames the victim

◦ "System Bashing": Those who disapprove of the offender's acts are defined as immoral, hypocritical, or criminal themselves.

◦ Appeal to Higher Loyalties: "Live by a different code" – The demands of larger society are sacrificed for the demands of more immediate loyalties.

Pathways To Desistance

Main Findings

▸ 2 sites, multi-year, over 1,400 youth

Psychosocial development is related to criminal offending patterns and desistance from crime.

https://www.pathwaysstudy.pitt.edu/

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Pathways To Desistance
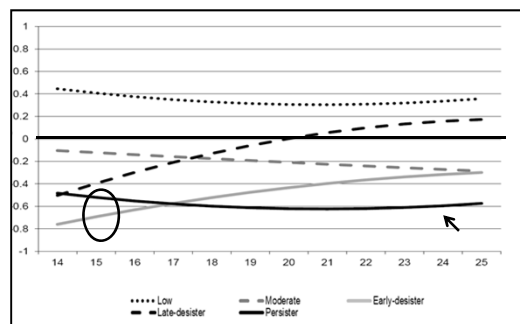
Main Findings

▸ **Psychosocial Maturity:**
- **Responsibility** – independence and self-care
- **Temperance** – self-regulation (self-control, impulse control, ability to delay gratification)
- **Perspective** – thinking about oneself, others, and consequences of one's actions; future orientation

https://www.pathwaysstudy.pitt.edu/

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Persistent Offenders Show Especially Stunted Development of Temperance

Low • • • • Late-desister – – – Moderate – – – Persister —— Early-desister ——

Monahan et al. (2009)

Targeting Multiple Criminogenic *Needs*

% Reduced Recidivism vs. Number of Criminogenic Needs
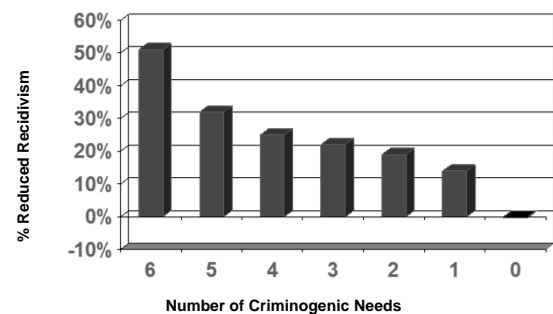
Gendreau, P., French, S.A., and A.Taylor (2002). What Works (What Doesn't Work) Revised 2002. Invited Submission to the International Community Corrections Association Monograph Series Project.

The Responsivity Principle

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Responsivity Principle

Refers to the learning/interaction styles of the juveniles or program characteristics which can affect responsiveness to programming
  ➢ External responsivity factors
    · Program characteristics
    · Facilitator characteristics
    · Program setting
  ➢ Internal responsivity factors
    · Motivation
    · Mental health – anxiety, depression, trauma
    · Substance use
    · Maturity
    · Transportation
    · Cognitive deficiencies
    · Demographics

Responsivity Factors

▸ General – programs that are based on cognitive-behavior/social learning theories are generally responsive to offenders

▸ Specific – individuals learn differently and may have certain barriers that should be removed before programming or addressed during programming

In three separate investigations...

Assessing mental health at probation intake:
  · Probation officer and court referrals for mental health services were linked to diagnosis (NY, AL, TX).

In two of those, when recidivism in the next 1-5 years was measured, both of the following resulted in significant reductions in recidivism:
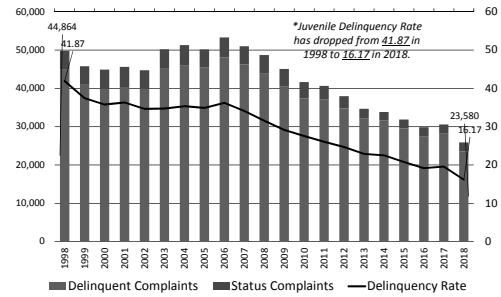 · Receipt of MH/SU services (TX) or
  · Court referral (AL) for MH/SU services.

Substance Use Disorders

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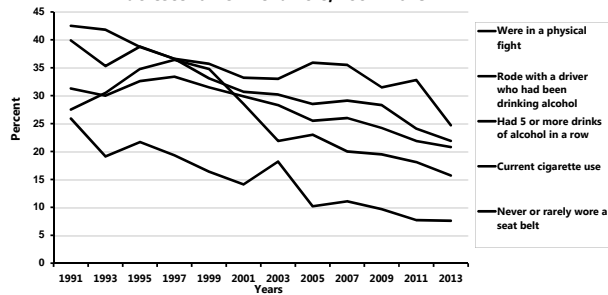
History of Juvenile Complaints in NC (1998-2018)

Juvenile Delinquency Rate has dropped from 41.87 in 1998 to 16.17 in 2018.

44,864   41.87

23,580   16.17

Legend: ■ Delinquent Complaints   ■ Status Complaints   — Delinquency Rate

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Improving Trends in Risk Behavior Among Adolescents

Adolescent Risk Behaviors, 1991–2013

- Were in a physical fight
- Rode with a driver who had been drinking alcohol
- Had 5 or more drinks of alcohol in a row
- Current cigarette use
- Never or rarely wore a seat belt

Youth Risk Behavior Surveys, 1991–2013

PREVALENCE OF ADOLESCENT SUBSTANCE USE DISORDER FROM 2002-2015

Legend: Alcohol or Illicit Drugs   Alcohol   Illicit Drugs
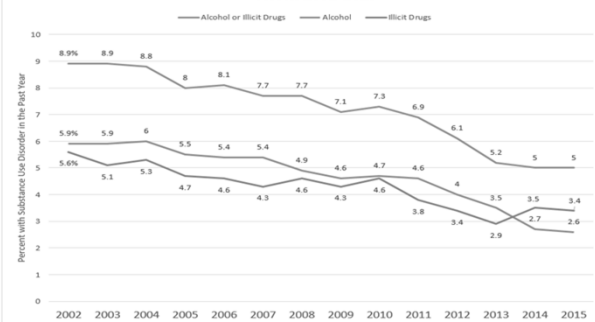
Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data/

Alcohol Use Disorder in the Past Year among People 12 or Older, by Age Group: Percentages, 2002-2017
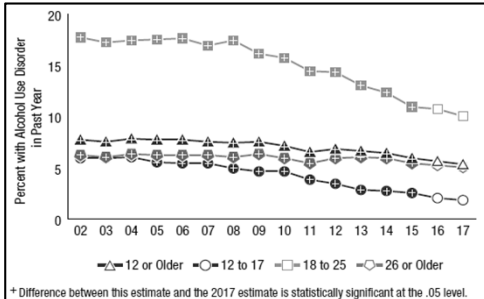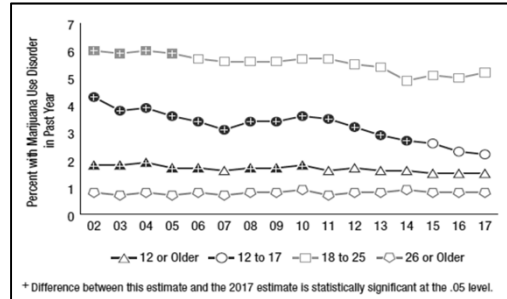

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Substance Abuse and Mental Health Services Administration. (2018). *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www. samhsa.gov/data/

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Marijuana Use Disorder in the Past Year by Age Group: Percentages, 2002-2017

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.
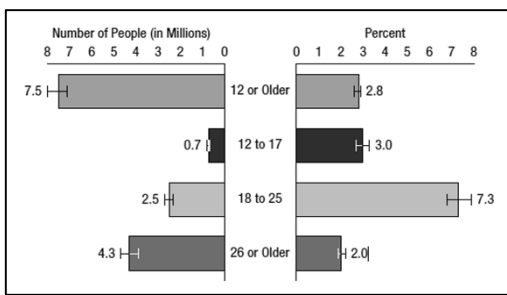
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Substance Use Disorder in the Past Year among People Aged 12 or Older, by Age Group: 2017
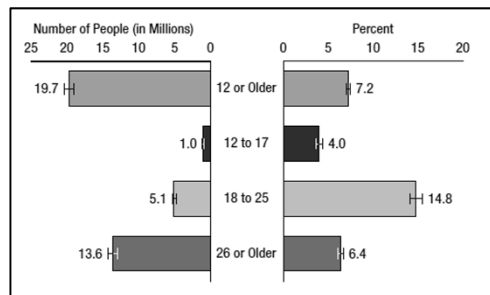
Substance Abuse and Mental Health Services Administration. (2018). *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www. samhsa.gov/data/
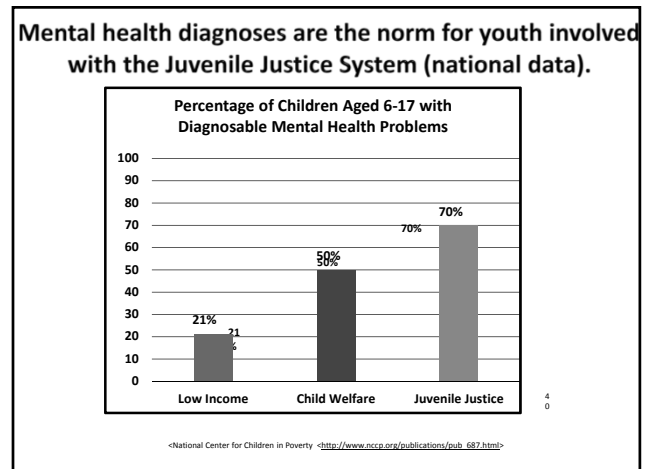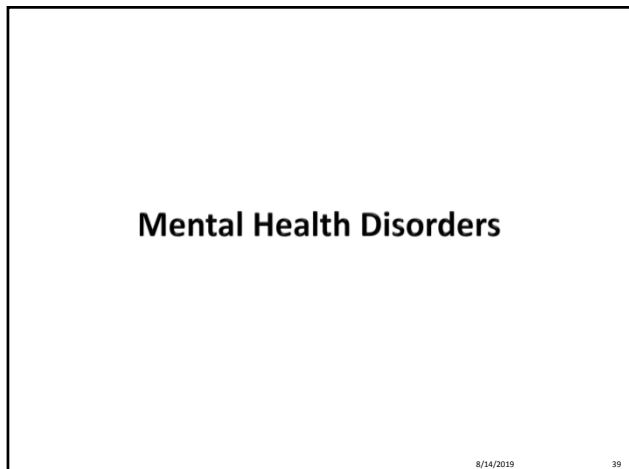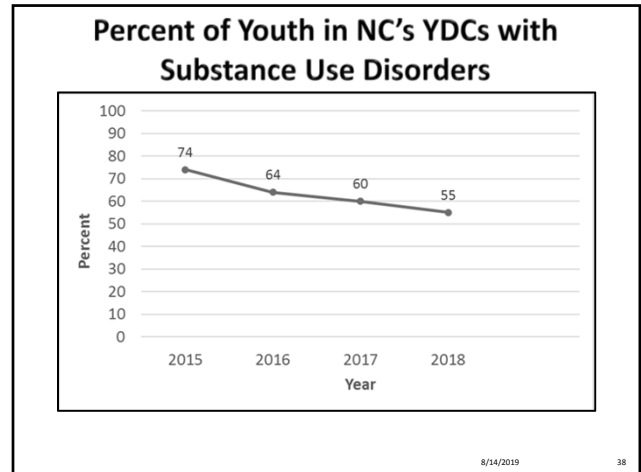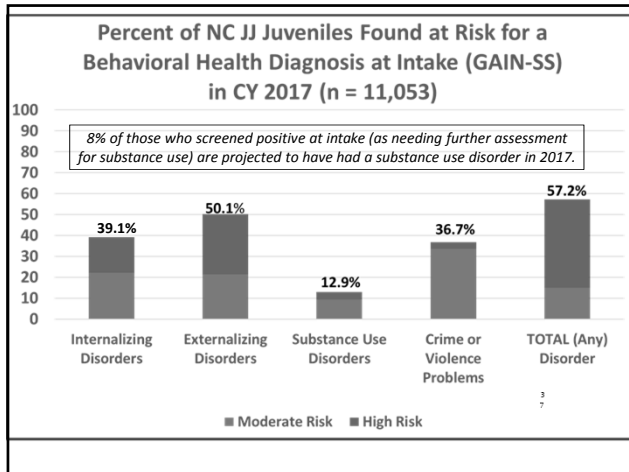
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Illicit Drug Use Disorder in the Past Year among People 12 and Older by Age Group (2017)

Substance Abuse and Mental Health Services Administration. (2018). *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www. samhsa.gov/data/
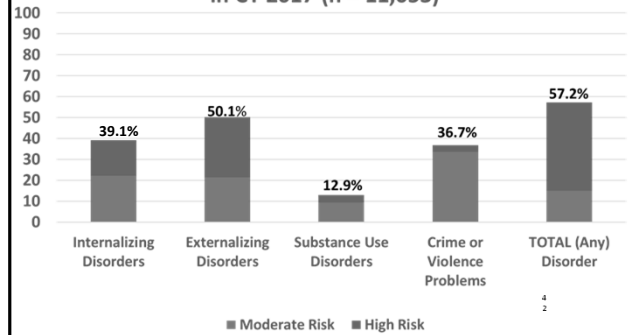
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Percent of NC JJ Juveniles Found at Risk for a Behavioral Health Diagnosis at Intake (GAIN-SS) in CY 2017 (n = 11,053)

8% of those who screened positive at intake (as needing further assessment for substance use) are projected to have had a substance use disorder in 2017.

Internalizing Disorders: 39.1%
Externalizing Disorders: 50.1%
Substance Use Disorders: 12.9%
Crime or Violence Problems: 36.7%
TOTAL (Any) Disorder: 57.2%

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■ Moderate Risk   ■ High Risk

Percent of Youth in NC's YDCs with Substance Use Disorders

2015: 74
2016: 64
2017: 60
2018: 55

Percent / Year

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Mental Health Disorders

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Mental health diagnoses are the norm for youth involved with the Juvenile Justice System (national data).

Percentage of Children Aged 6-17 with Diagnosable Mental Health Problems

Low Income: 21%
Child Welfare: 50%
Juvenile Justice: 70%

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<National Center for Children in Poverty <http://www.nccp.org/publications/pub_687.html>

Rates of disorder and comorbidity increase with justice system penetration.
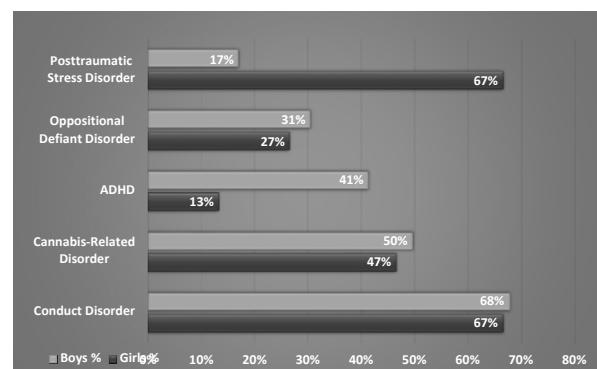
	System intake (n=3803)	Detention (n=1055)	Secure Care (n=4961)
Any disorder	35.1	58.9	63.7
Anxiety Disorder	18.7	26.9	20.3
Mood Disorder	5.7	11.2	8.8
Disruptive Behavior Disorder	15.1	32.2	35.7
Substance Use Disorder	16.7	38.8	47.0
2+ diagnostic clusters	12.1	29.6	32.8
Past month suicide attempt	1.9	3.7	2.5
Lifetime suicide attempt	10.8	17.7	16.3

Wasserman, McReynolds, et al. (2010), Criminal Justice and Behavior

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■ Moderate Risk   ■ High Risk

Most Prevalent Diagnostic Categories in 2018 YDC Youth

	Boys %	Girls %
Depressive Disorders	60%	24%
Trauma- and Stressor-Related Disorders	80%	40%
Substance-Related and Addictive Disorders	47%	55%
Neurodevelopmental Disorders	73%	69%
Disruptive, Impulse-Control, and Conduct Disorders	93%	89%

■ Boys % ■ Girls %
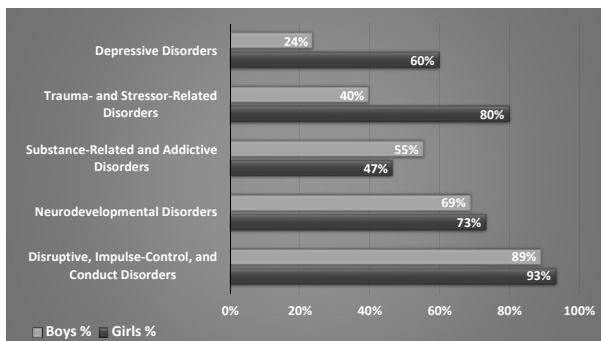
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Most Prevalent Diagnoses in 2018 YDC Youth

	Boys %	Girls %
Posttraumatic Stress Disorder	67%	17%
Oppositional Defiant Disorder	27%	31%
ADHD	13%	41%
Cannabis-Related Disorder	47%	50%
Conduct Disorder	67%	68%

■ Boys % ■ Girls %

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Prevalence of Co-Occurring Disorders in NC's Juvenile Justice Population

- 70% meet criteria for at least one Mental Health Disorder

- 50% of those meet criteria for co-occurring Substance Use Disorder

- 100% of those with a substance use disorder had a co-occurring mental health diagnosis

- 62 – 77% of confined juvenile offenders report lifetime histories of trauma (90 – 100% of girls)

Mental Health Disorders Most Likely to Co-occur with SUDs in Justice Populations

- **Externalizing Disorders**
  - Attention Deficit/Hyperactivity Disorder (ADHD)
  - Oppositional-Defiant Disorder
  - Conduct Disorder

- **Internalizing Disorders**
  - Anxiety Disorders (including Post-traumatic Stress Disorder)
  - Mood Disorders

Treatment Challenges for Co-Occurring Disorders

- Substance abuse treatment reduces symptoms of abuse and/or dependence, as well as frequency of use, but usually has only an indirect impact on emotional and behavioral problems.

- Mental health treatment alone for those with co-occurring mood and substance use disorders does not significantly reduce substance use, especially among the young.

  Integrated treatment addressing both is preferable.

(Graves et al., 2010)

Psychotherapy Approaches

- Sequential: treat one disorder before moving on to the other

- Parallel: treated simultaneously by different professionals

- Integrated: actively combining interventions in therapy or a treatment setting intended to address substance abuse and mental disorders in order to treat both, related problems, and the whole person more effectively.

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Trauma-focused care should be an essential component of management.

- ‣ Rates of traumatic exposure dramatically elevated in justice-involved juveniles (PTSD is 7X higher, trauma exposure is increased 2.5X, a history of forced sex is10x higher in justice-involved youth).
- ‣ Trauma exposure is related to:
  - ◦ all types of disorder (especially Depression and SUDs)
  - ◦ markers of antisocial behavior in adulthood
- ‣ Types of exposure vary by gender:
  - ◦ Males: assaultive violence
  - ◦ Females: forced Sex

Wasserman & McReynolds, JOTS, 2011

Comparison of Trauma Exposure

Type of Trauma	Incarcerated Adolescents	High School Students
Sexual violence (males and females)	16%	6%
Sexual violence (females only)	29%	11%
Community violence	6.8 types	3.1 types
Know someone who had been killed	92%	58%
Shot, or shot at	72%	23%

Wood et al. (2002)

ACE Study: Overall Findings

- ‣ Adverse Childhood Experiences (ACEs) are common.

- ‣ There is a dose-response relationship between ACEs and lifelong risk behaviors and poor health.

https://vetoviolence.cdc.gov/apps/aces/#

Adverse Childhood Experiences

- ‣ Emotional abuse
- ‣ Physical abuse
- ‣ Sexual Abuse
- ‣ Emotional neglect
- ‣ Physical neglect
- ‣ Household Dysfunction:
  - ◦ Mother treated violently
  - ◦ Household substance abuse
  - ◦ Household mental Illness
  - ◦ Parental separation or divorce
  - ◦ Incarcerated household member

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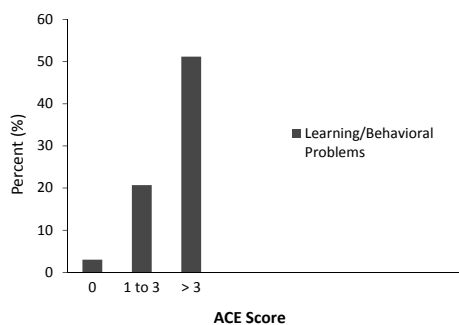Relationship Between ACE Score and Initiation of Substance Use in Adolescence

https://vetoviolence.cdc.gov/apps/aces/#

ACE Score and Drug Abuse

https://vetoviolence.cdc.gov/apps/aces/#
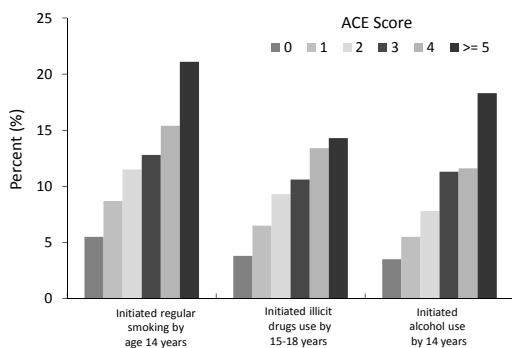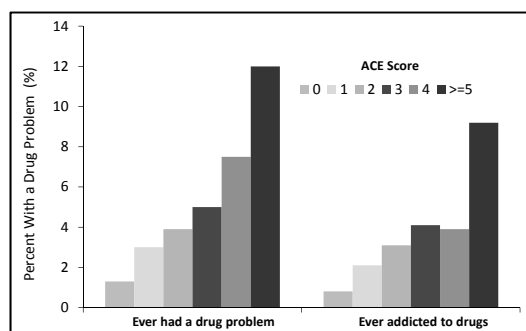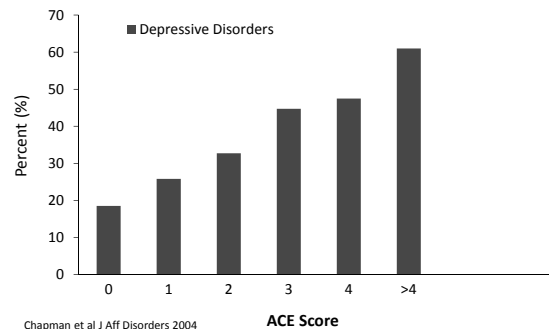

Relationship Between ACE Score and Learning/Behavioral Problems

Burke et al., Child Abuse Neglect, 2011

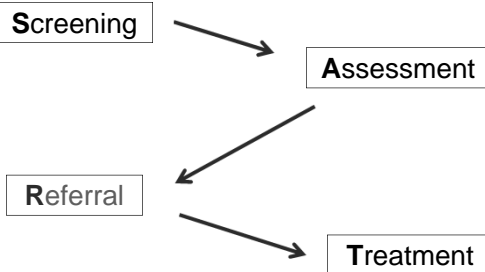Relationship Between the ACE Score and Lifetime History of Depressive Disorders

Chapman et al J Aff Disorders 2004
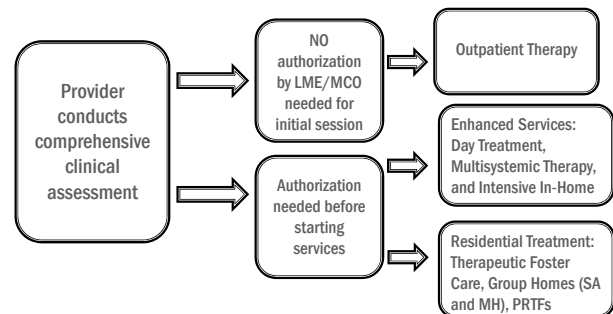
Accessing Medicaid- and State-Funded Services

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Detecting Mental Health And Substance Use Treatment Needs

Screening → **A**ssessment

Referral ←

Treatment

Screening and Assessment

▸ *Screening* is the identification of unrecognized problems in apparently well person via procedures that can be applied rapidly and inexpensively. Screening tools are usually designed to be used by a non-clinician (e.g., a court counselor).

▸ Persons who screen positive should receive further *assessment* to establish whether the problem is truly present.

How do families access services?

Provider conducts comprehensive clinical assessment →

NO authorization by LME/MCO needed for initial session → Outpatient Therapy

Authorization needed before starting services →

Enhanced Services: Day Treatment, Multisystemic Therapy, and Intensive In-Home

Residential Treatment: Therapeutic Foster Care, Group Homes (SA and MH), PRTFs

Navigating the Mental Health System in Juvenile Court. Johnson, R., Frison, S.L, and Powell, L. NC Association of District Court Judges' 2017 Summer Conference.

How do families access services?

Three ways to access services:

1. Call LME/MCO access line.

2. Go directly to a provider who is contracted with the LME/MCO.

3. Through a crisis service

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Comprehensive Clinical Assessment

- Intensive clinical and functional face-to-face evaluation of a youth's presenting mental health, developmental disability, and substance use disorder

- Results in a written report that provides clinical basis for development of a treatment or service plan and recommendations for service

- Completed before the start of treatment for enhanced services and residential treatment

- Determines medical necessity

- Used for Individual Therapy, Family Therapy, and Group Therapy

- Must be completed by a licensed or provisionally licensed individual

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Criteria for Involvement in Funded Services

◦ All covered services must be medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs.

◦ There must be a diagnosis reflecting need for treatment.

◦ Service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment.

Navigating the Mental Health System in Juvenile Court. Johnson, R., Frison, S.L, and Powell, L. NC Association of District Court Judges' 2017 Summer Conference.

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Levels of Service

Most restrictive
More costly
Less cost-effective
Serve fewer youth

Inpatient Hospital

Psychiatric Residential Treatment Facility (PRTF)

Residential Treatment: Group Homes and Therapeutic Foster Care, Substance Abuse Residential Programs

Enhanced Services: Intensive In-Home, Multi-systemic Therapy, Day Treatment, Substance Abuse Intensive Outpatient

Outpatient Therapy

Least restrictive
Less costly
More cost-effective
Serves more youth

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Juvenile Justice Behavioral Health Teams
<http://ncjjbh.org/>

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North Carolina: Juvenile Justice – Behavioral Health Initiatives

Reclaiming Futures Sites
Reclaiming Futures – Catawba County
Reclaiming Futures – Cherokee, Clay, Graham, Swain, Macon, Jackson & Haywood counties
Reclaiming Futures – Cumberland County
Reclaiming Futures – Forsyth County
Reclaiming Futures – Halifax, Northampton, Hertford & Bertie counties (July 2013)
Reclaiming Futures – Gaston County
Reclaiming Futures – Guilford County
Reclaiming Futures – Iredell, Yadkin & Surry counties
Reclaiming Futures – McDowell County
Reclaiming Futures – Mecklenburg County (In planning stage)
Reclaiming Futures – Orange & Chatham counties
Reclaiming Futures – Rockingham, Stokes & Davie counties
Reclaiming Futures – Rowan County
Reclaiming Futures – Transylvania & Henderson counties

Juvenile Justice Treatment Continuum
Smoky Mountain Center
Western Highlands
Communities for a Better Tomorrow (Halifax, Northampton, Hertford, Bertie)

Juvenile Justice Substance Abuse Mental Health Partnerships

Alliance - Cumberland	Eastpointe – Goldsboro
Alliance Behavioral – Durham	Eastpointe - Lumberton
Alliance Behavioral – Wake	Eastpointe – Rocky Mount
Cardinal Innovations – Alamance Caswell COC	East Carolina Behavioral Health (ECBH)
Cardinal Innovations – Five County COC	ECBH Northeast
Cardinal Innovations – OPC COC	Partners – Crossroads
Cardinal Innovations – Piedmont COC	Sandhills – Southern
CenterPoint	Western Highland
CoastalCare	

COMPENDIUM OF SERVICES

For the North Carolina
Juvenile Justice Substance Abuse Mental
Health Partnerships (JJSAMHP)

2018

North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services

North Carolina Department of Juvenile Justice and Delinquency Prevention

Compiled by
University of North Carolina at Greensboro
Center for Youth, Family & Community Partnerships

Local contact information for MCOs and JJBH teams can be found within the JJSAMHP Compendium of Services, available via a link at http://ncjjbh.org/publications

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Evidence-Based/Supported Treatments for Adolescents

- MET/CBT 5 and 12
- Adolescent Community Reinforcement Approach (A-CRA)
- Motivational Enhancement Therapy (MET)
- The Seven Challenges Program
- Seeking Safety (SS)
- Functional Family Therapy (FFT)
- Relapse Prevention Therapy (RPT)
- Multisystemic Therapy (MST)
- Multidimensional Family Therapy (MDFT)
- Trauma-Focused Cognitive Behavior Therapy (TF-CBT)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Brief Strategic Family Therapy (BSFT)
- Family Support Network (peer support)

- ‣ **Common thread running through treatment of SUD and MH disorders in adolescence: there is a family focus in treatment. Treatment models with a family component are among the most effective.**

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SUD Residential Treatment Center Census
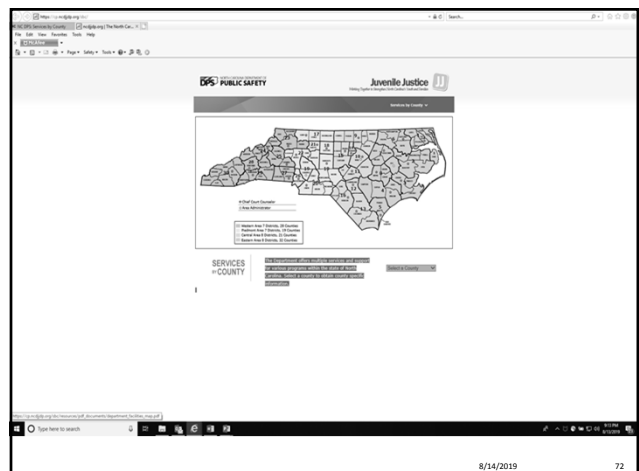### <http://ncjjbh.org/residential-census>

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Juvenile Crime Prevention Council Programs

- Ensure that appropriate dispositional options are available in the community

- Assess needs of juveniles in the community

- Assess resources available in the community to meet the needs identified

- Develop or propose ways to meet those needs

- Evaluate programs for effectiveness

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Accessing the JJ Service Directory

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Searching the Directory

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Program Entry: Program Administration Info.

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After treatment is completed, remember the Need Principle; have criminogenic needs also been addressed?

- Assess and target the needs/problems related to criminal behavior that have potential for change.

- Criminogenic needs = dynamic risk factors
  - Attitudes, peers, **substance abuse**, lack of empathy, family issues, impulsivity, low educational achievement, anger, egocentric

- Non-criminogenic needs = problems not related to criminal behavior
  - Medical issues, low self-esteem or **mental health issues**, artistic or musical ability and/or skills, physical ability

Questions? Need Help?

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