Northwest (HHS Region 10)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Northwest ATTC presents:

Addressing Youth Substance Abuse in the Juvenile Justice System

Jacqueline van Wormer, PhD
Joshua Leblang, EdS, LMHC

ADAI | ALCOHOL & DRUG ABUSE INSTITUTE

Today's Presenters

Jacqueline van Wormer, PhD

- Co-Director, Center for the Study of Advancement of Justice Effectiveness (SAJE)
- Assistant Professor, Whitworth University, Spokane, WA

Josh Leblang, EdS, LMHC

- Faculty, Department of Psychiatry, University of Washington
- 24 years training/consultation experience
  - Family and ecological-based intervention models for youth with substance abuse and behavioral health needs

Juvenile drug treatment courts

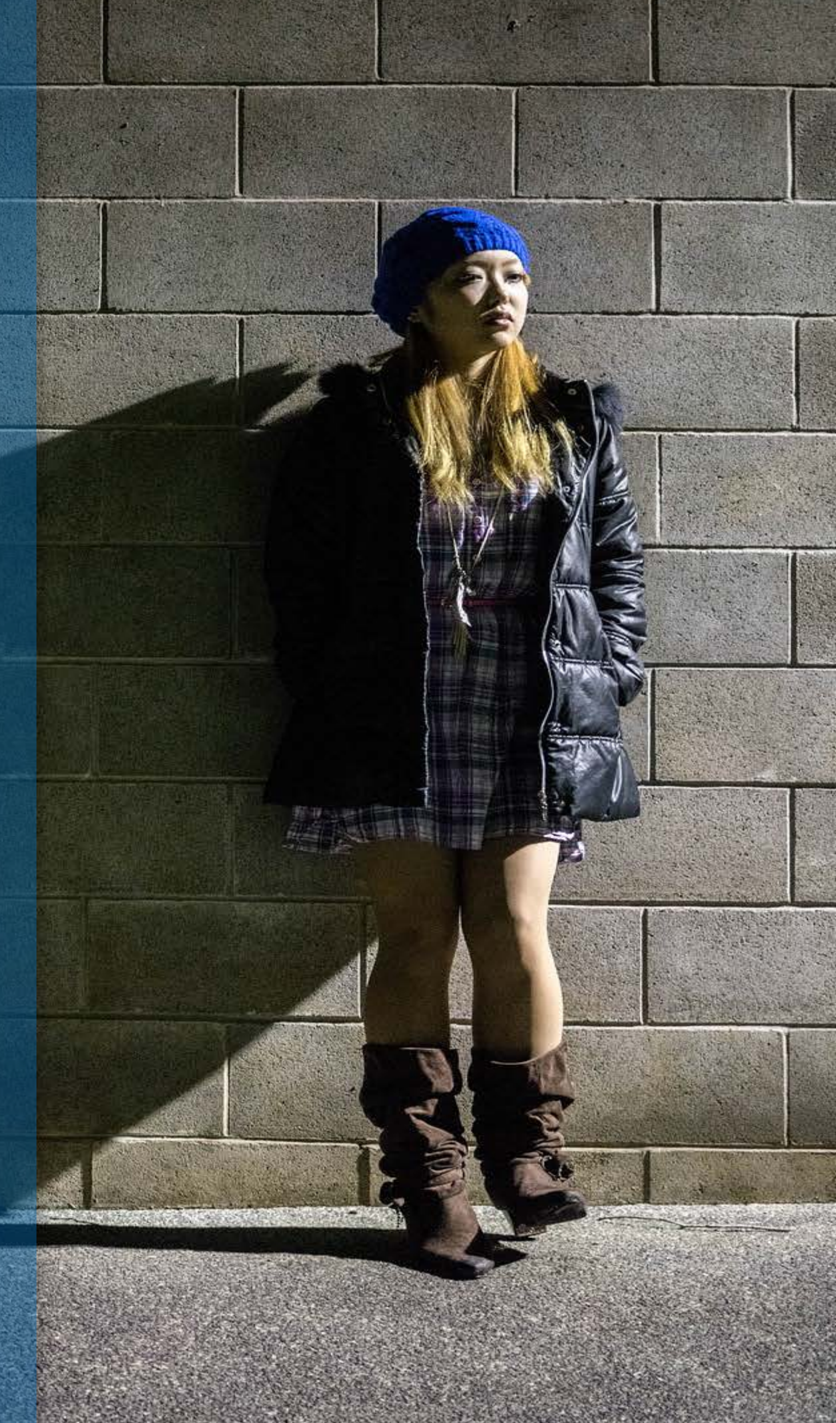
Jacqueline van Wormer, Ph.D.
Whitworth University
Co-Director, SAJE
NADCP, NCJFCJ

Disclaimer

Creation of these materials was funded through a grant awarded by the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice (Award Number 2016-DC-BX-K001). Neither the U.S. Department of Justice nor any of its components operate, control, are responsible for, or necessarily endorse the views, opinions, or contents expressed by the training, technical assistance, or TTA documents and materials herein.

History of the Juvenile Drug Court Movement

- Juvenile drug treatment courts developed from the successful adult drug court model
- Early courts followed the *10 Key Components for Drug Courts* (1997)
- *Juvenile Drug Courts: Strategies in Practice* (2003). Consensus document, to provide a framework for planning, implementing, and operating a JTDC.



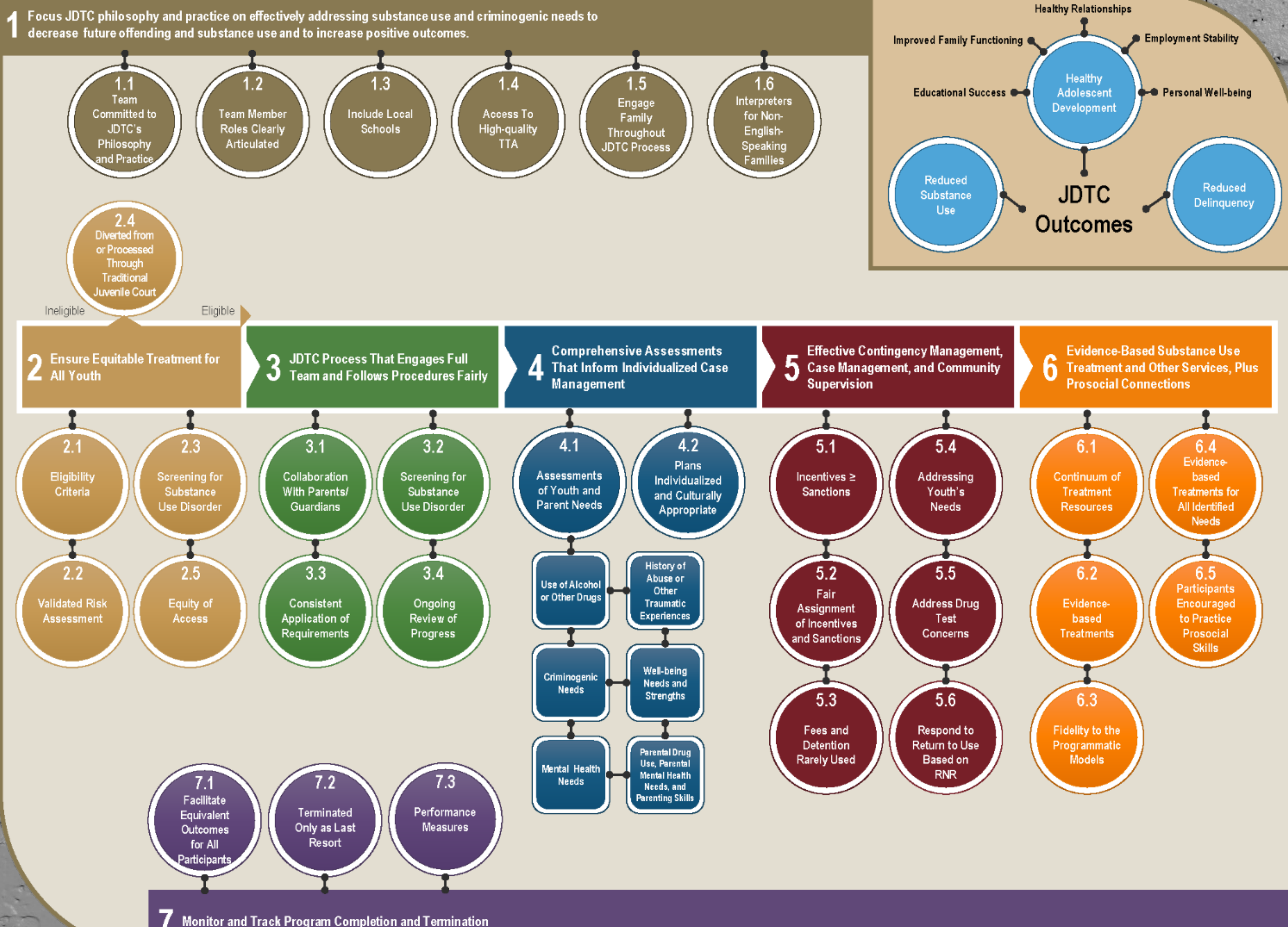
OJJDP Initiative to Develop & Test JDTC Guidelines

- Launched in 2014 via a competitively-awarded agreement between OJJDP and the American Institutes for Research (AIR) along with other researchers, experts, and federal agencies. This is a five-year project
- **Phase 1:** Develop and release the JDTC *Guidelines*. Built on a careful review of the literature and research, listening sessions and conference conversations.
- **Phase 2: JDTC t**esting phase and updating the JDTC *Guidelines* based on results

What led to the Development of the JDTC Guidelines?

- Research on Adolescent Substance Use/Adolescent Treatment and Research on Juvenile Court-Involved Youth with SUDs
- Research on Juvenile Drug Treatment Courts

JUVENILE DRUG TREATMENT COURTS
Have juvenile drug courts worked?
Overall, evaluations regarding the effectiveness of juvenile drug courts have been inconclusive. There is a lack of rigorous research and consistent implementation.



1 Focus JDTC philosophy and practice on effectively addressing substance use and criminogenic needs to decrease future offending and substance use and to increase positive outcomes.
1.1 Team Committed to JDTC's Philosophy and Practice
1.2 Team Member Roles Clearly Articulated
1.3 Include Local Schools
1.4 Access To High-quality TTA
1.5 Engage Family Throughout JDTC Process
1.6 Interpreters for Non-English-Speaking Families
Healthy Relationships
Improved Family Functioning
Employment Stability
Healthy Adolescent Development
Educational Success
Personal Well-being
Reduced Substance Use
JDTC Outcomes
Reduced Delinquency
2.4 Diverted from or Processed Through Traditional Juvenile Court
Ineligible
Eligible
2 Ensure Equitable Treatment for All Youth
3 JDTC Process That Engages Full Team and Follows Procedures Fairly
4 Comprehensive Assessments That Inform Individualized Case Management
5 Effective Contingency Management, Case Management, and Community Supervision
6 Evidence-Based Substance Use Treatment and Other Services, Plus Prosocial Connections
2.1 Eligibility Criteria
2.3 Screening for Substance Use Disorder
2.2 Validated Risk Assessment
2.5 Equity of Access
3.1 Collaboration With Parents/ Guardians
3.2 Screening for Substance Use Disorder
3.3 Consistent Application of Requirements
3.4 Ongoing Review of Progress
4.1 Assessments of Youth and Parent Needs
4.2 Plans Individualized and Culturally Appropriate
Use of Alcohol or Other Drugs
History of Abuse or Other Traumatic Experiences
Criminogenic Needs
Well-being Needs and Strengths
Mental Health Needs
Parental Drug Use, Parental Mental Health Needs, and Parenting Skills
5.1 Incentives ≥ Sanctions
5.4 Addressing Youth's Needs
5.2 Fair Assignment of Incentives and Sanctions
5.5 Address Drug Test Concerns
5.3 Fees and Detention Rarely Used
5.6 Respond to Return to Use Based on RNR
6.1 Continuum of Treatment Resources
6.4 Evidence-based Treatments for All Identified Needs
6.2 Evidence-based Treatments
6.5 Participants Encouraged to Practice Prosocial Skills
6.3 Fidelity to the Programmatic Models
7.1 Facilitate Equivalent Outcomes for All Participants
7.2 Terminated Only as Last Resort
7.3 Performance Measures
7 Monitor and Track Program Completion and Termination

7 Main JDTC Objectives

1. Effectively address substance use and criminogenic need
2. Ensure equitable treatment by adhering to eligibility criteria
3. Engage full team and follow procedures fairly
4. Comprehensive needs assessments and individualized case management
5. Effective implementation of contingency management, case management, and community supervision strategies
6. Refer participants to evidence-based treatment and other services
7. Monitor and track program completion and termination

Focus the JDTC philosophy and practice on effectively addressing substance use and criminogenic needs to decrease future offending and substance use and to increase positive outcomes.

The JDTC Guideline and Objective Statements

- Based on research
- 7 objectives with 31 corresponding guideline statements
- May also apply to youth with SUD in traditional juvenile court
- Some questions not addressed if evidence is insufficient

Objective 2:

2

Objective 2. Ensure equitable treatment for all youth by adhering to eligibility criteria and conducting initial screening.

Objective 3:

3

Objective 3. Provide a JDTC process that engages the full team and follows procedures fairly.

Objective 4:

4

Objective 4. Conduct comprehensive needs assessments that inform individualized case management.

Objective 5:

5

Objective 5. Implement contingency management, case management, and community supervision strategies effectively.

Objective 6:

6

Objective 6. Refer participants to evidence-based substance use treatment, to other services, and for prosocial connections.

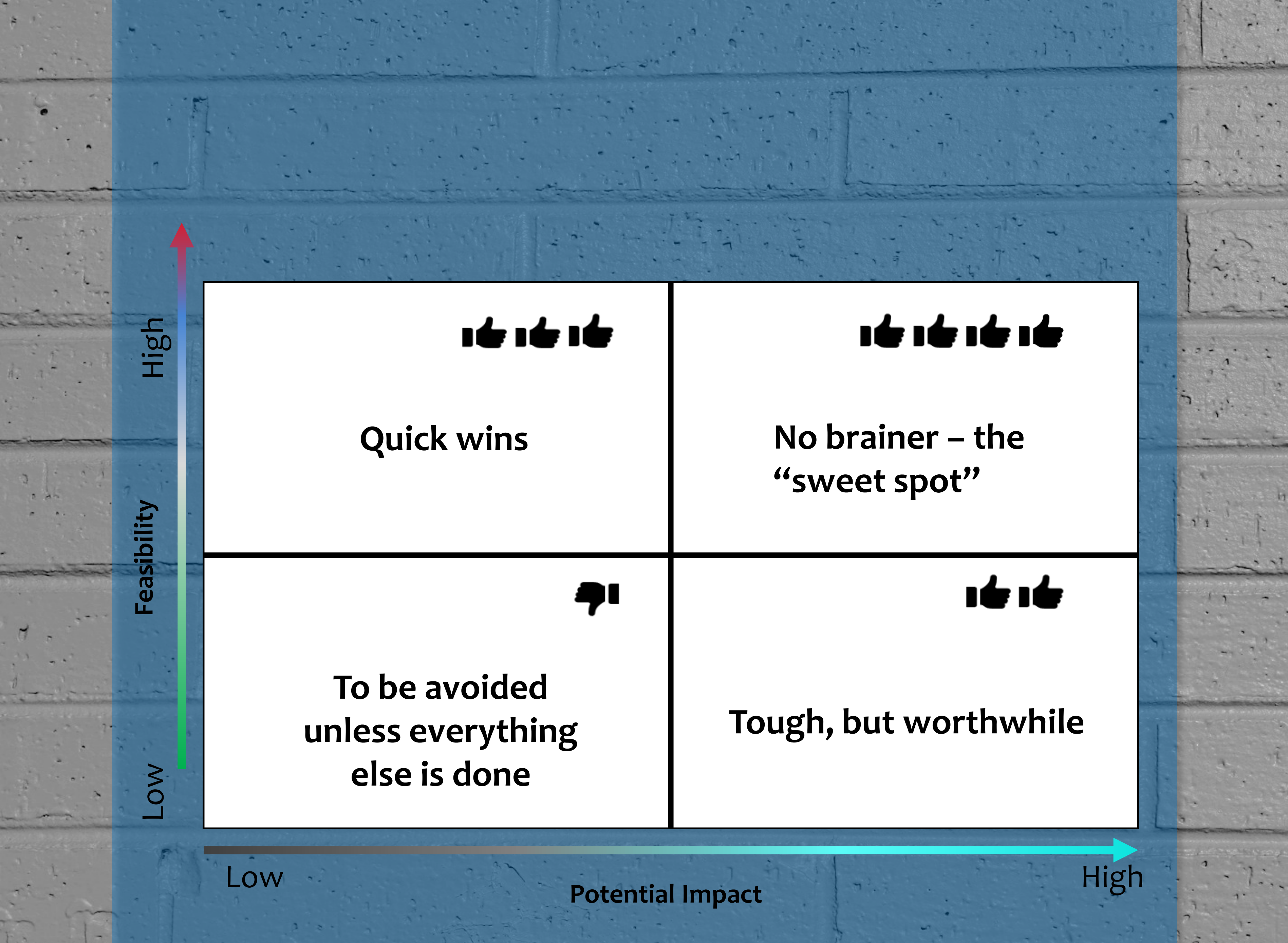
Objective 7:

7

Objective 7. Monitor and track program completion and termination.

IMPLEMENTATION TIPS

- Create JDTC Guidelines workgroup
- Review your current policies and procedures
- Collect and analyze data (if available): always disaggregate by race/ethnicity & gender
- Decide on improvement areas via priority matrix exercise. Team to ask themselves:
  - How big would the impact be if we made this change?
  - Is the change feasible?
- Prioritize changes: Start with low-hanging fruit, moving to “tough, but worthwhile” changes.
- Use GANNT chart or Action Plan to set timelines, track progress and close projects.


High
Feasibility
Low
Quick wins
No brainer – the "sweet spot"
To be avoided unless everything else is done
Tough, but worthwhile
Low
Potential Impact
High

Substance Treatment from an Ecological Approach

Joshua Leblang, Ed.S. LMHC LCPC
Senior Lecturer
Department of Psychiatry
University of Washington
jleblang@uw.edu

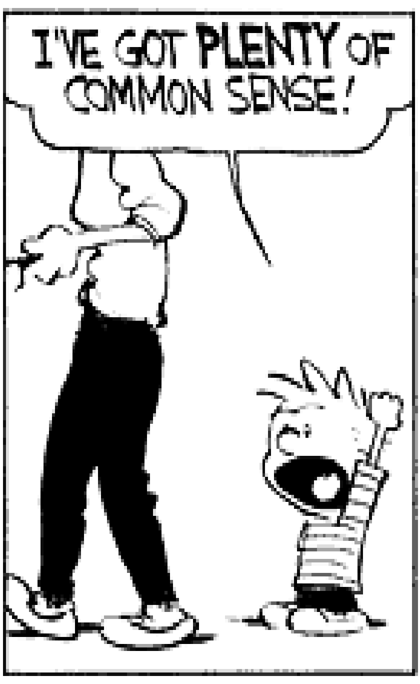
“Adolescent substance abuse is a behavior that, like criminal offending, is best conceptualized as complex, multidetermined, and supported by the interplay of numerous risk factors”

(Dishion & Kavanagh, 2003)

Traditional Substance Use Treatments

* **Restrictive treatment settings**
* **Empirical validation is nearly non-existent**
* **Based on adult models**
* **Poor retention rates (50-90% dropout rates)**
* **Not tailored to meet individual needs**
* **Removed from natural environment**
* **Placed with other substance-abusing youth**
* **Typical focus is solely on the substance use, not contextual factors!**

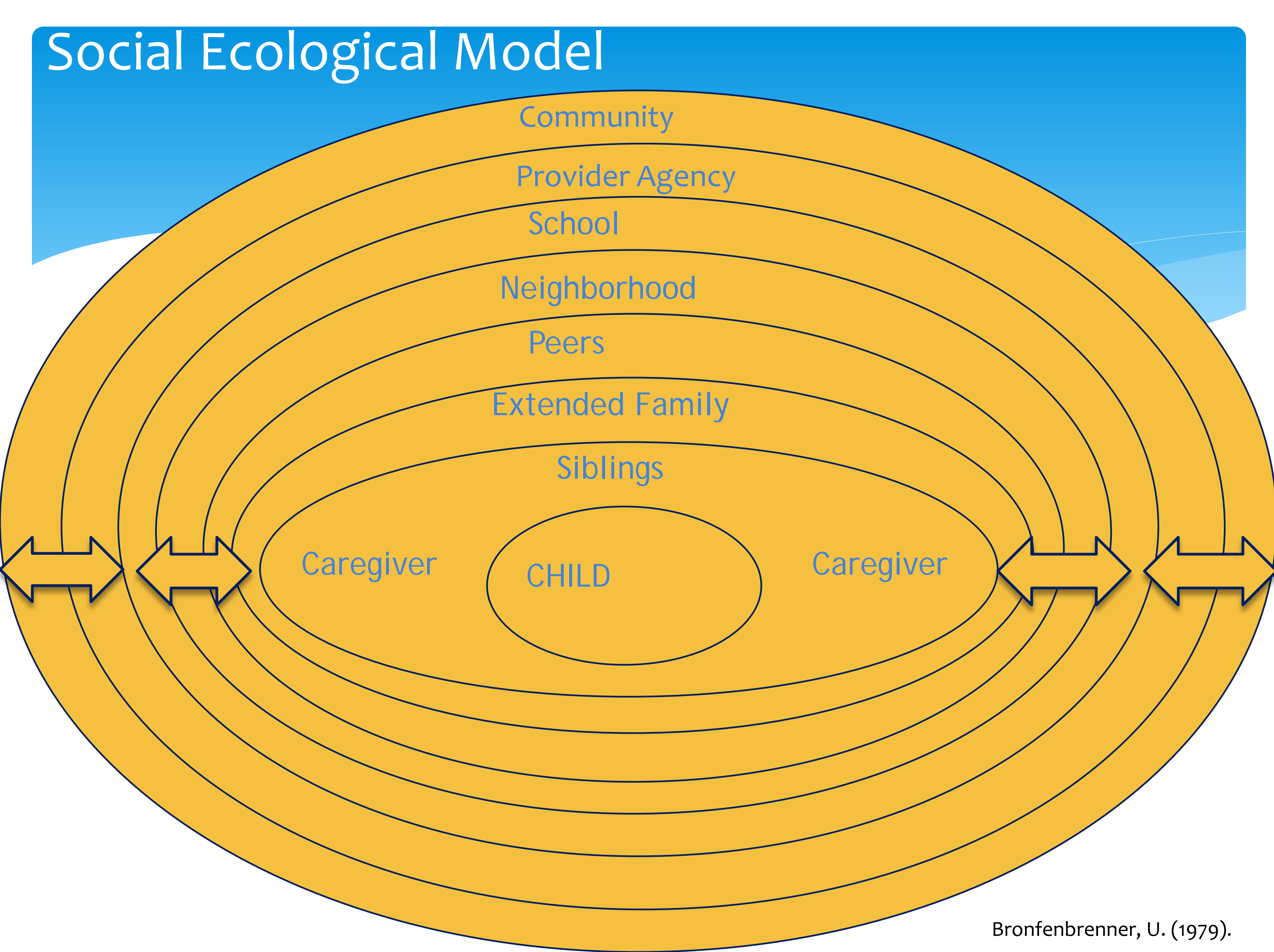
WHY USE A SYSTEMIC APPROACH?



Research on Delinquency and Drug Use

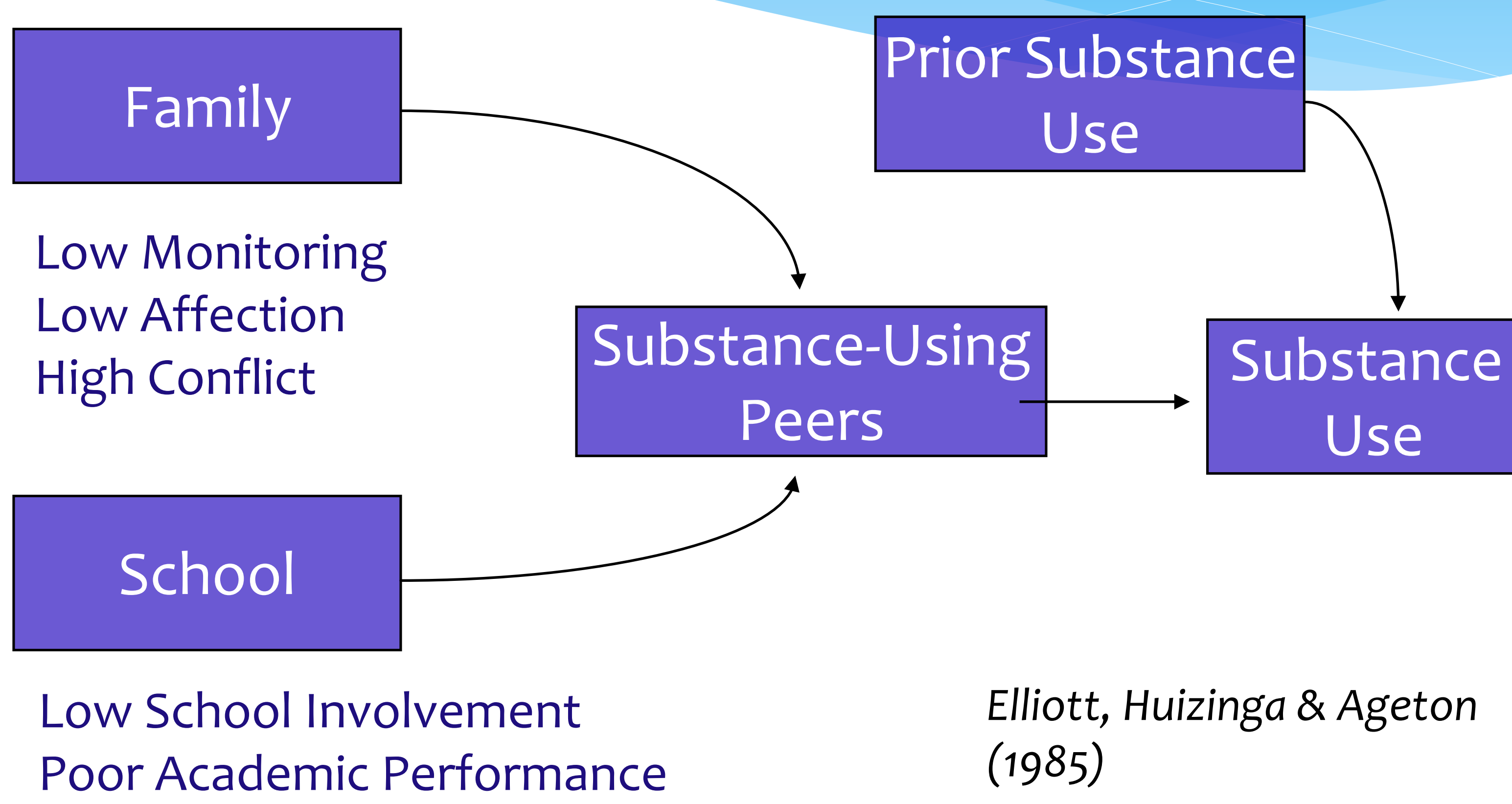
Common findings of 50+ years of research: delinquency and drug use are determined by multiple risk factors:

- Family
- Peer group
- School
- Community
- Youth

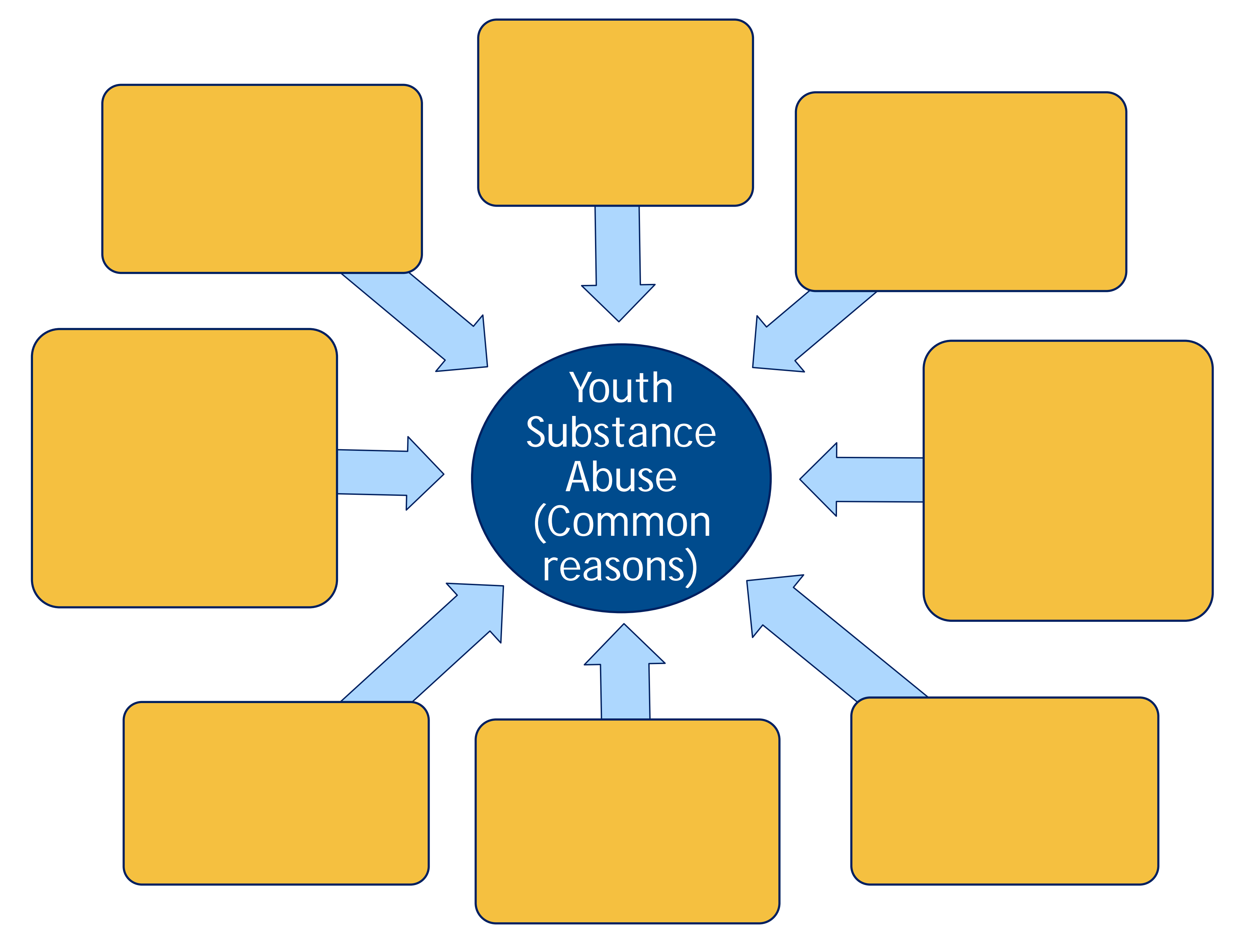

Social Ecological Model
Community
Provider Agency
School
Neighborhood
Peers
Extended Family
Siblings
Caregiver
CHILD
Caregiver
Bronfenbrenner, U. (1979).

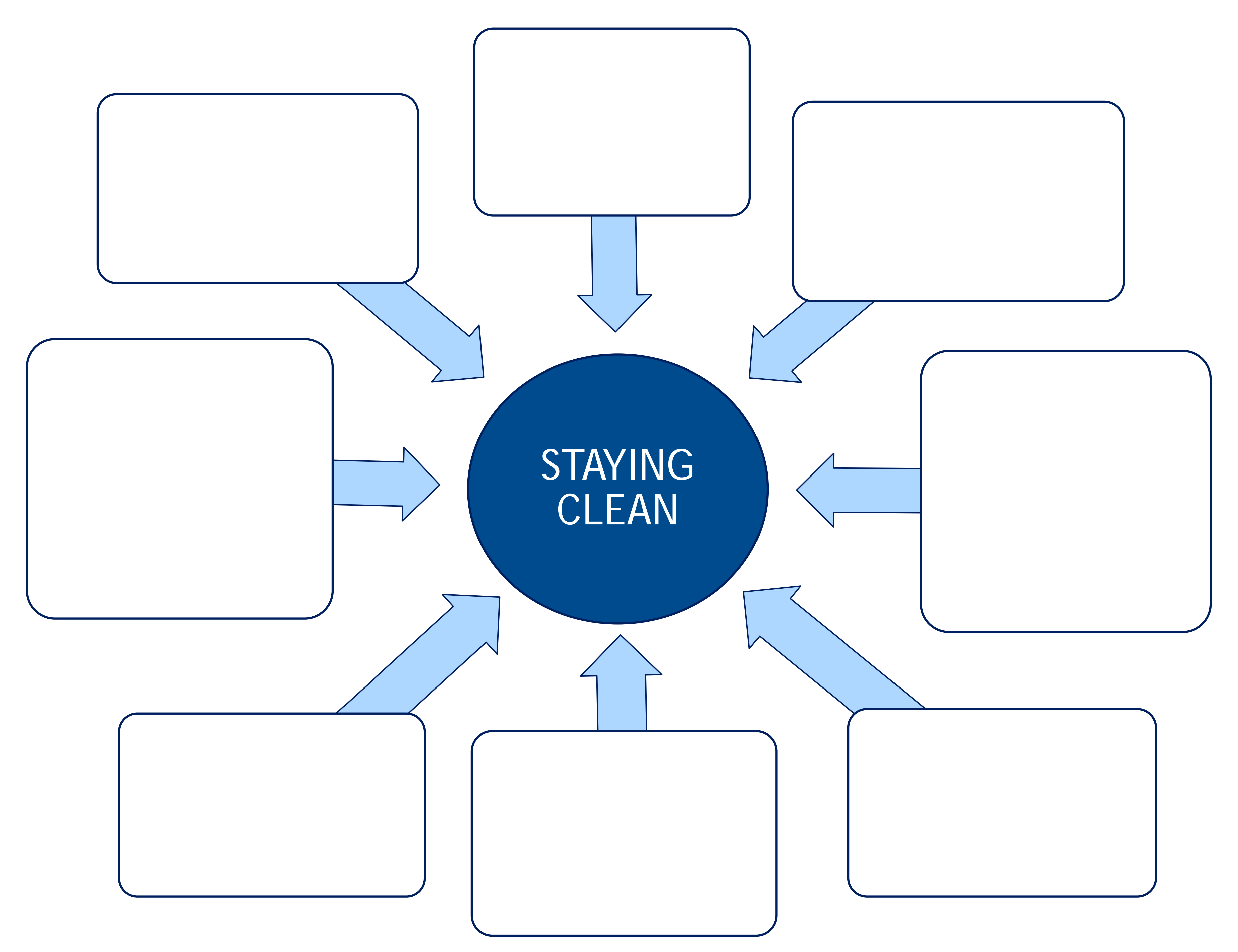
Causal Model of Substance Use in Youth

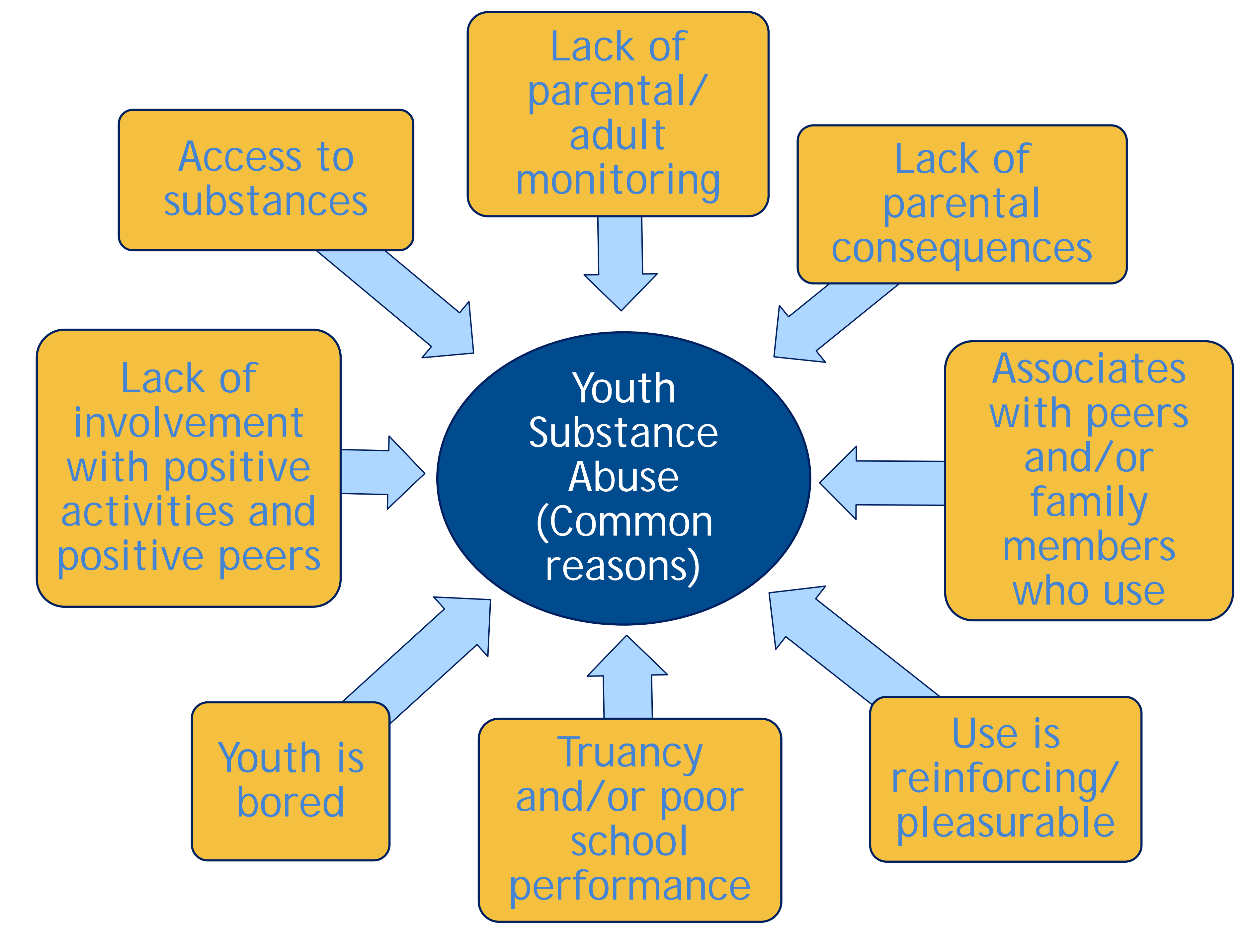
Condensed Longitudinal Model

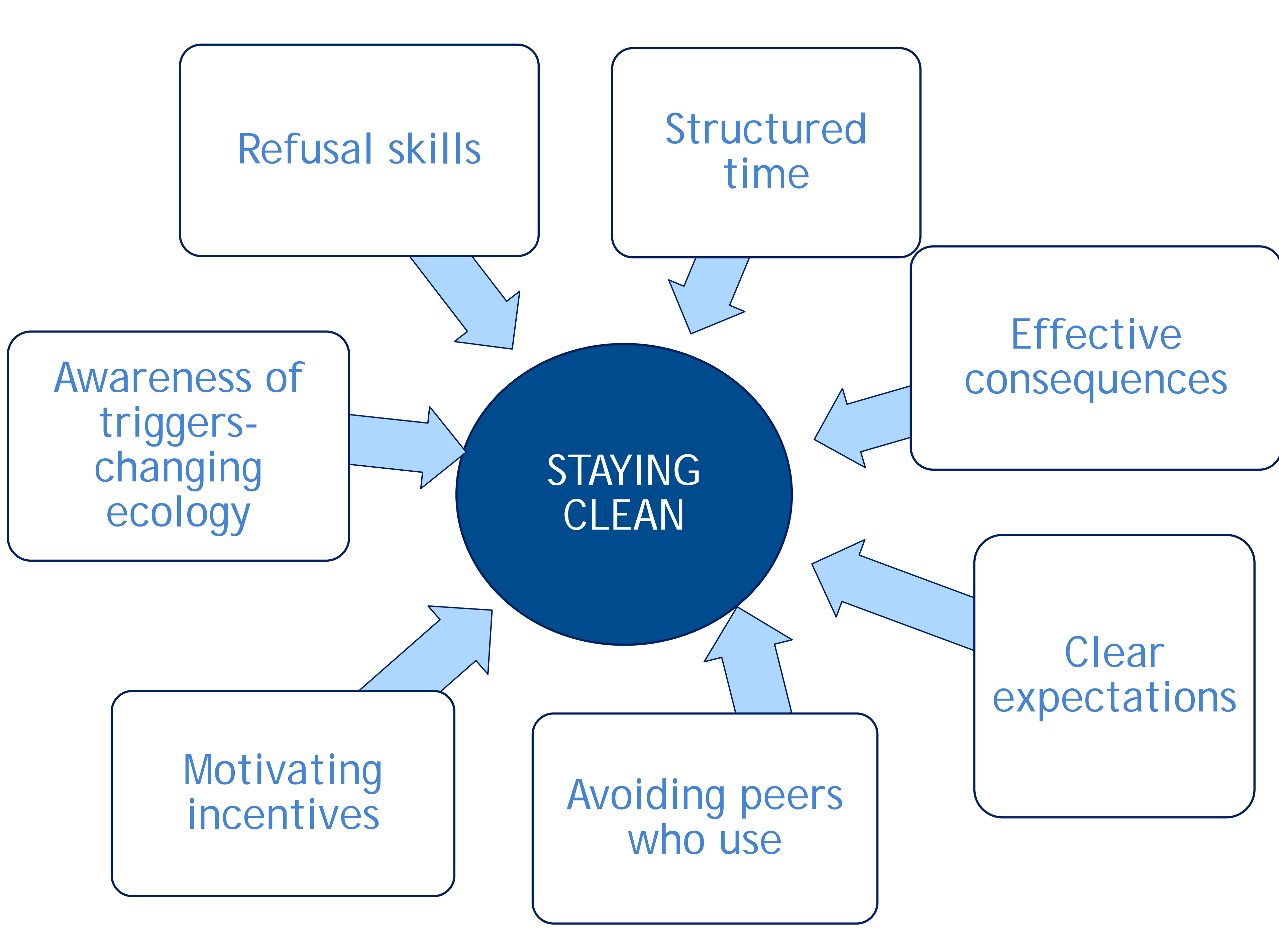


Elliott, Huizinga & Ageton (1985)


Youth Substance Abuse (Common reasons)


STAYING CLEAN


Access to substances
Lack of parental/ adult monitoring
Lack of parental consequences
Lack of involvement with positive activities and positive peers
Youth Substance Abuse (Common reasons)
Associates with peers and/or family members who use
Youth is bored
Truancy and/or poor school performance
Use is reinforcing/ pleasurable



Refusal skills
Structured time
Effective consequences
Awareness of triggers-changing ecology
STAYING CLEAN
Clear expectations
Motivating incentives
Avoiding peers who use

Systemic Factors for Substance Use

Individual: other antisocial behaviors, low self-esteem, low social conformity, psychiatric symptomatology, positive expectancies for substance effects, and genetic loadings

Family: ineffective management and discipline, low warmth and high conflict, weak social support network, parental drug abuse and mental health problems that interfere with effective parenting

Peers: association with violent substance using peers, which is the single most powerful predictor of antisocial behavior in adolescents;

School: low intelligence, achievement, and commitment to achievement;

Neighborhood: disorganized and high crime, availability of drugs, and availability of guns.

Elliot, 1994, 1998; Hawkins, Catalano, & Miller, 1992; Howell,2003; Schinke, rounstein, & Gardner, 2002)

Assess Recent Patterns of Substance Use

* Learn where, when, and with whom the youth usually uses (typical occurrence)
* Obtain detailed sequences regarding incidents of use
* Learn about the nature, length, and outcome of previous attempts to stop use
* Understand the reasons of use
* Understand the reasons of when youth doesn’t use

Interventions

Key Points:

* Engage Caregivers
* Identify Signs of Use
* Reduce Access to Substances
* Alter Peer and Community Ecologies
* Improve Parental Discipline Strategies
* Improve Home-School Link
* Improve School Monitoring and Discipline Strategies
* Involve Caregivers in Individual Youth Interventions
* Increase Self-Management Planning/Drug Refusal Skills

Reduce Access to Substances

* Therapist helps caregivers to:
  * Engage in close supervision of the youth 24/7, and youth's communications, to reduce opportunity to access and use drugs or alcohol
  * Remove or secure substances in all settings (home, community, peers' homes, etc.,) including substances found through searches
  * Carefully manage youth's access to money, including income from jobs

Change the Youth’s Peer and Community Ecologies

- Therapist helps caregivers to:
  - Increase the youth’s contact with peers and community members who don’t use
  - Increase youth’s involvement in prosocial activities
  - Decrease contact with peers and community members who do use
  - Engage stakeholders to avoid putting the youth in settings with other youth who use, including AA
- Reminder: addressing negative peer association is key

Improve Parental Discipline

* Therapist helps caregivers to implement consequences for use and non-use
  * Clear behavior plan
  * Effective consequences
    * Powerful incentives for non-use behaviors
    * Clear, agreed upon sanctions for use, e.g. for dirty drug screens
    * Increase intensity of consequences if needed to address higher intensity and higher frequency use, including use of graduated consequences

For additional information: see *Contingency Management for Adolescent Substance Abuse: A Practitioner's Guide* (2012) by Henggeler, Cunningham, Rowland, Schoenwald and Associates

Involving Family

Self Management- Utilizes family/ecological supports to assist in

a) Avoiding triggers/situations
b) Rearranging the ecology
c) Making new plans

Case Example

- James is a 16 year old white male. Currently living at home with his mother and younger sisters. He has been skipping school (missing over 50% of days), exhibits non-compliance at home, has 3 theft charges as well as uses marijuana both at home and in the community (frequency-2-3 times a day, $20-80 a week, intensity- smoking joints/bongs/dabs, duration for past 2 ½ years).
- Efforts to get James to attend outpatient treatment was ineffective. He refused to attend.

Case Example

* He was eventually referred to a home-based therapy model. They looked at the function of his substance use and identified a few key reasons:
    a. Lack of clear expectations at home
    b. Low monitoring/supervision/structure
    c. Ineffective incentives/consequences for use
    d. Ineffective coping skills

Case Example

* The clinician spent time understanding the function of the substance use utilizing information provided by mother.
* Mom was brought through a process to increase social supports to increase her ability to not only monitor, but to hold her son accountable.
* A safety plan was developed to reduce risk of escalations at home and increase mom's willingness to follow through with plans

Case Example

- Mother, with assistance of her supports, identified several pro-social activities
  - Set clear expectations for his behavior
  - Identified consequences & incentives

- Clinician and mom worked with James to assist him in developing alternative coping skills and ways to manage his urges, as well as refusal skills to use with his former friends.

Case Example

* None of this happened quickly- the process took 5-6 months of intensive therapy (2-3 appointments a week & 24/7 support).
* James pushed limits several times, and Mom was able to engage with James' probation counselor for additional support.
* At time of closure, James' overall behavior had improved, although there was a slip approximately 3 weeks prior to ending where James admitted to smoking on a Thursday night outing- however mom was able to enforce a consequence for his behavior.