

The Challenges of Treatment for Youths Inside and Outside of Corrections

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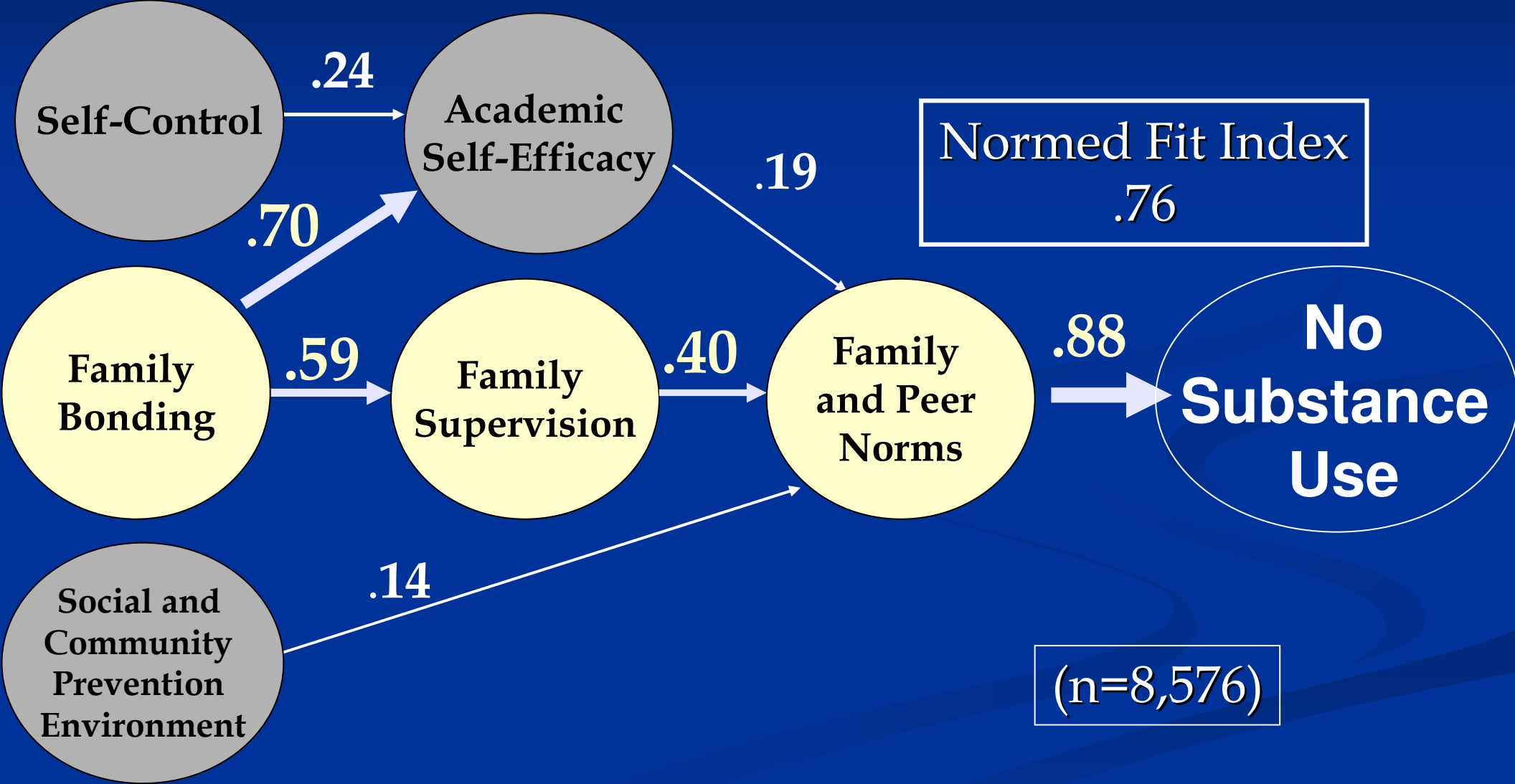
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- **Adolescents who abuse drugs:**
 - ✓ **Are at greater risk of failing to develop a prosocial identity**
 - ✓ **Have more risk of failing to acquire interpersonal and educational skills necessary for adult roles**
 - ✓ **Display poor impulse control and low tolerance for discomfort**
 - ✓ **Often have a history of school problems, involvement in antisocial activities**
 - ✓ **Emotional and psychological distress**

Pathways to Substance Abuse in High Risk Youth (CSAP)



What kind of treatment for whom???

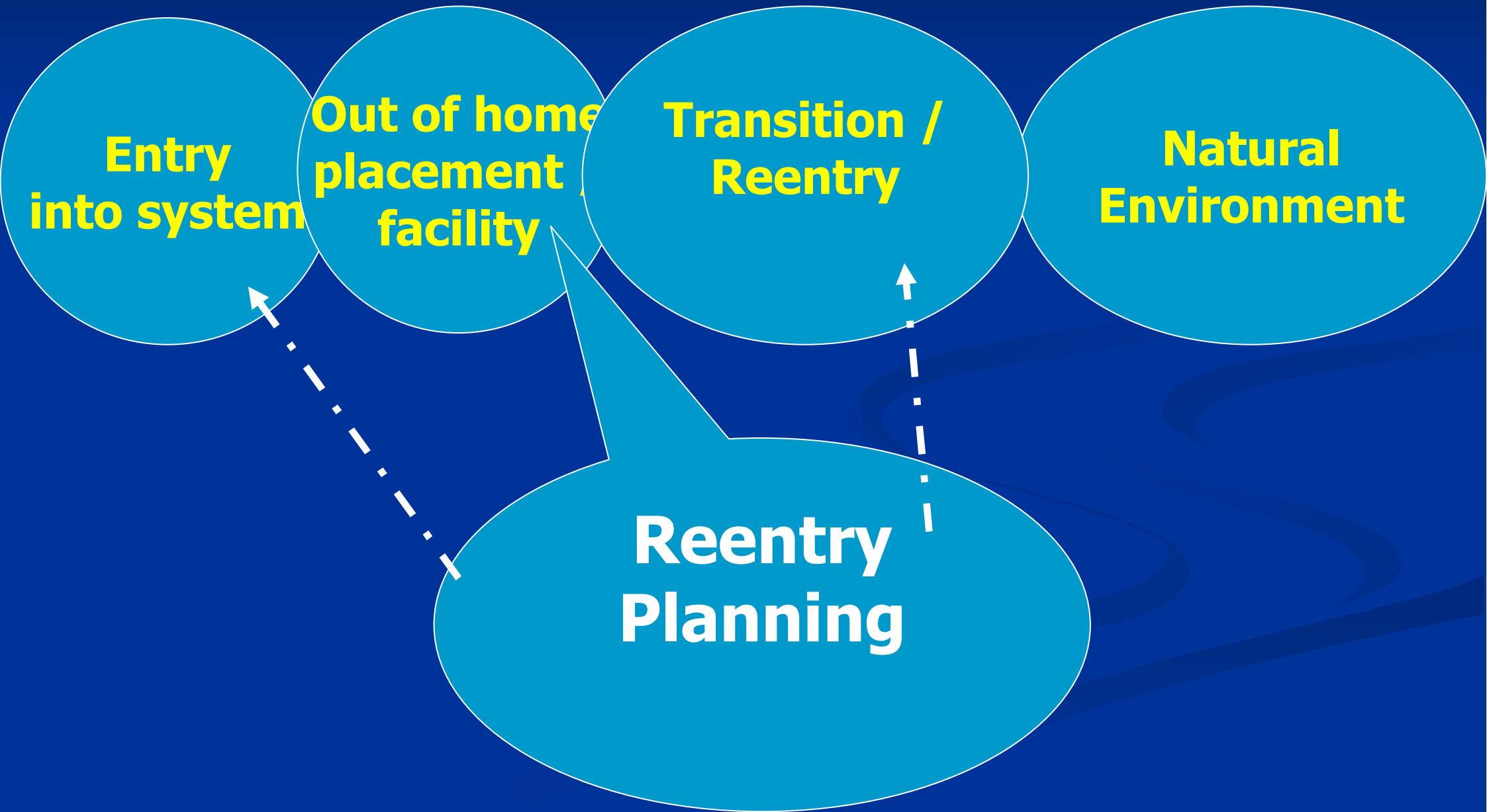
- **Both residential and outpatient modalities have demonstrated effectiveness**
- **However, the type of intervention will depend upon a young person's needs**
 - the level of risk & protective**
 -  **factors considering ecological, intrapersonal and interpersonal contexts**

Issues of Integration

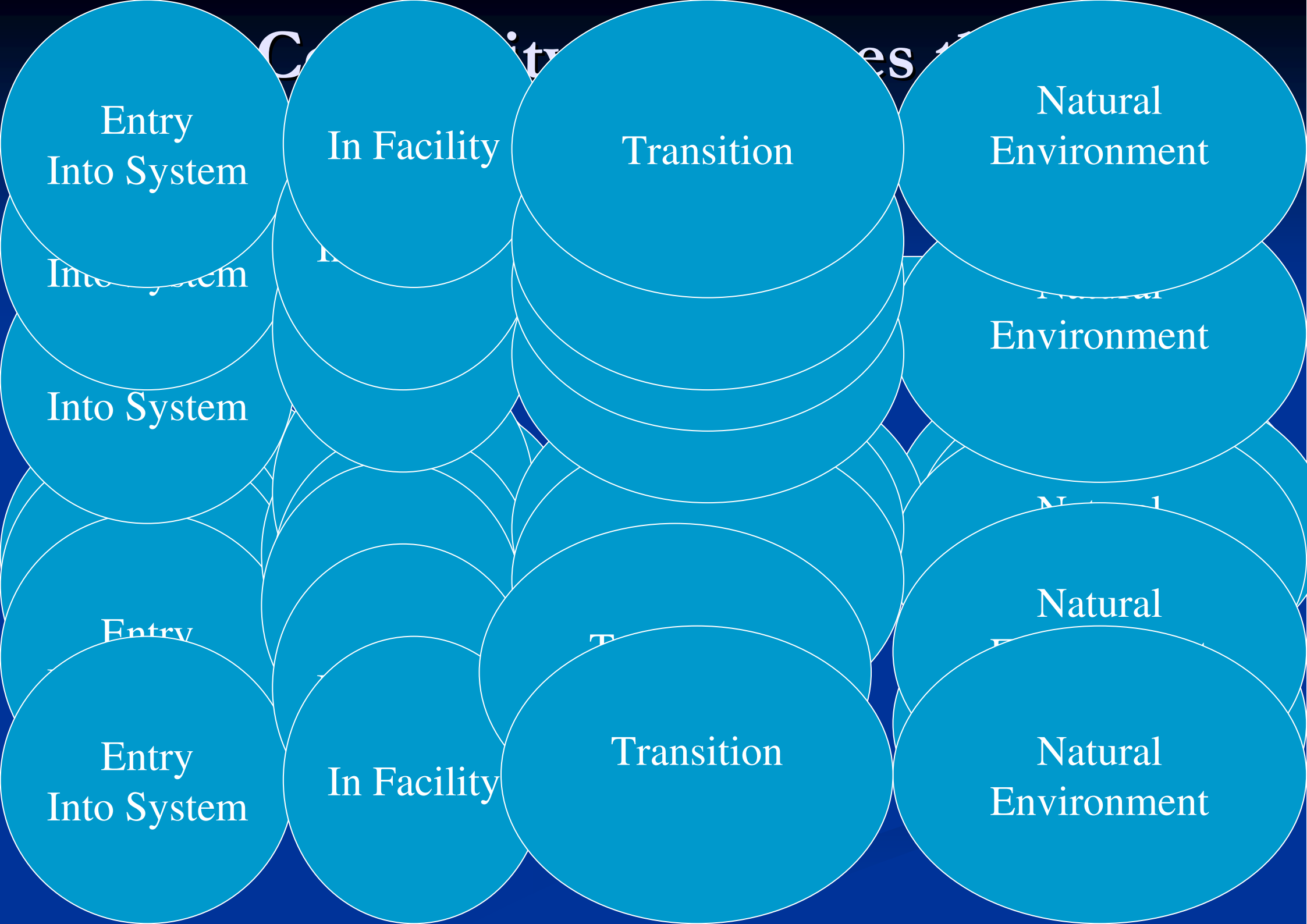
■ Point of access

- ✓ Drug Court
- ✓ Detention
- ✓ Residential Settings –
Community-Based
or Institutional
- ✓ Reentry

Out of Home Placement



Competencies for



Dimensions of System Diversity Impacting

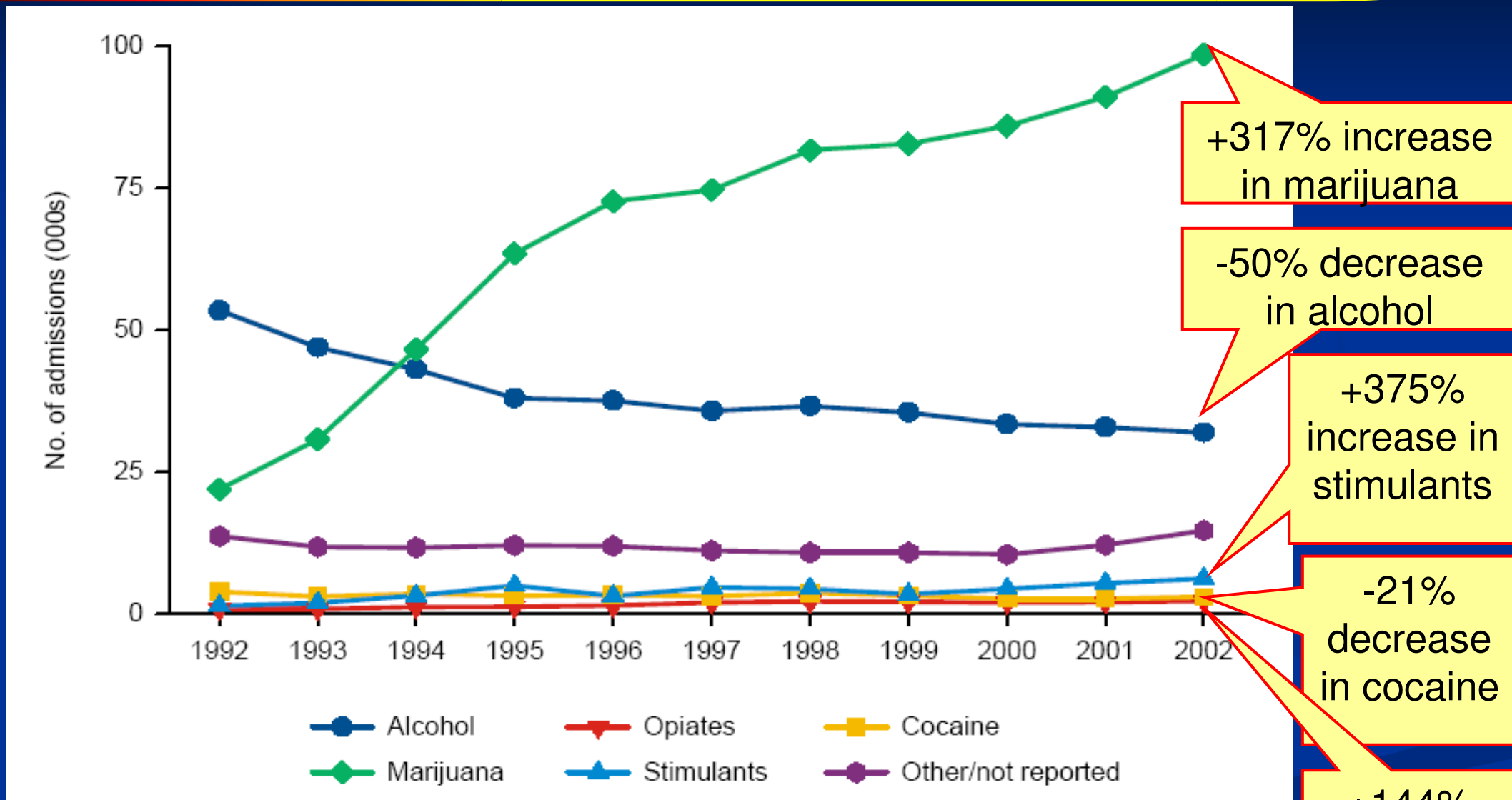
Treatment & Discharge Planning

- **Referral source**
- **System identifying “the problem”**
- **Nature (structure & level of security, treatment philosophy & programming, tenure) of out-of-home placement**
- **Supervisory authority (e.g., Parole, Probation, Conditional Release)**
- **Continuity of supervisory authority**
- **Geographic distances between systems**
- **Match of placement & reentry personnel to client characteristics**

Need to address...

- ✓ **Assessment and treatment matching**
- ✓ **Comprehensive, integrated systems & services**
- ✓ **Family involvement in treatment**
- ✓ **Engagement & retention**
- ✓ **Staffing (Treatment and Corrections)**
- ✓ **Gender & culture**
- ✓ **Continuing care**

Change in Primary Substance



Source: OAS 2004, Treatment Episode Data Set (TEDS) 1992-2002. Rockville, MD:

SAMHSA. http://www.dasis.samhsa.gov/teds02/2002_teds_rpt.pdf

+317% increase in marijuana

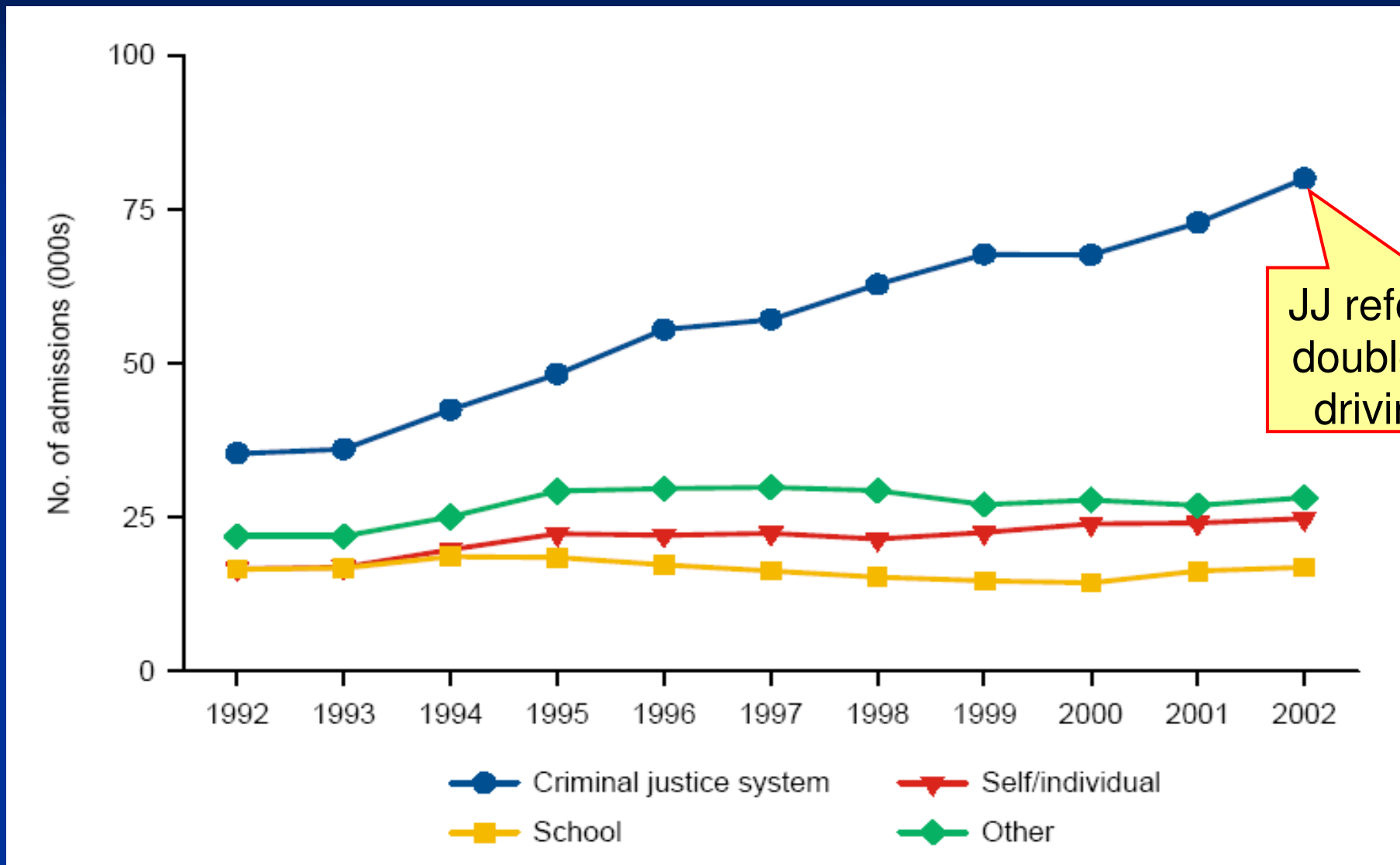
-50% decrease in alcohol

+375% increase in stimulants

-21% decrease in cocaine

+144% increase in opiates

Change in Referral Sources



Source: OAS 2004, Treatment Episode Data Set (TEDS) 1992-2002. Rockville, MD: SAMHSA.

http://www.dasis.samhsa.gov/teds02/2002_teds_rpt.pdf

Focus on Corrections

- **Pre-Incarceration**

- **Incarceration**

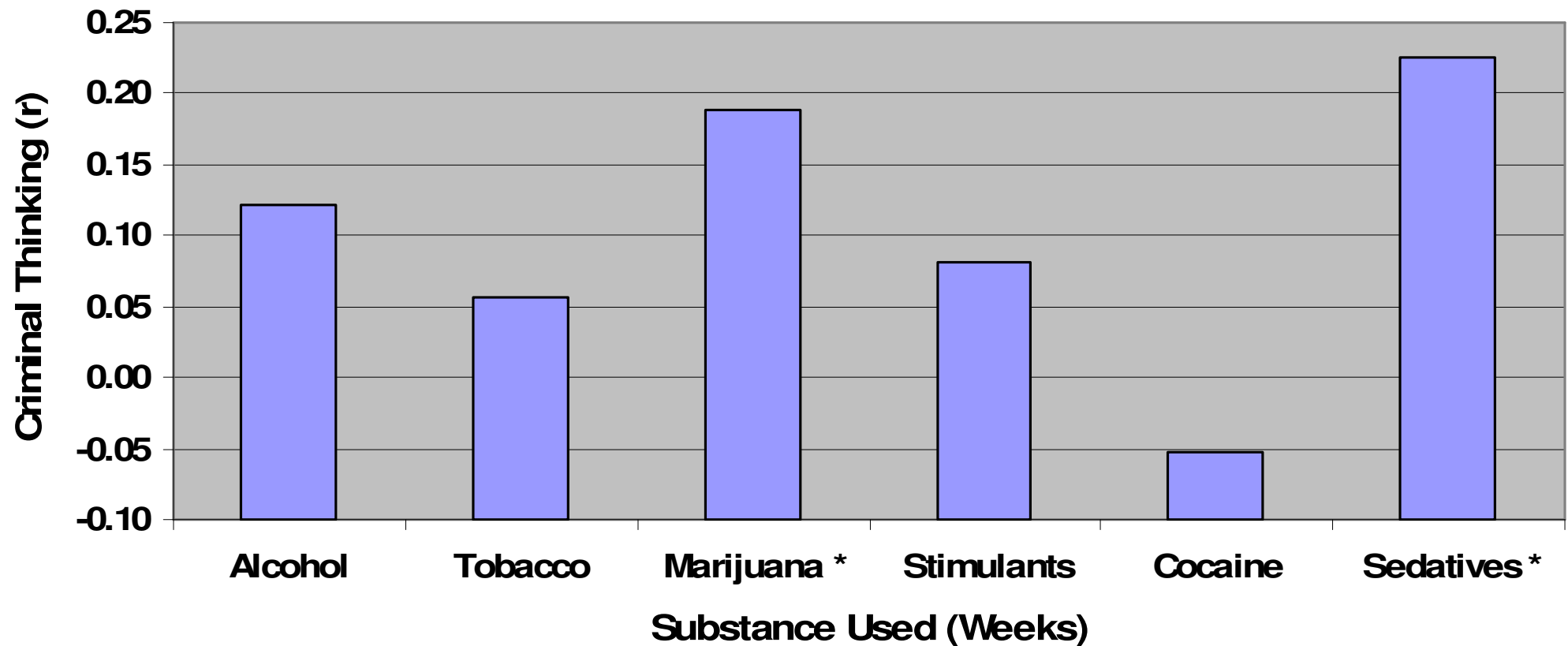
- **Re-Entry**

Background

- **In the United States, an estimated 2.3 million arrests were made of individuals under the age of 18 in 2001, accounting for 17% of all arrests and 15% of all violent crimes (OJJDP, 2003).**
- **The large majority (78%) are held for delinquency offenses, that is, behavior that would be criminal law violations for adults (Sickmund, in press).**
- **Arrests of females for various offenses are increasing more than arrests of males; females constituted 28% of those arrested, and 13% of those in custody.**

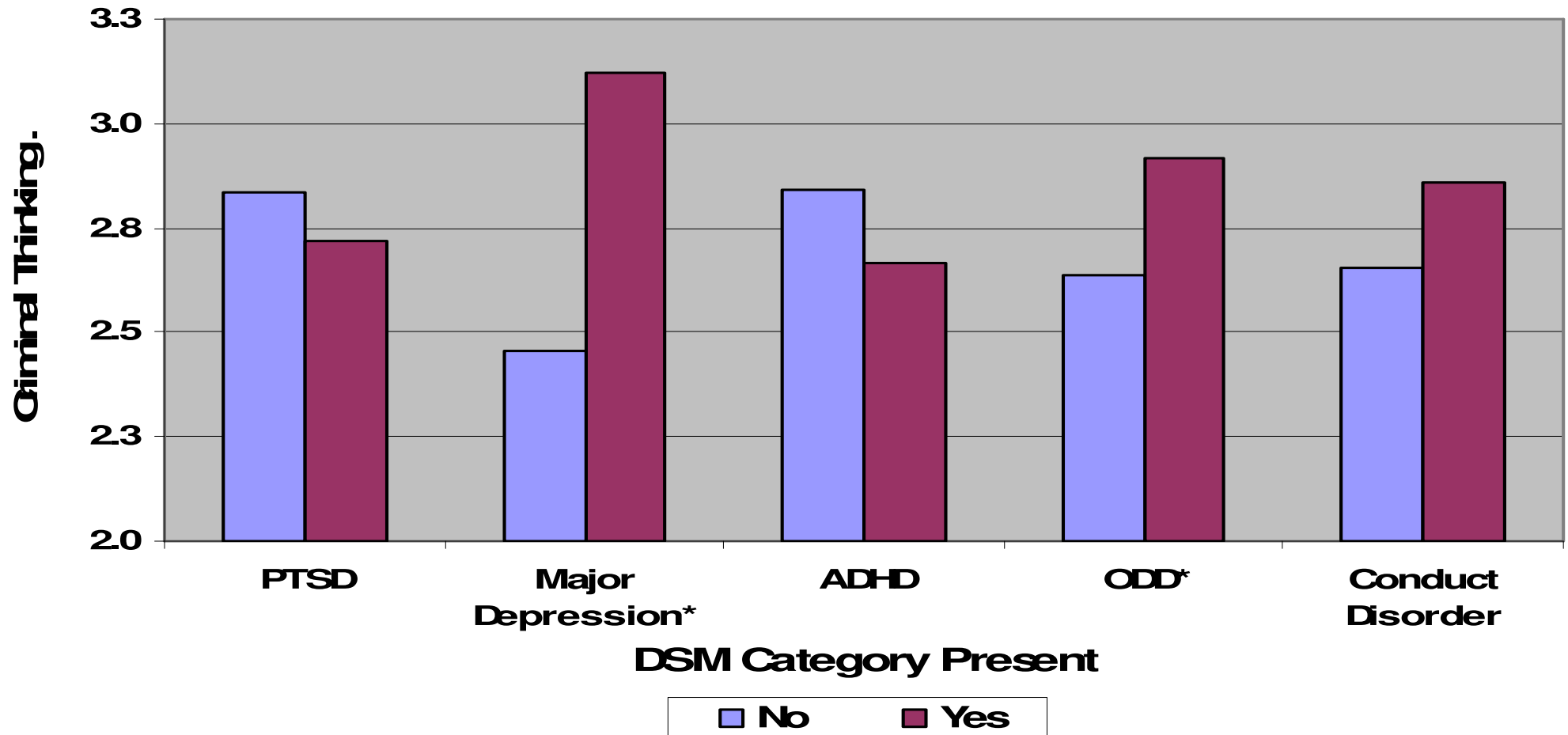
- **Justice involved youths have more serious behavioral, and emotional/mental health problems than youths in the community**
- ***The more youths penetrate the juvenile justice system, the more serious are these problems ->***
 - ✓ ***Drug use***
 - ✓ ***Antisocial behavior***
 - ✓ ***Mental health***
 - ✓ ***Family***

Correlation of Criminal Thinking Composite and Weeks of Substance Use in Past Year (Self Report)



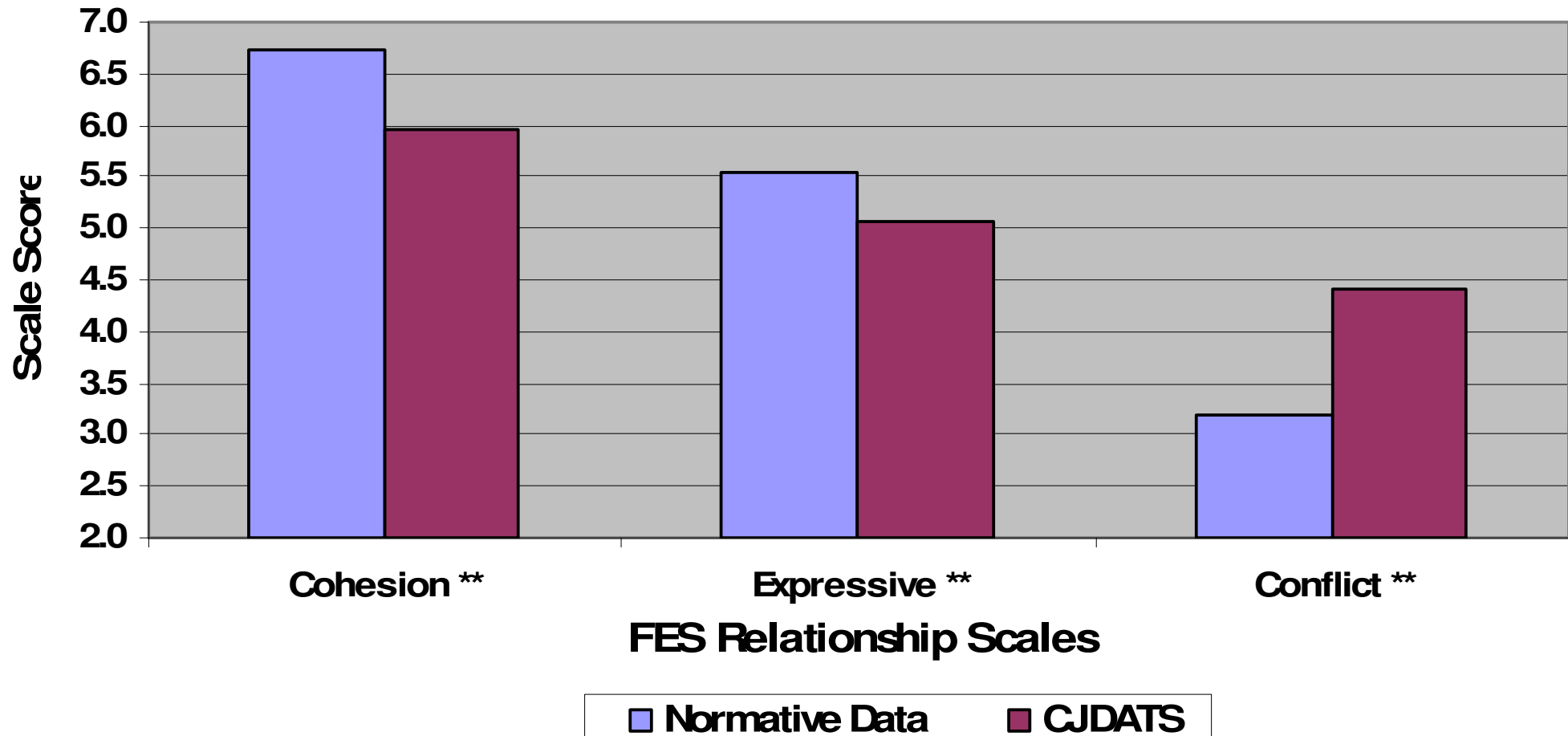
Note: The Criminal Thinking Composite was significantly correlated ($p < .05$) with the marijuana and the sedative use substances. Other correlations were not significant.

Means Criminal Thinking Composite Scores of Respondents With or Without DSM Diagnoses



Note: The mean level of Criminal Thinking was significantly different for respondents on the Major Depression and the Oppositional Defiant Disorder diagnoses.

Comparison of FES Relationship Dimension Scales to Normative Data



Note: All of the comparisons between the CJDATs sample and normative samples were statistically significant ($p < .001$). Higher scores indicate greater cohesion, expressiveness and conflict.

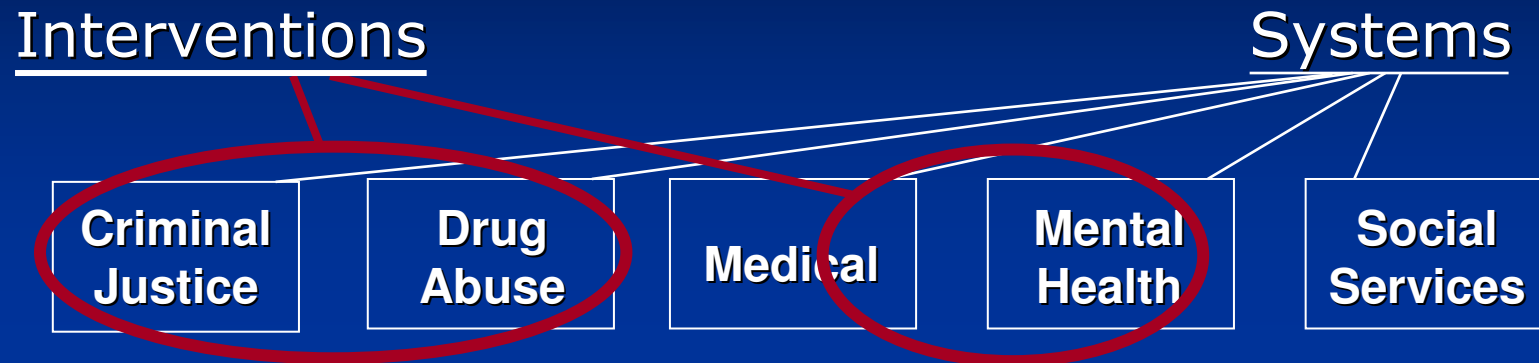
The Relationship between the FES Relationship Dimension, Gender, Substance Use, Criminal Involvement, and DSM Diagnoses

- **Gender.** There are no gender differences on the Relationship, System Maintenance and Personal Growth dimensions of the FES.
- **Substance Use.** Higher relationship conflict is associated with stimulant, cocaine, opiate, and sedative use.
- **Criminal Involvement.** Greater relationship dysfunction is correlated with Grand Theft and Index Crimes.
- **DSM Diagnoses.** PTSD was significantly associated with the FES Relationship dimension (+)

The Challenge

To improve outcomes for offenders with substance use disorders by improving the integration of drug abuse treatment with public safety and public health systems.

Need for Systems Thinking



System - Intervention Interactions

- **Individuals interact with multiple systems**
- **The effectiveness of an intervention may depend upon its functional relationship with other systems**
- **Improving interventions may require improving system-intervention relationships**
- **Therefore, the relationship of interventions across systems should be studied**

Staffing (Treatment & / vs. Corrections)

- *Differences in priorities and philosophical approaches – control/safety "vs." treatment*
- Training and cross-training (e.g., mental health and substance abuse)
- Staff renewal and retention
- Demographic profiles
- Staff in recovery
- (The union)

Gender and Cultural Competence

Gender: Girls are being arrested at a higher rate than male adolescents, for less serious offenses, typically less violent, and more likely to be detained for status offenses.

Delinquent girls are more often victims themselves and significantly more likely to have experienced sexual and/or physical abuse.

➔ Need for focus on comorbidity, violence and treatment pertaining to girls in JJ

Cultural competence/sensitivity: Attention to language needs, traditions and beliefs.

➔ Non-whites are significantly overrepresented in the JJ system; bias is cumulative.

The Problem of ReEntry

- Youth leaving corrections-based, residential settings are a heterogeneous group with diverse problems (e.g., negative peers, Criminal thinking, attitudes and beliefs, poor social coping skills)
- Youth return to disorganized communities, school problems, family problems, and negative peer groups
- Gains made in residential settings are not sustained; recidivism and relapse rates are high
 - Challenge: To provide appropriate services to address these multidimensional risk factors

Continuing Care - ReEntry

(OJJ OJJDP: Gies, 2003)

- A structured transition *initiated early in the residential phase*
- A balance between *treatment* (i.e., intervention strategies) and *community restraint (safety)*
- Targeting of specific dynamic and criminogenic characteristics (e.g., attitudes, cognitions, behavior regarding employment, education, peers)
- Implementing a plan that is *adhered to* by trained personnel -> therapeutic integrity
- Requiring frequent contact between staff and offenders -
> the most effective programs provide more (and meaningful) contacts over a longer treatment period
- Using cognitive and behavioral treatments -> structured, focused strategies
- **Appropriate use of surveillance and sanctions**

Psychosocial Treatments for Substance Abusing, Criminally Involved Youth

- **Treatment effectiveness**
 - Family therapy models
 - Individual cognitive behavior therapy
 - Group Cognitive Behavior Therapy
- **Studies suggests that each is effective but they do not differ in effectiveness**
- **Cost effectiveness analyses favor Group CBT over Individual CBT or Family Therapy approaches**

Family Based Interventions

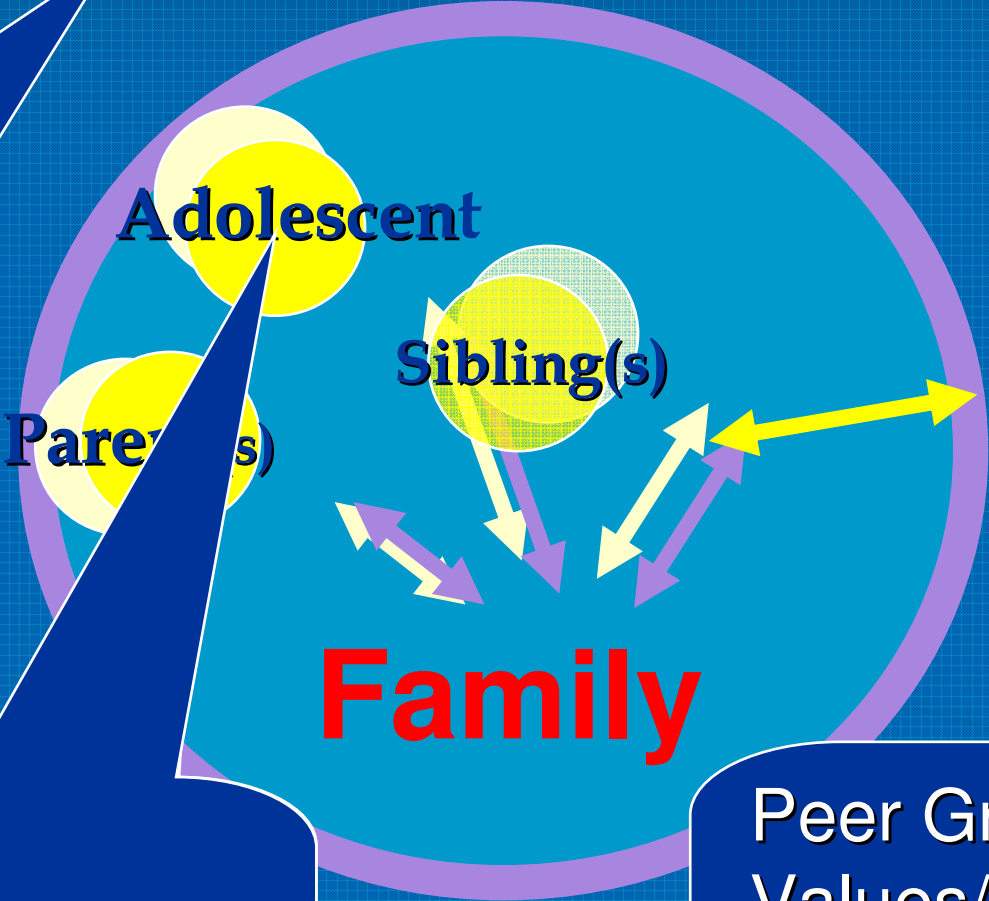
- *Brief Strategic Family Systems Therapy (BSFT)*
- *Functional Family Therapy (FFT)*
- *Multidimensional Family Therapy (MDFT)*
- *Multisystemic Therapy (MST)*
- **Behavioral Family Therapy (BFT)**
- **Integrative Behavioral Family Therapy (IBFT)**
- **Transitional Family Therapy (TFT)**
- **Strength Oriented Family Therapy (SOFT).**

- **Is the family involved in the assessment process?**
- **Is the family involved in the treatment process?**
 - **Where are family services provided? (e.g., home-based?)**
- **Need for a variety of options for family participation since needs and impact will vary**
- **How is family defined?**
- **What are the factors that “family” brings to the treatment process? ...**

What must effective family involvement consider?

Cultural/Ethnic/Racial "Context"

Traditions
History
Religion
Norms
Values
Risk & Protective Factors



Community

• Biological
• Historical
• Relational
Risk & Protective Factors

Peer Groups
Values/Norms
Socioeconomic Status
Risk and Protective Factors

Family Based Approaches

- Treatment ranges between 2 – 6 months
- Increasingly, home-based ->
 - ✓ maximizes likelihood of participation
 - ✓ More comprehensive picture of family, home ecology.
- **Engagement.** Begins with first contact.
- **Therapeutic Alliance.** Multiple systems & participants of family ecology. (Balance)
- **Changing Communications.** Non-blaming, learning how to listen. Identify, manage feelings.
- **Extrafamilial Systems.** Neighborhood, school, near network

Linking Change Resources

goals / activities / focus

Goals:

- Link family with appropriate help agent
- Build in success
- Eliminate barriers

Activities:

- Know community resources
- Use understanding of effective programs
- Maintain/use community contacts
- Family case manager role
- Use risk & relational assessments

Focus:

- relationships between the family members
- using assessment knowledge
- be relentless

Group and Individual CBT

- **Group CBT (CBT-G), 5- or 12-session versions**
- **Motivational Enhancement Therapy with CBT (MET/CBT5; MET/CBT12)**
- **Individual CBT, individual MET/CBT**
- **Adolescent Community Reinforcement Approach (ACRA)**
- **The Minnesota Model 12-step intervention**

Elements of CBT Approaches

- **Motivational Interviewing. Empathic listening & accurate reflection.**
- **Highlight discrepancy between stated goals and effects of drug use.**
- **Teach alternative coping skills.**
- **Address high risk situations, & coping with potential relapse.**
- **Management of feelings.**
- **Management of thoughts about drug use and behaviors.**

Cognitive Behavior Therapy (Cognitive Restructuring)

**A (Actions) + B (Beliefs)
= C (Consequences)**

- **Our Actions are driven by our Beliefs and they have Consequences.**

Cognitive Restructuring (CR)

- **CR** focuses on cognitions that lead to substance use and other problem behaviors.
- **CR** incorporates Cognitive Behavior Theory principles, adapts them for use by probation and parole officers.
- **CR** assumes our actions are driven by what we believe: *this is the key to social behavior.*

Two ReEntry Strategies: Objective of the Study

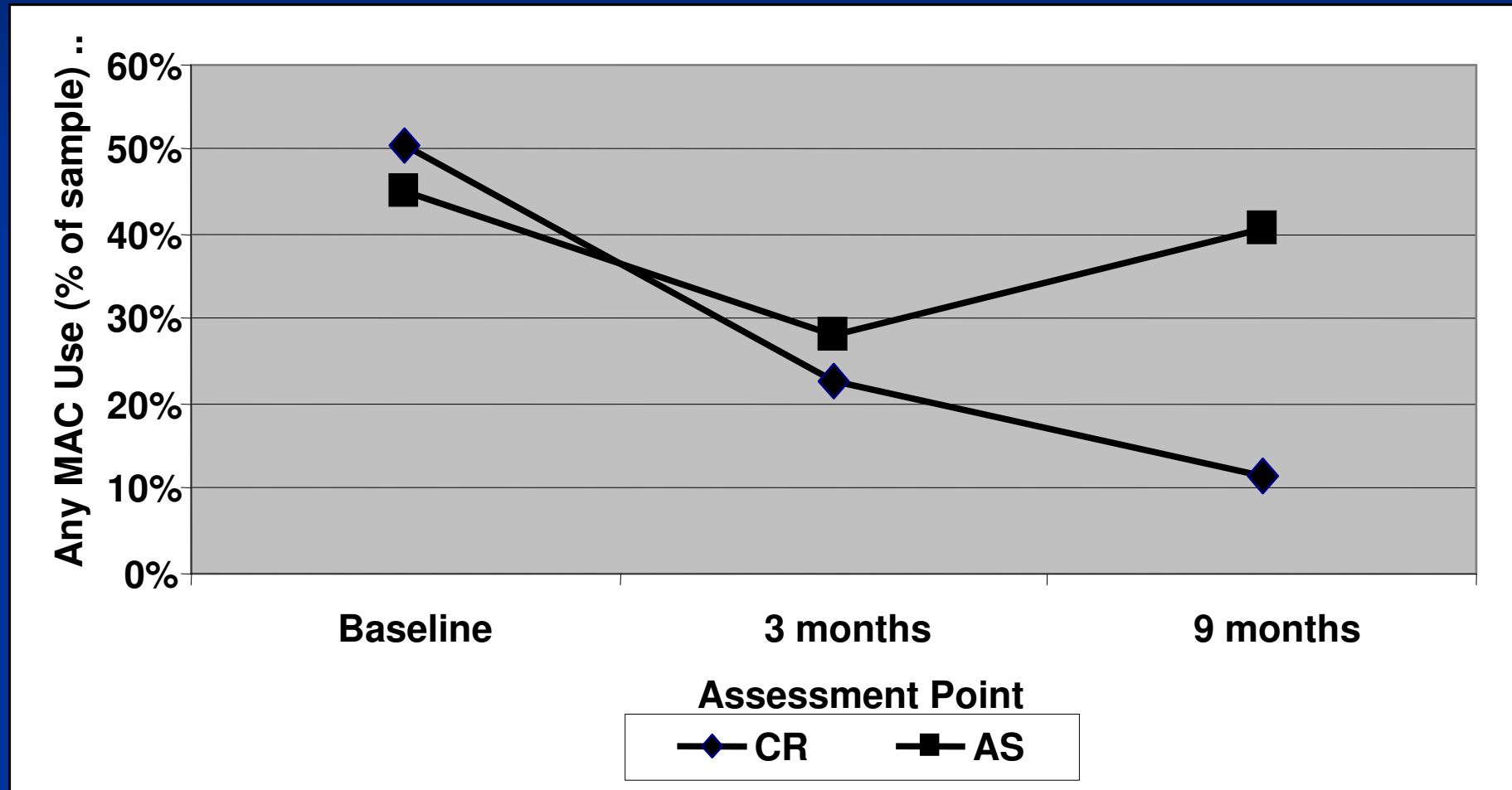
- **To implement, evaluate and identify effective aftercare/reentry programs**
 - ✓ **Identify pre-intervention measures that may predict different trajectories of change**
 - ✓ **Identify types of individuals who are most likely to benefit from each reentry intervention**

Interventions

- **Cognitive Restructuring (CR)**
- **Alternative Services (AS)**

- **Research:** identifies a subgroup described by greater antisocial behaviors (e.g., serious substance use) and poorer treatment outcomes.
- **Challenge:** to differentiate subtypes of these youths for more efficient matching of services to needs.
- **Goal:** to examine factors to clarify who these youths are, and how they respond to services.

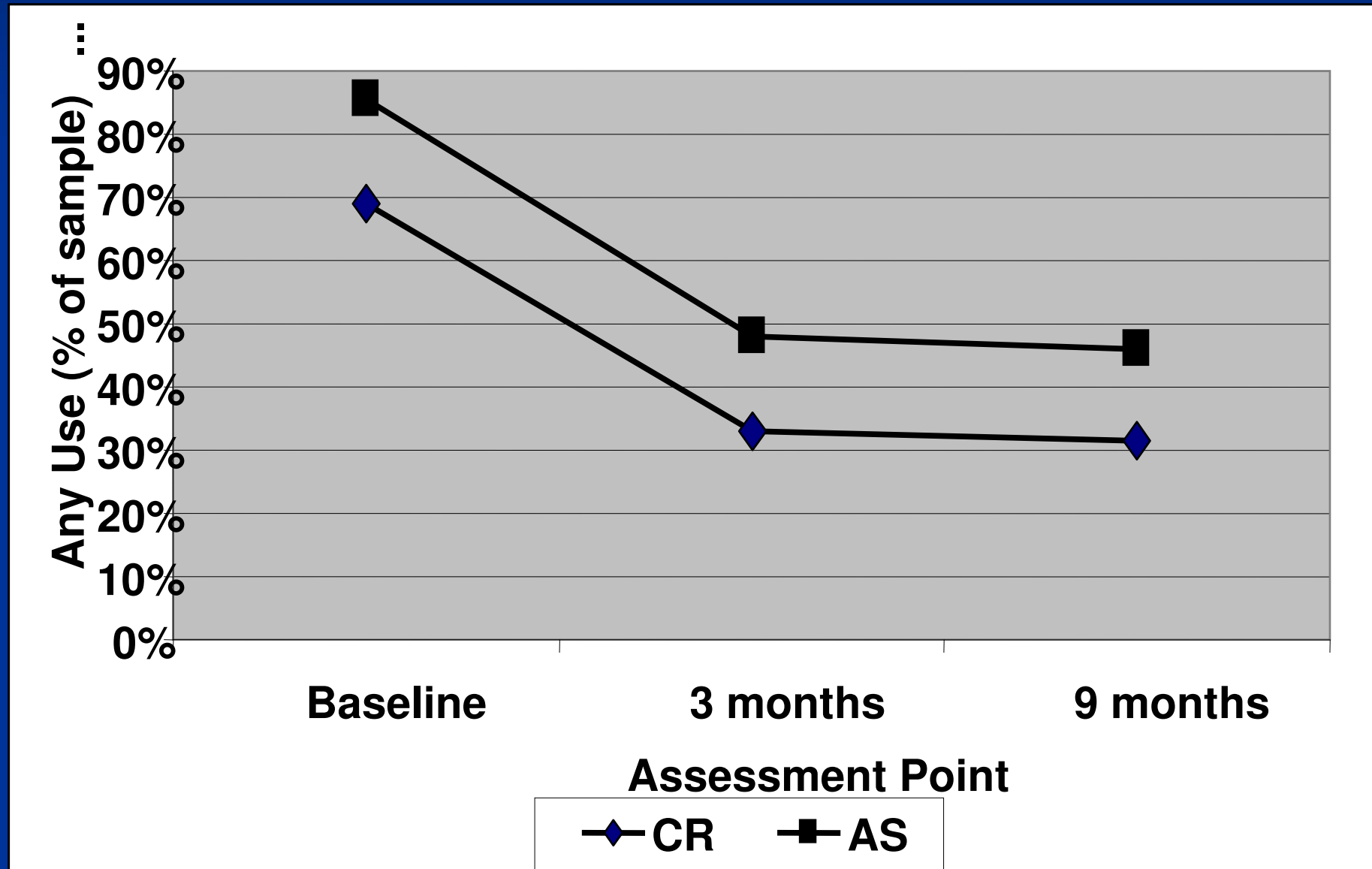
Effects of Treatment Interventions (CR; AS) Across Assessment Points for the African American Adolescents



Note: CR (Cognitive Restructuring); AS (Alternative Services). Any MAC use: marijuana, alcohol, or cocaine/crack.

CR < MAC use than AS: $p < .03$

Effects of Treatment Interventions (CR; AS) Across Assessment Points for non African American Adolescents (no differences)



Summary

Results indicate:

- CR is associated with a significantly lower likelihood of substance use than AS at the 9 month assessment point for African American participants. (for both CR-PO and CR-PO+Group intervention.)
- CR does not lower substance use rates below the AS condition for adolescents in non-African American groups. *However, both ethnic groups show reductions in substance use across the 9 months.*

NOTE: The 9 month assessment sample sizes represents only about 50% of the final projected sample; hence, these results should be considered provisional.

Lessons Learned

- **Select release site overseen by one agency**
- **Establish coordination between residential facilities and release site, and identify committed liaisons**
- **Adequate resources needed to support activities and deal with unanticipated events (e.g., staff turnover)**
- **Coordination and logistics improved if one agency operates release site and residential facilities**

SOME POLICY IMPLICATIONS

- **Probation officers can be trained as effective agents in the delivery of CR.**
- **Administrative and organizational alignment in support of the delivery of (CR) services are critical to their success.**
- **Sufficient incentives are needed to initially engage and sustain the engagement of the high-risk youths we work with.**
- **Differential incentives to participate between conditions represents a potential threat to the internal validity of these studies.**

Summary: Comprehensive, Integrated Systems & Services

The challenge: to bridge system differences, ultimately improving service delivery and efficacy

- **Develop and implement a continuum of supervision and treatment involving multiple systems, to interrupt a potential trajectory of antisocial behavior including drug use/abuse into adulthood**
- **Achieve congruence and collaboration between secure treatment settings and community-based institutions (e.g., schools) and interventions**
- **Provide diversity of services to address the diversity of youth problems**