Serving Adolescents in Family Treatment Drug Court: Identifying and providing youth with services for substance use, mental health and multiple co-occurring needs

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Family Drug Courts: A National Symposium to Improve Family Recovery, Safety and Stability
September 6, 2012

Family Drug Courts

Family dependency treatment court is a juvenile or family court docket of which selected abuse, neglect, and dependency cases are identified where parental substance abuse is a primary factor. Judges, attorneys, child protection services, and treatment personnel unite with the goal of providing safe, nurturing, and permanent homes for children while simultaneously providing parents the necessary support and services to become drug and alcohol abstinent. Family dependency treatment courts aid parents in regaining control of their lives and promote long-term stabilized recovery to enhance the possibility of family reunification within mandatory legal timeframes (Wheeler & Siegerist, 2003).
Marriage counseling movement begins before family therapy

“Actually we get along very well, it’s the kids we can’t stand.”

Age of Children in Foster Care as of September 30, 2005
Substance Abuse Treatment and Foster Care Status

- CSAT data set – 8.3% in treatment currently in foster care
- NSDUH (2005) – 0.6% of youth 12 – 17 ever in foster care
- Odds ratio of 15:1 (but an underestimate)

We know the parents are really the problem!
Multiple Clinical Problems are the NORM!

Source: CSAT 2009 Summary Analytic Data Set (n=20,826)

Youth are involved in multiple systems placing competing demands on them and potentially in conflict with each other

Source: CSAT 2009 SA Data Set Adolescent Subset (n=19,108)
The Number of Major Clinical Problems is highly related to Victimization

Significantly more likely to have 5+ problems (OR=13.9)

Source: CSAT 2009 Summary Analytic Data Set (n=21,784)

No. of Problems* by Severity of Victimization

Those with high lifetime levels of victimization have 117 times higher odds of having 5+ major problems*

Source: CSAT AT Common GAIN Data set (odds for High over odds for Low)

* (Alcohol, cannabis, or other drug disorder, depression, anxiety, trauma, suicide, ADHD, CD, victimization, violence/illegal activity)
Substance Use Careers Last for Decades

Median of 27 years from first use to 1+ years abstinence

Cumulative Survival

Years from first use to 1+ years abstinence

Source: Dennis et al., 2005

Substance Use Careers are Longer the Younger the Age of First Use

Cumulative Survival

Years from first use to 1+ years abstinence

Age of 1st Use Groups

under 15*
15-20*
21+

* p<.05 (different from 21+)

Source: Dennis et al., 2005
Substance Use Careers are Shorter the Sooner Treatment Occurs

The Number of Clinical Problems is Related to Level of Care

Source: Dennis et al., 2005

Source: CSAT 2009 Summary Analytic Data Set (n=21,332)

Significantly more likely to have 5+ problems (OR=5.8)
### The Cost of Treatment is Small Relative to Reductions in other Costs

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening &amp; Brief Inter. (1-2 days)</td>
<td>$407</td>
</tr>
<tr>
<td>In-prison Therap. Com. (28 weeks)</td>
<td>$1,249</td>
</tr>
<tr>
<td>Outpatient (18 weeks)</td>
<td>$1,132</td>
</tr>
<tr>
<td>Intensive Outpatient (12 weeks)</td>
<td>$1,384</td>
</tr>
<tr>
<td>Treatment Drug Court (46 weeks)</td>
<td>$2,486</td>
</tr>
<tr>
<td>Residential (13 weeks)</td>
<td>$2,907</td>
</tr>
<tr>
<td>Methadone Maintenance (87 weeks)</td>
<td>$4,277</td>
</tr>
<tr>
<td>Therapeutic Community (33 weeks)</td>
<td>$14,818</td>
</tr>
</tbody>
</table>

- $750 per night in Detox
- $1,115 per night in hospital
- $13,000 per week in intensive care for premature baby
- $27,000 per robbery
- $67,000 per assault

Source: French et al., 2008; Chandler et al., 2009; Capriccioso, 2004

### Major limits through 1997

- Lack of standardized and evidenced based assessment and treatment limited the reliability of what was done.
- Participation, treatment completion, and follow-up rates were often low limiting the validity of what could be learned.
- The lack of any manualized evidenced based adolescent approaches limited the ability to disseminate and replicate what did work.
- Difficult for clinicians, evaluators and/or researchers to work together or even enter the field.

$22,000/year to incarcerate an adult
$30,000/child-year in foster care
$70,000/year to keep a child in detention
Early Adolescent Treatment Work

1910 – Worth Street Narcotic Clinic in NY – 743 youth
1920 – Federal Narcotic Farms in Lexington, KY & Fort Worth, TX 22-440/yr
1930 – Riverside Hospital in NYC – 250 youth
1940 – Teen Addiction Hospital Wards in several cities
1950 – Drug Abuse Reporting Program (DARP)- 5,405 youth (587 followed)
1960 – Treatment Outcome Prospective Study (TOPS)- 1042 youth (256 followed)
1970 – Services Research Outcome Study (SROS) - 156 youth
1980 – National Treatment Improvement Evaluation Study (NTIES) - 236 youth
1990 – Drug Abuse Treatment Outcome Study of Adolescents (DATOS-A) - 3,382 youth (1,785 followed)
1996


What These Early Studies Taught Us

- Treatment of adolescents with adult models and/or mixed with adults does not work and is actually associated with drop out and increased use
- Need to modify models to be more developmentally appropriate for youth
- Need for assessment and treatment for a wider range of problems including victimization, co-occurring mental health and education needs
- Need to modify materials to be more concrete and use examples relevant to youth
The Current Renaissance of Adolescent Treatment Research

<table>
<thead>
<tr>
<th>Feature</th>
<th>1930-1997</th>
<th>1997-2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tx Studies*</td>
<td>17</td>
<td>Over 200</td>
</tr>
<tr>
<td>Random/Quasi</td>
<td>9</td>
<td>44</td>
</tr>
<tr>
<td>Tx Manuals*</td>
<td>0</td>
<td>30+</td>
</tr>
<tr>
<td>QA/Adherence</td>
<td>Rare</td>
<td>Common</td>
</tr>
<tr>
<td>Std Assessment*</td>
<td>Rare</td>
<td>Common</td>
</tr>
<tr>
<td>Participation Rates</td>
<td>Under 50%</td>
<td>Over 80%</td>
</tr>
<tr>
<td>Follow-up Rates</td>
<td>40-50%</td>
<td>85-95%</td>
</tr>
<tr>
<td>Methods</td>
<td>Descriptive/Simple</td>
<td>More Advanced</td>
</tr>
<tr>
<td>Economic</td>
<td>Some Cost</td>
<td>Cost, CEA, BCA</td>
</tr>
</tbody>
</table>

*Published and publicly available

15+ Year Investment in Improving Adolescent Treatment Effectiveness

- 1997-2001, Cannabis Youth Treatment (CYT) – 600 youth
- 1998-2001, Adolescent Treatment Models (ATM) -1334 youth
- 1998-2004, CSAT/NIAAA experiments – several hundred youth
- 2000-2002, Persistent Effects of Treatment Study of Adolescents (PETS-A) - 1200 youth
- 2001-2003, CSAT/RWJF Reclaiming Futures, 445 youth
15+ Year Investment in Improving Adolescent Treatment Effectiveness

- 2002-2007, Strengthening Communities for Youth (SCY) – 2,249 youth
- 2002-2007, Strengthening Communities for Youth (SCY) – 2,249 youth
- 2002-2007, Strengthening Communities for Youth (SCY) – 2,249 youth
- 2003-2012, Targeted Capacity Expansion (TCE) – 1,417 youth
- 2003-2006, Adolescent Residential Treatment (ART) – 1,458 youth

15+ Year Investment in Improving Adolescent Treatment Effectiveness

- 2003-2007, Effective Adolescent Treatment (EAT) – 5,854 youth
- 2002-2012, Targeted Capacity Expansion (TCE) – 1,417 youth
- 2003-2006, Adolescent Residential Treatment (ART) – 1,458 youth
- 2003-2007, Effective Adolescent Treatment (EAT) – 5,854 youth
- 2004-2009, Co-occurring State Infrastructure Grants (COSIG) – systems project w/CMHS
15+ Year Investment in Improving Adolescent Treatment Effectiveness

- 2004-2009, Young Offender Re-entry Program (YORP) – 1,597 youth
- 2005-2008, State Adolescent Coordinator (SAC) – system
- 2005-2010, Juvenile Treatment Drug Court (JTDC) – 1,678 youth
- 2006-2013, Adolescent Assertive Family Tx (AAFT) – 4,769 youth
- 2007-2011, Brief Interventions and Referrals to Treatment (BIRT) - 427 youth, Joint Funding (CSAT/OJJDP)

- 2009-2011, Reintegration of Youth and Families (Research Contract to randomly assign youth to one of three conditions of supportive services following residential treatment.
- 2009-2016, Reclaiming Futures structure joined with juvenile drug courts and their 16 Strategies (joint funding – OJJDP/RWJF/CSAT)
- 2012-2015, SA-TED – Grants to be awarded in FY 12 for up to 10 states/tribes/territories for developing their infrastructure to field and monitor EBPs for youth treatment
CYT
Cannabis Youth Treatment
Randomized Field Trial

Coordinating Center:
Chestnut Health Systems, Bloomington, IL, and Chicago, IL
University of Miami, Miami, FL
University of Conn. Health Center, Farmington, CT

Sites:
Univ. of Conn. Health Center, Farmington, CT
Operation PAR, St. Petersburg, FL
Chestnut Health Systems, Madison County, IL
Children’s Hosp. of Philadelphia, Phil., PA

Sponsored by: Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services

Rapid Screening & Assessment
Developing and Engaging a Community Network

The Importance of Teams

- Engage all stakeholders in creating an interdisciplinary, coordinated, and systemic approach to working with youth and families.

- Develop and maintain an interdisciplinary, non-adversarial work team.

- Schedule frequent interdisciplinary reviews and be sensitive to the effect that juvenile justice and treatment actions can have on youth and families, for both good and inadvertent harm when working at cross purposes.
Environmental Factors as Major Mediators/Moderators and Predictors of Use and Need for Early Reengagement in Treatment

- AOD use in the home, family problems, homelessness, fighting, victimization, self help group participation, structure activities
- The effects of adolescent treatment are mediated by the extent to which they lead to actual changes in the recovery environment or peer group
- Peer AOD use, fighting, illegal activity, treatment, recovery, vocational activity
- Model Fit
  - CFI=.97 to .99
  - RMSEA=.04 to .06

Most Programs Lack Standardized Assessment for...

- Substance use disorders (e.g., abuse, dependence, withdrawal), readiness for change, relapse potential and recovery environment
- Common mental health disorders (e.g., conduct, attention deficit-hyperactivity, depression, anxiety, trauma, self-mutilation and suicidal ideation)
Assessment for ALL disorders is needed because . . .

- Having one disorder increases the risk of developing another disorder;
- The presence of a second disorder makes treatment of the first more complicated;
- Treating one disorder does NOT lead to effective management of the other(s);
- Treatment outcomes are poorer when co-occurring disorders are present.

**Psychometric Properties GAIN-SS**

- **Prevalence (% 1+ disorder)**
- **Sensitivity (% w disorder above)**
- **Specificity (% w/o disorder below)**

Using a higher cut point increases prevalence and specificity, but decreases sensitivity.

- **99% prevalence, 91% sensitivity, & 89% specificity at 3 or more symptoms**

- **Total Disorder Screener (TDScr)**

- **Source:** Dennis et al 2006

- **(n=6194 adolescents)**

- **Total score has alpha of .85 and is correlated .94 with full GAIN version**
Rapidly Spreading

• State or Provincial wide implementation in multiple states (ID, CT, LA, MD, NH, NV, OR, SC, WA, WI) and provinces (BC, ON, QU) in one or more large systems (adolescent or adult addiction treatment, mental health, welfare, juvenile or criminal justice, Student or Employee Assistance Programs),

• Used by SAP or EAP in Brazil, Canada, Japan, Mexico, United States and being translated for use in China.

• In our GAIN ABS software, from other commercial vendors (e.g., Assessments.com) and local IT systems (e.g., ID, WA)

Assessing the true needs and resources: what is appropriate in a treatment setting?

• Conduct a strengths based assessment: (NPC Research Youth Competency Assessment) http://www.npcresearch.com/materials/_yca_tools.php

• Individualize responses and direct toward pro-social and strengths/needs of youth (picking up trash is not a treatment intervention, though it may be a logical and natural consequence from the court)

• “Build partnerships with community organizations to expand the range of opportunities available to youth and their families.”
Crime/Violence and Substance Problems Interact to Predict Recidivism

Knowing both was the best predictor

Source: CYT & ATM Data

Crime/Violence and Substance Problems Interact to Predict Violent Crime or Arrest

(Intake) Substance Problem Severity did not predict violent recidivism

Knowing both was the best predictor

Source: CYT & ATM Data
Change and Opportunity

- Over 80% participation, use of evidenced based assessment, use of evidenced based intervention, and follow-up
- Have pooled data from 19,229 youth assessed with the Global Appraisal of Individual Needs (GAIN), including 88% with one or more follow-ups, made available for program evaluation and secondary analysis, and helped to generate over 200 publications
- Have supported the creation and evaluation of over 20 adolescent treatment manuals
- Several System level grants

Treating Teens:

A Guide to Adolescent Drug Programs

http://drugstrategies.com/treatingteens.html
Key Elements of Effectiveness

- Screening/Assessment and Treatment Matching
- Engage and Retain Teens in Treatment
- Comprehensive, Integrated Treatment Approach
- Qualified Staff
- Family Involvement in Treatment
- Gender and Cultural Competence
- Developmentally Appropriate Treatment
- Continuing Care
- Treatment Outcomes

*Continued supports/services
*added post-hoc by presenter

Evidence-Based Practices

- Revised Policies to Support EBPs
- Sequenced EBP Implementation Plans
- Developed contracts requiring EBPs

Began During Grant Period
Existed Prior to Grant Period

N=16
Victimization and Level of Care Interact to Predict Outcomes

Traumatized groups have higher severity

High trauma group does not respond to OP

Both groups respond to residential treatment

Interventions Associated With No or Minimal Change in Substance Use or Symptoms

- Passive referrals
- Educational units alone
- Probation services as usual
- Unstandardized outpatient services as usual

Interventions associated with deterioration

- Treatment of adolescents with/in adult units

*Source: Funk, et al., 2003*
Cumulative Recovery Pattern at 30 Months Post Intake

- 37% Sustained Problems
- 19% Intermittent, currently in recovery
- 39% Intermittent, currently not in recovery
- 5% Sustained Recovery

The Majority of Adolescents Cycle in and out of Recovery

Source: Dennis et al, forthcoming

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THE VOICES OF YOUTH

Substance Abuse & Mental Health Services Administration

Center for Substance Abuse Treatment

National Summit on Recovery

Randolph Muck, M.Ed.
Team Leader/Adolescent Programs
Division of Services Improvement
Barriers to Recovery

• Staff uninterested in listening to youth

• Continuing care is optional or not offered

• No opportunity to practice skills in real life settings

• No linkages with mentors or sponsors before treatment ends

Evidence Based Practice

Tested with good outcomes

Manual exists so it can be replicated/trained

A training program exists

Supervision leading to certification

Ongoing monitoring

Outcomes measurement
Observable and Significant Differential Outcomes

**A Comparison of Nine Treatment Approaches**

- The Seven Challenges
- Chestnut Health Systems Intensive Outpatient
- Adolescent Community Reinforcement Approach
- Multi-Systemic Therapy
- Multi-Dimensional Family Therapy
- Motivational Enhancement Therapy-Cognitive Behavioral Therapy 5 sessions
- Family Support Network

*Focus on Co-occurring Disorders and Trauma*

- Emotional Problems Scale
- Days of Victimization
- Days of Traumatic Memories

*Scales, scores and norms derived from the Global Appraisal of individual Needs, author: Michael Dennis, Ph.D.*
Change (post-pre) Effect Size for Emotional Problems by Type of Treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th>n</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seven Challenges</td>
<td>114</td>
<td>0.37</td>
</tr>
<tr>
<td>CHS Treatment</td>
<td>192</td>
<td>-0.18</td>
</tr>
<tr>
<td>A-CRA-CYT/AAFT</td>
<td>214</td>
<td>-0.28</td>
</tr>
<tr>
<td>MST</td>
<td>85</td>
<td>-0.29</td>
</tr>
<tr>
<td>MDFT</td>
<td>258</td>
<td>-0.34</td>
</tr>
<tr>
<td>METCBT-CYT/EAT</td>
<td>5262</td>
<td>-0.29</td>
</tr>
<tr>
<td>METCBT-Other</td>
<td>878</td>
<td>-0.34</td>
</tr>
<tr>
<td>FSN</td>
<td>369</td>
<td>-0.32</td>
</tr>
<tr>
<td>A-CRA-Other</td>
<td>276</td>
<td>-0.15</td>
</tr>
</tbody>
</table>

Emotional Problem Scale

Days of traumatic memories

Days of victimization

Four best on mental health outcomes include 7 challenges, CHS, A-CRA, & MST

Workforce Implications

- All programs reduced mental health / trauma problems with 4 doing particularly well: Seven Challenges, CHS, A-CRA, & MST

- A-CRA with a mix of BA/MA did as well as MST which targets MA level therapists and family therapists that are often in short supply

- Seven Challenges, with a mix of para-professional (non-degreed), BA/MA therapists did as well as A-CRA and MST
Proliferation of EBPs

% Change: Abstinence at 6-months post-initial assessment

*MET/ *ACRA/ **TARGET **SEE
CBT 5 ACC YOUTH YOUTH

60.6 69.3 12.6 21.1

* GAIN Mandated
** GAIN Optional
Source: SAIS System (GPRA)
Interventions that Typically do Better than Practice As Usual in Reducing Recidivism (29% vs. 40%)

- Aggression Replacement Training
- The Seven Challenges
- Reasoning & Rehabilitation
- Moral Reconciliation Therapy
- Thinking for a Change
- Interpersonal Social Problem Solving
- Multisystemic Therapy
- Functional Family Therapy
- Multidimensional Family Therapy
- Adolescent Community Reinforcement Approach
- MET/CBT combinations and Other manualized CBT

NOTE: There is generally little or no differences in mean effect size between these brand names


Meta Analysis of the Effectiveness of Programs for Juvenile Offenders

<table>
<thead>
<tr>
<th>Offender Sample</th>
<th>N of Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preadjudication (prevention)</td>
<td>178</td>
</tr>
<tr>
<td>Probation</td>
<td>216</td>
</tr>
<tr>
<td>Institutionalized</td>
<td>90</td>
</tr>
<tr>
<td>Aftercare</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>509</td>
</tr>
</tbody>
</table>

Source: Adapted from Lipsey, 1997, 2005

Most Programs are actually a mix of components

Average of 5.6 components distinguishable in program descriptions from research reports

- Intensive supervision
- Prison visit
- Restitution
- Community service
- Wilderness/Boot camp
- Tutoring
- Individual counseling
- Group counseling
- Family counseling
- Parent counseling
- Recreation/sports
- Interpersonal skills
- Anger management
- Mentoring
- Cognitive behavioral
- Behavior modification
- Employment training
- Vocational counseling
- Life skills
- Provider training
- Casework
- Drug/alcohol therapy
- Multimodal/individual
- Mediation

Source: Adapted from Lipsey, 1997, 2005
Major Predictors of Bigger Effects

1. A strong intervention protocol based on prior evidence
2. Quality assurance to ensure protocol adherence and project implementation
3. Proactive case supervision of individual
4. Triage to focus on the highest severity subgroup

Impact of the numbers of these Favorable features on Recidivism in 509 Juvenile Justice Studies in Lipsey Meta Analysis

<table>
<thead>
<tr>
<th>Number of favorable features</th>
<th>Distribution of programs</th>
<th>Percentage reduction recidivism</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>7%</td>
<td>+12</td>
</tr>
<tr>
<td>1</td>
<td>50%</td>
<td>-2</td>
</tr>
<tr>
<td>2</td>
<td>27%</td>
<td>-10</td>
</tr>
<tr>
<td>3</td>
<td>15%</td>
<td>-20</td>
</tr>
<tr>
<td>4</td>
<td>2%</td>
<td>-24</td>
</tr>
</tbody>
</table>

Source: Adapted from Lipsey, 1997, 2005

The more features, the lower the recidivism.
Implementation is Essential
(Reduction in Recidivism)

The best is to have a strong program implemented well.

Thus one should optimally pick the strongest intervention that one can implement well.

The effect of a well implemented weak program is as big as a strong program implemented poorly.

Range of Effect Sizes (d) for Change in Days of Abstinence (intake to 12 months)
by site: First evidence of rapid movement of a clinical trial to an effectiveness study with promising outcomes and quick adoption. More to come from the CSAT AAFT program and is showing promising preliminary results.

EAT Programs did Better than CYT on average.

6 programs completely above CYT.

75% above CYT median.

Source: Dennis, Ives, & Muck, 2008

Results of a community based Type IV Clinical Trial for Effectiveness.
Other Common Findings

- Low structure and ad hoc “treatment as usual” does not do as well as evidenced based practice
- Wilderness programs have mixed effects
- Treating adolescents like adults (or with adults), and in boot camp causes harm on average
- Relapse is still common and there is a need for on-going support, monitoring and when necessary re-intervention

Continuing Care

- The continuation of services in a seamless flow is imperative for successful client outcomes
- All too often, they fall through the cracks in the system

= 14 days
Time to Enter Continuing Care and First Use after Residential Treatment

Source: DARTS 2000 and Godley et al 2002

Do adolescents attend 12 step meetings after residential discharge?

Source: DARTS 2000 and Godley et al 2002
High Risk Recovery Environments

Source: CSAT AT Common GAIN Data set

Assertive Continuing Care

- The Assertive Continuing Care Protocol (ACC) is a continuing care intervention specifically designed for adolescents following a period of residential treatment.
- ACC is delivered primarily through home visits.
- ACC case managers are assertive in their attempts to engage participants.
- Case managers deliver the Adolescent Community Reinforcement Approach (ACRA) procedures
Early (0-3 mon.) Abstinence Then Improves Sustained (4-9 mon.) Abstinence

<table>
<thead>
<tr>
<th>Substance</th>
<th>Early (0-3 mon.) Relapse</th>
<th>Early (0-3 mon.) Abstainer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any AOD (OR=11.16*)</td>
<td>19%</td>
<td>69%</td>
</tr>
<tr>
<td>Alcohol (OR=5.47*)</td>
<td>22%</td>
<td>59%</td>
</tr>
<tr>
<td>Marijuana (OR=11.15*)</td>
<td>22%</td>
<td>73%</td>
</tr>
</tbody>
</table>


Ongoing Supportive Services (Ages 0 – 26) as defined by CMS

The Future
NEXT EXIT
Ongoing Support/Cost Effective Strategies

Self-Management and Recovery Training: (SMART) Recovery

- Origins in Rational Emotive Therapy
- Portable, applicable in real world
- Group Modality
  - Led by trained facilitators
  - Open enrollment
  - Uses common elements of CBT
  - Considered easy to learn and use
  - http://www.smartrecovery.org/intro/
Alternative Support Services

- Club House Model (several types, organized differently)
- The Seven Challenges Support Group
- SMART Recovery
- Alternative Peer Groups
- Mentoring
- Pima Prevention
- CRAFT
- Peer to Peer
- Technological Supports (very little in the scientific literature to support or disprove these approaches, with the exception of many promising studies in allied professions on the use of technological supports now emerging)

Evidence Based Practice

Tested with good outcomes

Manual exists so it can be replicated/trained

A training program exists

Supervision leading to certification

Ongoing monitoring

Outcomes measurement
Technological Approaches For Ongoing Supports

- University of Arizona – pod casting, texting, geo-fencing
  • 90 – 95% Engagement, Utilization, Satisfaction

- Recovery Services for Adolescents and their Families (RSAF) CSAT Research Project (Cell phone, Texting, Web Site, CRAFT for Parent Groups)

- Dick Dillon, St. Louis – Second Life
  • Continuing Care Participation Increased from 40% to 90% over 6 months

Issues to Consider

- Juvenile Justice involved youth increasing presence in the treatment system
- Youth who need treatment and not receiving it has swollen to 1:20
- Support for funding relies on ability to demonstrate effectiveness
- Treatment needs of the youth that we see and the need to incorporate appropriate and effective interventions for these needs
- Continuing Care is as, or more important than the treatment delivered
- Ongoing Support Services Promising and potential for being a key ingredient
The resource center is continually updating its website with materials relevant to the reentry field.

Sign up for the monthly NRRC newsletter to receive news about upcoming distance learning and funding opportunities.

Summary

• Achieving reliable outcomes requires reliable measurement, protocol delivery and on-going performance monitoring.

• The GAIN, CASI, and T-ASI (assessment tools) and MET/CBT 5, A-CRA, and Seven Challenges (treatment interventions) training is available through the National Council of Juvenile and Family Court Judges (OJJDP Grant) Contact: Jessica Pearce jpearce@ncjfcj.org

• Standardized and more specific screening/assessment helps to draw out treatment planning implications of readiness for change, recovery environment, relapse potential, psychopathology, crime/violence, and HIV risks.
Summary

• Adolescents entering more intensive levels of care typically have higher severity.

• Multiple problems and child maltreatment and justice involvement are the norm and are closely related to each other.

• There are a growing number of standardized assessment tools, treatment protocols and other resources available to support evidenced based practices.

Summary, cont.

• Know what treatment services are provided (EBP?, Appropriate for identified problems?, Implemented with fidelity?)

• Choose EBPs that can be done well given limitations (staff experience/training, cost, belief in approach)

• Push for appropriate services and demand outcome data

• DO NOT Ignore Continuing Care/Supportive Services! =
Contact Information

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