

ASSESSMENT OF CO-OCCURRING DISORDERS AND RISK ASSESSMENT IN ADOLESCENT OFFENDERS

Presented by Scott Reiner, MS

About the Presenter

For the past 13 years, Scott Reiner has focused his work on addressing the substance abuse and mental health concerns of juvenile offenders as a clinician, program manager and administrator. He is presently the Court Services Specialist for the Virginia Department of Juvenile Justice (“DJJ”) and is responsible for planning and implementing major initiatives in the juvenile probation and parole services. Prior to assuming this position in November of 1999 he spent nine years as DJJ’s Substance Abuse Program Manager, providing management and oversight to the agency’s substance abuse activities. He has been with DJJ since 1987.

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CHANGING CLIMATE

The interface of the juvenile justice system with the mental health and substance abuse systems complicates an already complex situation. Unfortunately, with each system often approaching assessment and intervention separately instead of together, many youngsters struggle a long time and get deep into difficulty before anybody pays attention or identifies the full picture of what is going on. Some of the issues that stand out in this interplay of services and systems are:

- **It has become increasingly difficult for adolescents to access behavioral health care because of changes in the reimbursement funding streams.** There are discrepancies between substance abuse and mental health insurance rate reimbursement, there now are more and more types of insurance that have varying coverage, and in some States the resources for youth are shrinking in favor of the much larger adult population.

- **Over the last 10 years there has been a shift in the way the juvenile justice system is operated, from a philosophy with a focus on rehabilitation to a system that has become increasingly oriented toward public safety and punishment.** This shift is in part in response to both the media portrayal of and the real changes in juvenile violence. Facilities that used to be open now are behind barbed wire. Youngsters who, at the age of 14, never before would have been eligible to serve adult sentences now are being transferred to adult correctional facilities with greater frequency. Even for those who are retained within the juvenile justice system, the prevalent philosophy is that these are criminals, not children needing or deserving rehabilitation. These shifts have complicated the climate for providing treatment services.
- **And, finally, is the prevalence and severity of substance use and mental health disorders among court-involved and incarcerated youth, which have increased over the last several years.**

PREVALENCE

Comparing national studies of prevalence for mental health disorders in youth to those of youth involved in the juvenile justice system, those involved in the juvenile justice system have 3 to 4 times the rates of mental health disorders. Comparing substance use disorders in these populations, 25% to 80% of the young people in the juvenile justice system have either substance abuse or dependence disorders, as compared to 2% to 30% in the general youth population. And, disturbingly, only a small percentage of the youth in the juvenile justice system (13%) have any record of receiving any treatment services for those substance use disorders. There is a lag of 2 to 4 years between when a youngster initiates substance use and when they experience enough trouble with substances to receive treatment.

The higher prevalence of substance abuse and mental illness in the juvenile justice population often is a result of communities not responding effectively prior to the youth's becoming involved in the justice system. Parents who are struggling with their youngsters, even when there is not an offense against the community, property or a violent crime, are often

advised to go to the court for help. The courts are seen either as being able to bring the resources to bear in terms of funding of services by ordering those into place or as an avenue of last resort.

Sixty-six percent to 95% of youth in the juvenile justice system who have a substance use disorder also have at least one other mental health disorder. One study compared frequency of reported delinquent and depressive behavior to frequency of past year marijuana use. The results showed that rates of a whole variety of problem behaviors - being on probation, running away from home, having physically attacked others, or thought about suicide - were found to be directly proportional to the frequency of marijuana use.

PROGNOSIS

Youth who have co-occurring disorders more quickly progress from initial substance use, through abuse, and into dependence. They also have increased levels of poor compliance with psychotropic medication, are more likely to drop out of treatment and have higher rates of suicide.

INTERRELATIONSHIPS AMONG SUBSTANCE USE, MENTAL ILLNESS AND DELINQUENCY

HOW SUBSTANCE USE AND MENTAL ILLNESS INTERRELATE

There are a variety of ways in which substance abuse, mental health disorders and delinquency interrelate. Substance use can precipitate mental health symptoms that may have not been previously present. Where mental health concerns and symptoms exist, substance use can either exacerbate or mask them. Symptoms of substance misuse also can mimic mental health symptoms. Frequent amphetamine or cocaine use in both youngsters and adults can, after a short while, look like a paranoid psychosis. Also, substances frequently may be used to self-medicate underlying psychiatric conditions and, when the substance use stops, those mental health symptoms emerge.

HOW SUBSTANCE USE AND JUVENILE OFFENDING INTERRELATE

Impaired Judgement

The other part of the equation is - where's the relationship with offending? In young

people, as well as in adults, much criminal behavior is a result of bad judgment. The ability for good decision-making about what is appropriate behavior often becomes impaired. Many of us have thought about doing inappropriate things but never do them. Values, morals and good judgement prevent us from acting. Substance use often impairs those higher processes that inhibit us. You often will see a number of youngsters who are significantly involved in both delinquency and substance abuse who say, “Well, I never do that stuff unless I’m high because I’d be too frightened.” The use of substance disinhibits behavior by impairing judgment.

Motivates Crimes

Drug use, abuse, and dependence also can play a motivating role in crime, particularly around financial issues. Many youngsters get involved in a full range of criminal behaviors in order to get money to supply their drug habits.

Global Pattern

Finally, in many youngsters, substance abuse is really part of a more global pattern of difficulty in getting along in the community and in the world. They break the rules and substance abuse is just one of the rules that they break. They have a nonconforming orientation. Treatment needs to address both the thinking and the pattern of behavior of which substance abuse is just one component. A number of good longitudinal studies now indicate that for most substance involved juvenile offenders, that pattern began early- not with substance abuse, but with a variety of minor nonconforming behaviors. Running away, staying out late, cutting school are behaviors that may progress with the addition of substances to more serious offenses and more involvement with significant negative involvement with drugs and alcohol.

Substance Abuse Is Illegal

The fact that substance use alone is illegal from a juvenile justice perspective complicates treatment goals. Many youth in recovery will continue to use to some extent, but the justice system says, “No, that’s against the rules and we don’t have any tolerance for that.”

SCREENING AND ASSESSMENT

THE NEED FOR COLLABORATION

All professional disciplines - substance abuse, mental health and juvenile justice, need to have at least a basic understanding, if not a more detailed background, in recognizing signs of substance abuse, mental illness and delinquency. Without this basic competency, there are missed opportunities to intervene early. And, by doing this collaboratively, it allows the professionals in each system to focus on those things they know best and to bring that expertise to the table and share it with others. Collaboration also overcomes the discontinuity between systems that result in poorer outcomes for the client. This means evaluations do not have to be duplicated and information can be shared across systems. Continuity of care can be supported. In addition, collaboration can result in a treatment and supervision plan that is supported by all parties.

PURPOSES OF SCREENING AND ASSESSMENT

Screening is a preliminary procedure used to identify the likely presence of a problem and to identify the need for further evaluation. Assessment is a more comprehensive, detailed approach that results in a diagnostic impression and the beginning of the treatment process.

KEY CONSIDERATIONS IN SCREENING

Screening should be done at the initial contact by the police, the detention center, whoever is that initial contact, and should be available at different points in time to identify changes. The method of screening and assessment can vary - by juvenile justice staff or through collaborative relationships with behavioral health staff, but it must be available throughout the continuum. Standardized instruments that are reliable and valid with the populations with which they are being used build confidence. Information gained from the screenings and assessments should be communicated across the systems. In evaluating for the presence of a mental illness, the guideline is 4 to 6 weeks of abstinence from alcohol or other drugs to see whether the mental illness still exhibits itself, whether it has gotten worse or whether it has improved. Collateral information and drug testing is an important component of the screening process. Typically, chemical testing in the form of urine drug testing is an important adjunct to the screening

process. Self-report by the juvenile has been found to produce a significant underreporting of drug use in comparison to the results of urine drug testing.

SCREENING FOR MENTAL HEALTH

Key areas that need to be screened for in mental health include acute symptoms, suicidal thoughts and behaviors, prior mental health treatment (including past and present psychotropic medications), cognitive impairment (either through injury or illness), and family history of mental health problems.

MENTAL HEALTH SCREEING INSTRUMENTS

The following are a few screening instruments that are particularly useful:

- **Brief Symptom Inventory (BSI)**

- **Massachusetts Youth Screening Instrument (MAYSI)**

This instrument has been used extensively in juvenile detention facilities. It has excellent validity when compared to clinician judgement based upon more extended interview. It is brief and a variety of staff can be trained to use it.

- **Symptom Checklist 90 (SCL-90-R)**

- **Problem Oriented Screening Inventory for Teenagers (POSIT)**

The POSIT is an instrument that is in the public domain from NIDA (National Institute on Drug Abuse). It generated “red flags” in ten different domains of functioning, substance use being one of them. It also picks up flags in a variety of other functional areas that can be used to trigger further assessment.

SCREENING FOR SUBSTANCE ABUSE

Key areas that are included on a substance abuse screening include:

- **Acute signs of intoxication**

- **Withdrawal or tolerance effects**
- **Self-reported substance abuse**
- **Negative consequences associated with substance abuse, including delinquent behavior**
- **Prior involvement in substance abuse treatment**
- **Family history of substance abuse**

SUBSTANCE ABUSE SCREENING INSTRUMENTS

The following are substance abuse screening instruments. This list is not inclusive and there are many good instruments available:

- **Substance Abuse Subtle Screening Inventory (SASSI)**
- **Personal Experience Screening Questionnaire (PESQ)**
- **Problem Oriented Screening Inventory for Teenagers (POSIT)**

TYPES OF CHEMICAL TESTING

Urine testing is really the “gold standard” in determining the use of illicit substances. It is cost-effective and very accurate. For alcohol, breath testing is very helpful. Newer technologies, such as hair and sweat patches, have a longer window of detection, but these methodologies are costly and their accuracy is still being studied. Similar to any other tool, the strengths and limitations of the particular test must be evaluated. For example, a negative urine drug test does not mean that someone is not a drug user. It means that they probably have not used in the last week or so, or for even a shorter period, depending on the drug. And, a positive test does not mean someone is substance dependent.

COMPREHENSIVE ASSESSMENT INSTRUMENTS

Broader, more comprehensive assessment instruments look at an adolescent's functioning across a variety of life domains:

- **Child and Adolescent Functional Assessment Scale (CAFAS)**

This instrument uses a rating system and is particularly useful as it may readministered every three months. It may be used to track progress within a treatment program.

- **Comprehensive Addiction Severity Index for Adolescents (CASI-A)**

- **Personal Experience Inventory (PEI)**

- **Psychopathy Checklist (PCL)**

This instrument is of particular relevance to the criminal justice population. It is from the work of a psychologist by the name of Robert Hare, who has worked primarily with adults in terms of psychopathy or anti-social personality but recently has been working on validating a psychopathy scale for adolescents.

RISK ASSESSMENT IN JUVENILE JUSTICE

The justice system has its own technology of screening and assessment that often falls under the general category of risk assessment. Risk assessment tools assist juvenile justice practitioners to make various decisions. The tools and the information that they provide are different based upon the points that are used and the outcomes desired. One of the decisions that judges and juvenile justice workers have to make when youngsters come before them is whether they need, at that moment, to be in a secure environment while they are waiting for their case to be heard. The concern is whether they are likely to continue to get in trouble or if they are going to take off before they get to court. Risk assessment instruments can be used to help us to determine which youngsters are likely to do that by looking at their characteristics. What is their likelihood, relevant to other juveniles who are before the court, of continuing to offend? A very small portion of juvenile offenders commit the majority of juvenile crime. About 65% of all juvenile criminal acts are committed by only 8% - 9% of all juveniles involved with the criminal

justice system. The risk assessment tools help to determine which juveniles are most likely to continue to re-offend, so that appropriate responses may be implemented to help deter them from those behaviors. For example, if they are in a community setting on probation, the risk assessment will help to determine how much supervision they need. Supervision can range from check-in once every other month to what is called intensive supervision, where someone may be checking up on the juvenile five and six times a week through methods such as electronic monitoring. Risk assessment helps to determine where to place resources in order to maintain safety. If a juvenile is already in a secure environment, risk assessment can help to determine which of those individuals need the closest custody. The risk assessment is completed at each different decision point, at court appearance/detention hearing, level of community supervision or institutional assignment/placement.

Juvenile justice systems, just like substance abuse and the mental health providers, assess different issues. The juvenile justice assessment will examine the current offense, prior detentions, disciplinary incidents in detentions, drug-related offenses and prior probation or parole violations. More serious offenses are going to be matched to higher sanctions, regardless of the severity of behavioral health disorders. Collaboration between the systems is needed in order to create a mutually supportive plan. The justice system needs to know what it looks like from the treatment side so that it can respond to behavior and support treatment. The justice system can put structure around the treatment through sanctions and consequences.

ASSESSMENT FOR CO-OCCURRING DISORDERS

Assessment for co-occurring disorders means taking careful histories in all three areas: substance use, mental health and criminal activity. Good treatment requires an understanding of the relationship among the three sets of problem behaviors. The diagnosis and current status alone are not sufficient for assessment, as one or more disorders may be in remission at the time of assessment. Assessment also identifies specific strengths that may be used in the treatment plan. This process of assessment begins the treatment engagement process.

WHY THE PERIOD OF ABSTINENCE?

A period of abstinence is needed in order to get a reasonably conclusive assessment of the presence of a dual disorder or co-occurring disorder. The biochemical effects of drug use need to clear out before one may make a determination of what one sees as the underlying psychological or psychiatric disorder. Without this period of abstinence it is difficult to clarify what behaviors, symptoms or disorders are driving the others.

IMPORTANCE OF HISTORY

Below are some of the key areas that should be addressed in gathering historical data:

- **Age of symptoms began**
- **Pattern of how symptoms are expressed**
- **Age and pattern of first substance use**
- **Patterns of use including ‘drug of choice’ and motivations for using**
- **Family history of mental illness/substance abuse**
- **The effects of one disorder on the other**
- **Motivations for treatment**

The chronological and longitudinal emergence and relationship across all realms, mental health, substance abuse and criminal behavior, must be analyzed in order to develop an effective treatment plan. However, the issue of which diagnosis is primary does not matter. The primary versus secondary diagnosis has been used historically to deny services and to shift individuals from one system to another. Currently, most experts feel that the distinction is not very useful in making treatment decisions, particularly for persons who are substance dependent. All systems have to work in an integrated manner in order to identify what is going on, and then need to work

collaboratively in order to coordinate their activities to address the needs of the juvenile offender with co-occurring disorders. No matter which system one is working in- whether it be mental health, addictions, or juvenile justice - the knowledge and the skills to identify those youngsters who have involvement in one or more of those problems areas is a prerequisite.

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