

## **DEVELOPING EFFECTIVE PROGRAMS IN THE JUVENILE JUSTICE SYSTEM**

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### **HISTORY OF SEPARATE SYSTEMS: WHAT PRICE?**

Historically, in both adult and adolescent services, there have been two separate systems of funding and authority for mental health and substance abuse services. This fragmentation has had detrimental consequences for the provision of services for clients with co-occurring disorders. These consequences include:

- **Clients with co-occurring disorders have been excluded from receiving treatment in both mental health and substance abuse programs.** If a client had a mental illness, a substance abuse program said, “we can’t help you until you’re stable.” And to a client who had a substance abuse problem, the mental health program said, “you can’t come here until you stop using.” There was no place in the service delivery system to call home for the client with co-occurring disorders. Many clients who were not accepted in either the mental health or the substance abuse systems or who had histories of violence or sexual offenses were and continue to be directed into the juvenile justice system. These separate systems developed exclusionary criteria that have restricted and limited care.
- **Providers lack knowledge about both substance abuse and mental illness.** Educational preparation has not prepared providers to treat both types of disorders. Mental health training programs historically have focused on the mental health disorders with the belief that the substance abuse problems will go away if the mental health issues are treated. Similarly, traditional addiction training programs have stayed away from teaching psychopathology and focused solely on substance disorders with an underlying believe that mental health disorders will go away if the substance abuse issues are treated. And juvenile justice providers often did not get either mental health or substance abuse training and behavior was viewed in a third way - “folks just need to learn to follow the rules.”
- **Treatment models that are fragmented place the burden of integration on the client.** The young person and their family have to go to one place for substance abuse treatment and

another place for mental health services. The adolescent and their family then have to put all that together and make those linkages themselves.

### **CHARACTERISTICS THAT COMPLICATE TREATMENT FOR YOUTH**

Not only does the historical fragmentation of the systems create confusion, youngsters with co-occurring disorders often have a number of characteristics that also complicate treatment.

- **Multiple psychiatric diagnoses.** Many records for adolescents list 5 or 6 diagnoses, everything from bipolar disorders to conduct disorders. Some of these diagnoses make sense and some do not. The picture can be muddy and many of the behaviors that receive the focus of attention, such as self-mutilation, self-destructive or acting out behaviors, do not fit neatly into any diagnostic category.
- **Multiple drugs of abuse.** Early on, youth may use alcohol and marijuana, but later on as the adolescent progresses, they tend not to be selective and they will use whatever is available.
- **Removal of current coping strategy.**
- **Episodic nature of the disorders.**
- **Cognitive limitations.**
- **Recurrent suicidal and/or self-mutilating behaviors.**
- **Repeated incarcerations.** Effective treatment is based on a strong relationship with some consistency. For youth that have multiple episodes of juvenile detention, continuity is very difficult to maintain.
- **Potential for violent behavior.**

- **Family members with mental illness/substance abuse.**
- **Lack of stable housing.**
- **Lack of school/vocational involvement.**
- **Schools that do not allow youth to return following incarceration.**
- **Lack of supportive adults.**
- **Deviant peers.** It is very difficult for recovering youth to find a healthy peer group to support abstinence.

### **KEY PRINCIPLES**

- **Treatment of mental health, substance abuse and delinquency must be integrated and be considered primary.** It does not make sense to have a young person who stops getting high and gets his depression under control who is still out breaking into cars. The treatment must address all the issues that the youth is experiencing.
- **Programming must be individualized and tailed to what the youth and family needs.** Programs cannot be of a “cookie cutter” variety. The programming should address the symptom severity, skill deficits and levels of motivation of the youth. For example, a youth that has low level of psychiatric and substance abuse symptoms but high levels delinquency might be in a juvenile detention facility, even though his clinical treatment might have pointed to a community treatment setting. The potential for delinquency places the youth in more restrictive settings. Moreover, youth on probation who have severe substance abuse problems with minimal offending might have their supervision monitoring matched to both the justice and clinical needs.

- **“Phased” treatment intervention should be of a graduated intensity.** Interventions should be titrated to engage with the young person. Interventions should be matched to both to the clinical status of the young person as well as to the need to slowly build a level of engagement. A strong engagement in treatment is needed to support the youth in doing the hard work - confronting the lifelong nature of some of these disorders and the fact that they have to look at making some serious changes. The issue of motivation and treatment matching is critical. Often treatment providers attempt to provide “treatment” to youth who are not ready for it. The beginning work needs to focus on motivational enhancement and engaging the youth in their treatment.
- **Treatment comprehensiveness, flexibility and continuity.** There need to be an array of treatment options across the continuum that can be individualized to the needs of the youth and their families including youth that have justice system involvement. Access is needed, either through individual agencies or through collaboration, to the full continuum of care that includes everything from brief residential or in-patient stabilization all the way through relapse prevention, briefer intervention and support services. Youth need to be able to move fluidly across services as their condition improves or deteriorates.
- **Engagement of the youth and their family.** The family work is critical as the family’s influence will always be more important than anything the treatment providers are going to do. There are a lot of concrete ways the youth and their family can be engaged, e.g., providing food at the program site or providing childcare for the siblings.
- **Psychopharmacological interventions are used to stabilize co-occurring disorders when appropriate.** There is an emerging body of knowledge about the use of medication treatments for substance abuse. A psychiatric perspective is a necessary part of the team for treating co-occurring disorders.
- **Peer and self help groups.**

## **THREE TREATMENT MODELS**

### ***SEQUENTIAL***

The sequential model provides treatment services first in one system (either mental health or substance abuse) and then the other. Unfortunately, the drug or alcohol use does not stop while the treatment providers are trying to figure out what to do about being depressed and suicidal and vice versa.

### ***PARALLEL***

The parallel model uses mental health and substance abuse treatment services to treat co-occurring disorders concurrently. This model is better than sequential but not ideal. A parallel model requires the client to make a lot of the linkages themselves.

### ***INTEGRATED***

In the integrated model, disorders are addressed within the same setting, with combined program elements delivered by cross-trained staff. It does not mean that everybody has to be an expert in all areas, but the program elements need to be comprehensive so that the relationships among the issues can be addressed. An example of an integrated program element is a group session on managing symptoms of depression that also addresses drug use factors in the management of the depressive symptoms. The same multidisciplinary clinician (or team) provides all services and has continuous responsibility for the treatment. Treatment is integrated in the program by selectively modifying, combining, and tailoring interventions for the specific client.

## **TREATMENT MODELS**

### ***THERAPEUTIC COMMUNITY***

Therapeutic communities (“TC”) operate in increasing numbers within correctional centers. They are a highly structured, long-term residential program of 6 - 18 months duration. Research suggests that the best length of treatment in a TC setting for adults is 9 to 15 months. There is little empirical research on the appropriate length of stay for adolescents. The program focus is on habilitation and changing negative behavior patterns and cognitive processes that lead to drug abuse and offending. Typical in therapeutic communities, there are strict community

norms that regulate participant behavior with positive and negative sanctions for behaviors and there is a wide range of client involvement in the community management itself.

## **History**

The original therapeutic communities grew out of a model in Great Britain for psychiatric facilities. They originally were very supportive, peer-governed models with heavy professional emphasis. The model was brought to America and became what is called a traditional American model therapeutic community, often associated in its foundations with the Synanon Program. The programs targeted individuals addicted to heroin, most of which had criminal justice involvement. Treatment was not simply for an addictive disorder but also the lifestyle disorder associated with drug use. The problem was not just substance use; it was lack of skills for jobs, lack of educational accomplishments, poor social relationships and the handling of problems through aggression and power.

## **Characteristics**

The focus in therapeutic communities is on habilitation or learning the skills for the first time rather than on rehabilitation. This is very germane to work with adolescents. The youth involved with treatment providers and the juvenile justice system typically have not mastered many of the age appropriate skills because of their impairment by psychiatric disorders or by their addictions. The therapeutic community helps to create a bridge for adolescents into adulthood by teaching them the developmentally appropriate skills and by changing a whole variety of negative behaviors and thinking processes. The problem in therapeutic community is seen not as the drug abuse but rather the client's behavior. Therapeutic communities are a socialization experience. They are highly structured with a very clear and constantly reiterated set of rules and expectations often termed "right living." The healing agent in the therapeutic community is not the professional staff, but the community itself. The peer community is the healing agent as a core strategy of "community-as-method." It occurs 24 hours a day, 7 days a week. It allows for a self-governance where participants are members and is called a family because it is a socialization experience. Community members are given roles that simulate what it is like out in the world with personal responsibility. Members have jobs - cleaning up the

dining hall, posting information for the community, working at the reception desk or answering the phone and taking messages.

### **Key Changes to the Therapeutic Community Model**

The therapeutic community model, however, has been found to need adaptation for adults with co-occurring disorders. These key changes now need to be evaluated for changes in adolescent co-occurring treatment in therapeutic communities. These adaptations include:

- **More flexible**
- **Less intense**
- **More individualized**

These changes mean that sometimes the programs need to be longer in duration and sometimes shorter. The emphasis is on education and supportive approaches rather than confrontation and compliance. Movement through the program and specific tasks are more individualized. Rewards focus more on positive reinforcement (e.g., verbal praise, and privileges) rather than negative sanctions. Correctional research indicates, in terms of behavior change, four reinforcers are needed for every punisher. Conflict resolution or “community” groups replace encounter groups with more emphasis on affirmation of progress and individual change efforts. Youth in general and especially youth with co-occurring disorders have shorter attention spans and their cognitive skills are different. The pace, therefore, is slower with more overlap. Information is provided gradually with significant repetition. There is more individual counseling with higher staffing ratios, with staff that are cross-trained. And as opposed to an adult TC, any adolescent TC has to be more staff-driven and staff directed. Staff provides more monitoring and coordination of treatment activities.

### **Effective Linkages to Aftercare**

Linkage and referral is critical if recovery is to be maintained when a person leaves a correctional facility. Special attention must be provided to ensure the continuation of psychotropic medication. Pre-release planning must involve the following: continuation of

psychotropic medication, preparation for stressors and high risk situations, strong client involvement, involvement of family and friends, support services and case management and criminal justice supervision, if required.

### **COGNITIVE BEHAVIORAL APPROACHES**

Cognitive behavioral approaches work at changing the way people feel and behave by examining and changing how they think. Research suggests that for both for addiction and for mental disorders outside of those that respond to medication, as well as for offending, cognitive behavioral interventions are highly effective. The goals of cognitive behavioral approaches include changing the way the individual thinks about things, helping individuals identify obstacles to thinking and acting in a new and more helpful way and improving coping skills to improve functioning and access to social support. Self-control strategies can be taught to look at impulses, anxiety, mood elevation and handling and expressing emotions and managing anger. Skill-building strategies focus on planning daily activities, improving relationships through assertiveness, negotiation, asking for help, active listening, and use of positive self-statement and techniques that include didactic presentation, modeling, role-playing and feedback and homework to promote skill acquisition and self-monitoring. There are structured curriculums available to address all of these areas. A particular application to juvenile offenders and to offenders in general is the issue of cognitive restructuring and identifying patterns of thinking, called “thinking errors” that characterize offenders. Interventions help an individual to identify those thinking patterns and to confront and change them. Thinking errors that support continued offending behavior are targeted. An example of those offending thought processes include the victim stance: “It’s never my fault. Poor me. The system is stepping on me.” Self-centeredness is another thinking error: “If I want it, so what if it belonged to you. You can go buy another one.” Interventions in the cognitive behavioral domain help to identify those thinking patterns and to confront and change them.

### **FAMILY-BASED INTERVENTIONS**

Family intervention is a critical part of adolescent treatment. The adolescent must be viewed within the context of the family and the broader social system. The principles of the family interventions are the following:

- **Helping parents to develop skills to more effectively manage their children’s behaviors;**
- **Services are provided in the family’s natural environment;**
- **Services should promote responsible behavior among all family members; and**
- **Adolescent behaviors are targeted in multiple settings and systems.**

### **1 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.

Mr. Reiner has a master’s degree in clinical psychology fro Syracuse University and received his bachelor’s degree from Brandeis University in Waltham, MA. He holds adjunct faculty appointments in the Departments of Criminal Justice and Addiction Medicine at Virginia Commonwealth University.

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