Key Elements of Effectiveness

Bridging the Gap:

A Guide to Drug Treatment in the Juvenile Justice System

Juvenile Justice At-A-Glance

Brief History

The first juvenile court in the United States was established in Chicago, Illinois in 1899, growing out of reform campaigns across the country to deal with juvenile delinquents separately from adult criminals. The Chicago court marked the beginning of states' efforts to design juvenile justice systems that would both reform and protect youthful offenders. The juvenile judge and court officials were to serve "in loco parentis" – in place of the parent – to ensure the "best interests of the child." Courts were designed to be rehabilitative in nature rather than punitive and to protect children from being labeled as "criminal" and incarcerated with adults. The underlying assumption was that juvenile offenders were more amenable to rehabilitation than adult criminals.

Juvenile courts had exclusive jurisdiction over children under age 18 who were charged with criminal offenses. The most serious cases could be transferred to adult court if the juvenile court waived its jurisdiction over the child. Dispositions (the equivalent of criminal sentences) were often indefinite in length: they could last until the juvenile was considered rehabilitated or reached the age of majority.

By 1945, separate juvenile courts existed in every state and the District of Columbia. Today there are 51 different juvenile court systems and no common standards of practice or accountability nationwide.

During much of the 20th century, juvenile justice systems acted to protect and rehabilitate young offenders and juvenile court judges had ultimate discretion. The constitutional guarantees of the adult criminal system, such as the right to counsel and trial by jury, were not formally available to juveniles. Although the original intent of the juvenile court concept was to provide guidance and treatment, punishments of juveniles could be as harsh as adult sentences. In the 1960s, concern about potential abuses arising from the informality of juvenile proceedings led to a series of U.S. Supreme Court decisions that extended many of the due process safeguards to juvenile offenders already available to adults. These included the right to counsel, questioning of witnesses, protection against self-incrimination, a transcript of the proceedings, and appellate review. In 2005, the U.S. Supreme Court ruled that it was unconstitutional to sentence juvenile offenders to death, which includes adults who committed their crimes before the age of 18.

During the 1980s and 1990s, most states moved away from the early rehabilitative goals of the juvenile court to focus more on punishment. An increase in juvenile arrests for violent offenses and drug law violations as well as greater media attention to juvenile crime may have contributed to this shift. Many states have lowered the age for juvenile court jurisdiction and enacted tougher laws to hold violent, serious, and chronic offenders more accountable for their actions. These laws have made it easier for juveniles to be tried as adults, narrowed the age range of those classified as juveniles, and set mandatory minimum sentences for certain juvenile offenders.

Still, in recent years, new efforts to improve the ability of the juvenile justice system to address the many complex problems of juvenile offenders have led to the development of innovative strategies and programs. These efforts include community assessment centers, juvenile drug courts, graduated sanctions and integrated case management.

CURRENT REALITIES

- 2.4 million juveniles (under the age of 18) were arrested in the year 2000[1]
- 54% of those arrested tested positive for drugs (not including alcohol) at time of arrest[2]
- 62.5% of those arrested reported substance abuse problems[2]
- 75% of arrested juveniles reported mental health problems in 1999
- Black juveniles were more than 1 1/2 times likelier then white juveniles to be arrested for drug crimes
- In the last decade, the juvenile arrest rate for drug law violations increased by 105% compared to a 12.9 % decrease in arrests for all juvenile offenses
- Between 1991 and 2000, the number of drug law cases handled in juvenile court increased by 197 percent, the largest increase of all major offenses

[1] *Criminal Neglect: Substance Abuse, Juvenile Justice and the Children Left Behind.* (2004) National Center on Addiction and Substance Abuse and *Juvenile Court Statistics* 2000. Pittsburgh, PA: National Center for Juvenile Justice. Full citations available at www.drugstrategies.org

[2] Ibid: estimate based on NIJ Arrestee Drug Abuse Monitoring (2000), drawn from testing 2,106 juvenile male detainees at 9 sites across country.

Overview of the Juvenile Justice System

This chart presents a general overview of key stages in the juvenile justice system. It is important to note that each state has somewhat different procedures and disposition alternatives.

DELINQUENT ACT: An act committed by a juvenile, which if committed by an adult, would be a criminal act. Delinquent acts include crimes against persons, crimes against property, drug offenses, and crimes against public order.

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ARREST: To seize and hold under the authority of law.

DIVERSION: Directs juvenile to alternative educational, treatment, or work programs in place of juvenile court proceedings.

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DETENTION: Court-ordered placement of a youth in a secure facility between the time of arrest and referral to court.

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INTAKE DECISION: Determination whether a case should be handled informally or formally in juvenile court.

INFORMAL HANDLING: Cases where court personnel decide not to file a formal petition. Dispositions include voluntary referral to social services agency or out-of-home placement, informal probation, payment of fines or restitution in response to an intake decision not to handle the case by the court.

FORMAL HANDLING: Cases appearing on the official court calendar in response to the filing of a petition, complaint, or other legal instrument requesting the court to adjudicate a youth as a delinquent, status offender, or dependent child or to waive jurisdiction and transfer a youth to criminal court for processing as a criminal offender.

PETITION: A document filed in juvenile court alleging that a juvenile is a delinquent and asking that the court assume jurisdiction over the juvenile or that the juvenile be transferred to criminal court for prosecution as an adult.

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ADJUDICATION: Judicial determination that a juvenile is responsible for an offense, similar to a conviction in adult criminal court.

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DISPOSITION: Court-ordered handling of adjudicated juvenile. Dispositions can include:

- **DISMISSED/RELEASED:** Dismissal or release with no further sanction or consequence.
- **PROBATION:** Voluntary or court-ordered supervision of juvenile in the community. Violation of probation conditions can result in stricter sanctions or incarceration in juvenile correctional facility.
- **PLACEMENT:** Mandating placement of juvenile in a residential drug treatment program, correctional facility, or other out of home placement.
- **WAIVER:** Process by which jurisdiction over juvenile (usually 14 or older) is transferred to adult criminal court.
- **OTHER DISPOSITIONS:** Wide range of alternatives, including fines, restitution, community service, referrals for services.

PAROLE: Conditional release from incarceration after serving part of sentence, generally under supervision of a parole officer. Violation of parole terms can result in juvenile being sent back to correctional facility.

Key Elements of Effectiveness

Both treatment research and clinical practice suggest that certain elements are critically important in providing effective drug treatment to adolescents in the juvenile justice system. Drug Strategies, guided by an expert advisory panel, has identified the following eleven key elements:

- Systems Integration
- Assessment and Treatment Matching
- Recognition of Co-Occurring Disorders
- Comprehensive Treatment Approach
- Qualified Staff
- Developmentally Appropriate Program
- Family Involvement in Treatment
- Engage and Retain Teens in Treatment
- Gender and Cultural Competence
- Continuing Care
- Treatment Outcomes

Systems Integration

Although we often refer to the "juvenile justice system" as if it were a single, internally coherent system for dealing with juvenile offenders, in fact, it involves many different agencies with diverse missions, philosophies and concerns. The responsibilities of these distinct agencies, including juvenile courts, probation, police departments, schools, family welfare, mental health, drug treatment and other service organizations, intersect as each endeavors to protect public health and safety through the care and supervision of juvenile offenders.

The goals of agencies working within the juvenile justice system may be dissimilar and even conflict with each other. The goal of juvenile justice as articulated in most state statutes is to protect public safety, reduce recidivism and serve the "best interests" of the child. Those involved most directly with juvenile justice, such as corrections staff, often have differing priorities from treatment providers who typically view recovery and rehabilitation as paramount. These goals are not necessarily mutually exclusive: juveniles who are no longer abusing drugs and alcohol are much less likely to be rearrested or present a threat to the community. However, in practice, philosophical differences often shape the context in which decisions are made and how treatment is structured. In particular, juvenile justice agencies and personnel may stress safety first whereas more clinically oriented agencies and individuals stress treatment. Juvenile justice dispositions may appear punitive, without regard to treatment needs, in order to maintain control and ensure that the juvenile is held accountable for his offense, while more treatment focused strategies may be perceived as not carefully considering safety issues. Greater collaboration and systems integration are essential if efforts to improve treatment outcomes are to succeed.

In addition to obstacles arising from mission differences, effective integration of services among vari-

ous agencies is difficult. Community services often occur within what have become known as professional and funding "silos" which operate separately from each other without collaboration or regular communication. Contact between agencies is very limited, if existent at all.

The absence of consistency in practices between jurisdictions also makes it difficult to cooperate and provide an appropriate continuum of care to youth. Legal constraints relating to confidentiality, lack of trust, uncertainty about how information will be used, and organizational culture pose obstacles to information sharing between agencies. For example, treatment providers are often aware of information related to mental health or behavioral problems that could assist a probation officer responsible for supervising juvenile offenders. Case management across systems and over time is critically important in achieving effective integration of services at all levels.

Juvenile justice systems vary widely depending on differences in state laws and organizational structures. Some states, like Delaware, have a single statewide system, with centralized intake and probation offices. Others have decentralized, locally administered systems. Pennsylvania, for example, has 67 counties that have considerable autonomy in their operations, including separate probation offices. Achieving effective collaboration in managing integrated care for individual juveniles becomes even more challenging when juvenile justice systems are fragmented and highly diffuse.

The widespread lack of integrated care for juveniles is a major barrier to providing effective drug treatment and reducing recidivism. Organizational fragmentation contributes to juveniles "falling through the cracks" and discourages accountability by explaining away lack of results through failure to collect and analyze cross-system effectiveness data. The process of integrating services is complex and lengthy: there are few shortcuts. Rigorous self-analysis, cross-system accountability and effective leadership are all ingredients of systems that move from fragmentation to integration. Various parts of the system must come to know and trust one another and then work together in new ways.

Assessment and Treatment Matching

Screening and assessment are among the most critical services youth with substance abuse problems need in navigating the juvenile justice system. Yet there is currently no requirement for screening for substance abuse or mental disorders in most juvenile justice systems. Moreover, the availability of screening, assessment and mental health and drug treatment services is uneven nationally, exacerbating the current crisis in the capacity to address these problems effectively.

Screening is the first step in identifying whether a youth is involved with drugs and alcohol; assessment explores more deeply the nature of the youth's substance abuse and other problems. Assessment can help distinguish between problem drug users and those who are already drug dependent. The assessment should include a thorough psychiatric and medical examination to determine whether physical, biomedical and psychiatric conditions may relate to the adolescent's substance abuse.

Assessment provides a basis for developing a comprehensive treatment plan to address the individual's needs and for determining the appropriate level of treatment intensity. For example, a youth in the early stages of substance abuse who does not have other major behavioral problems should not in most cases be placed in treatment with seriously addicted adolescents whose problems may be far more severe. The assessment should be reviewed periodically and revised throughout treatment in light of the youth's progress.

Many adolescent drug treatment programs do not use standard, nationally recognized screening and assessment instruments and rely instead on questionnaires they develop in-house. Treatment experts agree that programs should use standard screening instruments that have been rigorously evaluated for reliability and validity, such as the Substance Abuse Subtle Screening Inventory (SASSI) and Personal Experience Screening Questionnaire (PESQ). After the initial screening, a comprehensive assessment may be needed to explore in depth the teen's substance use, risk behaviors, mental health problems, learning disorders, peer and family relationships. Two standard assessment instruments that have been independently

tested are the Comprehensive Addiction Severity Index for Adolescents (CASI-A) and the Global Assessment of Individual needs (GAIN).

Many persistent serious delinquents face additional problems that need to be addressed, according to the Office of Juvenile Justice and Delinquency Prevention's long-term Research on the Causes and Correlates of Delinquency. Careful assessment of multiple domains can identify and inform the development of an appropriate treatment plan. Not all delinquent youth require interventions such as mental health or drug treatment services. Providing appropriate interventions based on identified needs is an important component of effective treatment.

Within the juvenile justice system, establishing the use of consistent screening and assessment instruments has proved altogether more complex even than in drug treatment programs, most of which still use their own untested questionnaires. The typical juvenile intake process is already lengthy and cumbersome, and assessments generally focus on criminological risks that use a different set of measures than most drug treatment assessments. Operationally, there is also widespread systemic resistance to increasing what is already perceived to be onerous intake tasks by adding new screening and assessment requirements. However, without building these systems into the front end of juvenile justice processing, only a fraction of youth who need treatment services can be correctly identified. The Reclaiming Futures initiative, funded by the Robert Wood Johnson Foundation, is working with ten communities to incorporate new screening and assessment tools into the juvenile justice intake process. After initial resistance, judges and other juvenile justice personnel have come to recognize the benefits of being able to match youth more effectively and consistently to services.

Recognition of Co-Occurring Disorders

The rate of mental disorders among youth in the juvenile justice system is very high. Recent studies indicate that three-quarters of the juveniles in public and private juvenile facilities reported mental health problems during screening. In addition, more than half reported that they had previously received treatment of some kind for mental health problems.

The juvenile justice system is now the largest single source of youth referrals to drug treatment. Almost half of all adolescents currently in treatment have been mandated to programs by the juvenile justice system, or in the case of older teens, by the adult criminal courts.

Substance abuse and psychiatric disorders share common biological, behavioral and environmental risks and may be precipitated or exacerbated by each other. For example, an adolescent may have a mood disorder that was induced by substance abuse or a conduct disorder that resulted in substance abuse.

Youth in the juvenile justice system often have a broad range of mental health disorders, learning difficulties and problem behaviors including substance abuse. Juveniles may also have difficulties in other areas of life, including school, family, physical health and peer relationships. It is critically important that these multiple problem areas in individual youth be identified early and addressed with the necessary professional services.

Dual diagnosis of both substance abuse and mental health problems is one of the most important challenges in treating juveniles. Detailed measures of mental health severity and needs, including depression, anxiety, ADHD, conduct disorder and trauma are needed but usually lacking. Screening and assessment of youths in the juvenile justice system for co-occurring disorders are often not priorities in the intake process, where too few trained staff may be available to conduct structured interviews. Even when well-standardized interview instruments, such as the Diagnostic Interview Schedule for Children (DISC), are used, accurate diagnosis is often difficult. Moreover, treatment resources for dually diagnosed juvenile offenders are scarce and many youths go untreated.

Comprehensive Treatment Approach

Adolescents entering the juvenile justice system often have a constellation of personal and family problems. In addition to substance abuse and mental health disorders, these teens may have learning disabilities, a

history of delinquent and/or violent behavior, sexual abuse, dysfunctional families as well as medical and other problems. Addressing these multiple challenges comprehensively is critical to the juvenile's success in treatment. Many states struggle to provide comprehensive, integrated services or case managed access to services in the community. Despite the challenges, some programs are finding new ways to bring these elements together.

The first step in developing a comprehensive treatment plan is thorough screening and assessment, conducted when the youth first enters the juvenile justice system. Thorough assessment provides the basis for an individualized treatment plan that can be revised throughout the course of treatment. To be effective, a comprehensive approach requires dynamic case management. Case managers help juveniles and their families navigate the considerable complexities of juvenile court, probation, substance abuse treatment and other services. This coordination of care helps ensure that the adolescent and the family are receiving services that will contribute to treatment success.

Providing medical, mental and sexual health services whether onsite or by referral is another critical component of comprehensive care. Treatment providers must address the attitudes and behaviors that put juvenile offenders at high risk of developing health problems, including HIV and sexually transmitted diseases. A 2003 study of juvenile offenders in a Chicago detention center found that 95 percent of the juvenile detainees said they had engaged in at least three behaviors that could put them at risk of HIV, and roughly two-thirds of them reported 10 or more behaviors that increased their chances of contracting the virus, such as having unprotected sex while drunk or high.

A comprehensive treatment approach takes into account the full range of diverse issues the juvenile faces. Compared to adults, adolescents have relatively little control over their environment, including where they live, their economic status, access to transportation, and community support services. Rather than focusing only on substance abuse and criminal involvement, good treatment plans address the various social systems that shape the daily life of adolescents: family, peers, school and community.

Treatment programs should also strive to expand the adolescent's horizons and aspirations through recreational, educational and cultural activities and by connecting teens to mentors in the community who will encourage emotional and intellectual growth. Collaboration with the home school system and vocational training help ensure that adolescents have a promising future after treatment. Continuing care is essential to address relapse prevention and provide social support and necessary services after the adolescent leaves the treatment program or the juvenile facility.

Qualified Staff

The challenge of finding and retaining qualified staff is central to providing effective drug treatment for juvenile offenders. Staff salaries may not be competitive, resulting in high turnover rates. Some states outsource juvenile justice services, with contracts going to the lowest bidders who in turn hold down their costs through low salaries. The challenge is further complicated by differences in perspective and background among court, probation and correctional staff and treatment providers. Professional staff who are trained to recognize psychiatric problems, understand adolescent development and are able to work effectively within the current realities of the juvenile justice system are critically important to treatment success. In addition to professional training and credentials, caring staff attitudes are also important in connecting adolescents to the treatment process.

Some programs do not have staff who are qualified to conduct accurate screenings and comprehensive assesments, which form the basis for developing an effective treatment plan. In some areas, centralized juvenile intake centers provide essential screening and assesment services. However, in many areas, these resources are not available. In addition, when specific treatment approaches are used, staff must receive intensive training in order to implement the intervention successfully.

Very few states in their certification standards for treatment programs require that staff have any specific knowledge or experience in treating youth. In the absence of state standards, counselor qualifications vary

widely. Some programs require their professional staff to have a college or graduate degree. Some also require state certification in addiction counseling. A few programs have staff with cross training in both substance abuse and mental health treatment. Regular clinical supervision by more experienced staff is important in providing guidance and ongoing training for counselors. In the absence of onsite staff, treatment programs should have arrangements to refer clients to highly trained professionals in the community for a range of services, such as psychotherapy, remedial education, and health care, including testing for HIV, sexually transmitted diseases (STDs) and other infectious diseases.

Developmentally Appropriate Program

Treatment experts agree that adolescents are not simply immature adults and that adolescent programs cannot be effective if they are essentially adult programs modified for children. Adolescence is a period of rapid developmental change involving major biological, behavioral and cognitive transitions as well as important physiological growth. Nonetheless, relatively few programs take developmental differences into account in treating adolescents. Most drug programs continue to rely on treatment models originally developed for adult addicts, whose history of substance abuse and behavioral problems is often much longer, destructive and more complex.

Adolescents also think and behave differently than adults. Teens are beginning to move away from family-based to peer-based identity on the way to defining themselves as individuals. They are also ready to try new, often quite risky behaviors with little regard to the consequences, including drinking, drug use and delinquent activity. Even when substance abuse poses acute risk of injury, overdose, or addiction, adolescents usually do not think they have a problem. They are unlikely to seek treatment on their own. Their first experience with treatment is often through the juvenile justice system, where the court mandates them to participate in outpatient or residential drug programs.

Compared to adults, adolescents also think more in concrete than in abstract terms. Program materials and activities should take these developmental differences into account, such as using examples that are meaningful to adolescents, particularly in terms of imminent effects and immediate consequences. In practical terms, adolescent programs must address the many different contexts which shape the delinquent youth's life, not only juvenile court and probation but also school, peers, family, medical care and vocational development.

The need for developmentally appropriate programs for adolescents in the juvenile justice system is particularly pressing since the ages of juveniles under court jurisdiction may vary widely. Each state establishes minimum and maximum ages for juvenile court jurisdiction, resulting in considerable age differences. For example, in North Carolina, the youngest children subject to delinquency laws are age 6, although the majority of states set the minimum age at 10. (Younger children are generally referred to family court.) Moreover, most states give juvenile courts continuing authority over a youth even after the upper age of original delinquency jurisdiction. For example, in New York, although a child of 7 can be charged with delinquency, once adjudicated, he can be retained under court supervision until the age of 20. In Wisconsin, the youngest age for original juvenile court jurisdiction is 10, although the court may retain jurisdiction until the age of 22. Juvenile justice systems face a particular challenge in making sure that programs are appropriately designed for youth at various stages of development, ranging from children to young adult offenders.

Family Involvement in Treatment

Parents and relatives are a dominant reality in the lives of most adolescents, no matter how troubled those relationships are. For youths in the juvenile justice system, family ties may be particularly problematic. Nonetheless, family involvement in the treatment process is critically important. Recent research suggests that the more actively the family is involved, the better the outcomes will be. Several new treatment models that emphasize family involvement show promise in reducing both substance abuse and delinquent

behavior in juvenile offenders. Engaging parents—or in the absence of parents or other family members, the responsible caregiver—increases the likelihood that treatment gains will be sustained after treatment has ended. Moreover, even when family cannot or will not participate in treatment, helping youths better understand and respond to family relationships is an important part of equipping them to maintain treatment gains and to step into adulthood better prepared for family and other relationships.

Involving families in treatment for youth in the juvenile justice system can be challenging. Although most juveniles remain at home on probation or diverted to programs in the community while they are under the jurisdiction of the juvenile court, about one in four go to residential facilities that may be located far from the family residence. To arrange family visits requires organizing travel as well as time off from work. In addition to logistical obstacles, family members may have their own serious substance abuse or other behavioral problems. From a program perspective, enlisting families in treatment can take a great deal of time and staff effort and may not prove successful. For programs that are already understaffed and overcrowded, involving families may not seem the best use of limited resources.

However, engaging the family even on a limited basis can prove valuable in strengthening family relationships and in improving the juvenile's home environment. Family involvement may range from telephone conversations with counselors to scheduled meetings with parents while the juvenile is in treatment, including family sessions. The Council of Juvenile Correctional Administrators emphasizes the importance of family involvement for incarcerated youth in "Performance Based Standards" (October 2003). Best practices include family visits, videoconferencing when families live far away, telephone and email contact, and treatment plans that include family information.

Teaching families how to clarify roles and to change problem behavior can lead to stronger family functioning and longer-term stability. Providing family training in how to monitor and support the juvenile following treatment is important in helping sustain the gains made during treatment. Encouraging families to examine their own drinking and drug use and to address these problems is also critically important.

Engage and Retain Teens in Treatment

Staying in treatment is the single most important factor in recovery. Recent research has found that juveniles who complete treatment reduce their substance abuse and delinquent activity substantially as well as show marked improvement in school, work and relations with others. Juvenile offenders with substance abuse problems are generally mandated to treatment in nonresidential programs in the community. They are subject to court sanction if they drop out or if regular drug tests show they have resumed using drugs. However, court supervision does not guarantee that a juvenile will remain in treatment. For juveniles detained in correctional facilities or in residential programs, the likelihood of retention is greater. The critical question is whether juveniles in either setting will actively engage in the treatment process.

One widespread approach that seeks to engage adolescents in treatment is motivational enhancement therapy (MET), based on principles of cognitive and social psychology. Through motivational individual interviewing, MET seeks to encourage adolescents to develop a personal commitment and plan for recovery. Counselors work with clients to create a broad range of individualized long-term goals. MET can also include family members to further engage clients.

Another promising way to engage juveniles in treatment builds on the "strengths-based approach," in which the counselor concentrates on strengths rather than on failures and focuses on developing solutions together. The goal is to validate the competence of the juvenile and his family in defining what needs to be done and to increase their belief that problems can be solved. This approach views the youth as healthy, capable and able; makes the participation of the adolescent and family central; and recognizes that successful outcomes depend on the resources identified during therapy. The interaction and exchange between the counselor and youth during this process tends to strengthen the therapeutic alliance—a climate of trust, confidence, and acceptance—that is vitally important in treatment success.

Treatment for adolescents has to have tangible, concrete aspects and outcomes if the teen is to remain engaged. Some programs develop reward systems, such as giving vouchers for drug-free urine tests. Others provide services in sites that might be more convenient for teens and their families, including home visits or probation offices, and provide transportation where necessary. Programs can also offer activities that deal with sexuality, pregnancy and parenting—critical issues for many teens. The key is to find ways to make treatment relevant to the everyday concerns of the adolescent so that he or she will be motivated to make the necessary effort to change fundamental behavior patterns.

Parents' perceptions and attitudes strongly affect whether a teen remains in treatment, according to a recent study of juvenile offenders. Parental recognition that there is a serious problem increases the likelihood that the youth will stay in treatment, perhaps because these parents are more motivated to seek help than are parents who minimize or ignore these problems. Parental expectations about their children's educational potential are also critically important in treatment engagement. Parents who believe their children can overcome their problems and be successful in school make a powerful difference even when faced with difficult circumstances.

Gender and Cultural Competence

Although girls are still a minority in the juvenile justice system, their numbers have increased sharply in recent years, largely because of drug law violations. Girls are involved in one-third of all arrests of youth ages 13 to 15 years old account for more than 25 percent of juvenile offenders. Most of them have both serious mental health and substance abuse problems.

Very few programs are designed for female adolescent substance abusers, including those detained in juvenile facilities, with gender-specific services that take into account female socialization and pathways to substance abuse and delinquency. Depression and trauma, including physical and sexual abuse, usually precede drug use; many adolescent girls say they drink and use drugs to make themselves feel better and more "connected" to others. Often they develop problems with drugs in the context of relationships with drug-abusing partners or family members. Abandonment, abuse and depression are key issues girls must address in treatment. They also must be physically safe and free from sexual and psychological harassment both from staff and other adolescents. Programs should provide the opportunity for girls to participate in single-sex groups and to have female counselors for individual sessions. Girls may be reluctant to talk freely in front of men about their own experiences, particularly sexual abuse, which many regard as shameful. Moreover, juvenile justice programs often reward girls for compliance and silence, even if that means not voicing important issues related to their recovery.

Although research is still very limited, many experts believe that understanding cultural differences is critically important in being able to treat minority youth effectively. In the juvenile justice system, black youth are disproportionately represented at every stage of the process. One in three (36 percent) of all detained cases involve blacks, although they represent only 15 percent of the juvenile population ages 12-17. The further one moves into the system, the greater the concentration of minority youth. Indeed, the rate of residential placement for black juveniles is five times higher than that of white juveniles.

Very little information is available about the numbers of Hispanic juvenile offenders, in part because national statistics include Hispanics in the category of "other races." Nonetheless, it is known that the residential placement rate for Hispanic juvenile offenders in 1999 was more than twice as high as the rate for white youth. National studies of Latino adolescents indicate that ethnicity and acculturation are likely to impact various aspects of treatment. Some programs, like Brief Strategic Family Therapy (BSFT) in Miami, Florida, are specifically designed for Hispanic youth and their families. Retention rates are significantly higher than in other outpatient programs that do not address cultural issues.

Continuing Care

The majority of adolescents relapse in the first three months following treatment. Gains that teens make in treatment can quickly disappear without continuing support. For juveniles under court supervision, relapse can result in more severe sanctions, including a longer, more intense period of probation or to incarceration in a juvenile facility. For juveniles returning to the community from correctional facilities, jails or detention centers, a system of care that provides help with this transition is critically important. Wherever drug treatment has taken place—in outpatient programs, residential treatment facilities or correctional institutions, supportive services must be extended beyond the active intervention phase to provide continuing care as a youth builds a new identity in the community. This can be particularly challenging once a youth leaves the security of a locked setting or the structure of regular meetings with a probation officer.

The transition from juvenile court jurisdiction to school can also be difficult. Some states do not obligate schools to admit children over the age of 15. Education within juvenile facilities is often not based on grade levels, so that older children who may already have learning problems face significant obstacles in returning to the public school system. Providing educational support as an essential aspect of continuing care can reduce the likelihood of dropping out of school.

Programs vary widely with regard to continuing care. Most programs provide referrals to community resources, including Twelve Step meetings and group therapy where available. Less frequently, programs develop a continuing care plan while the juvenile is still in treatment. Some programs provide ongoing services, including counseling, education, and continuing contact with probation officers, and a few have counselors who specifically follow up with juveniles who have completed the formal treatment program.

Continuing care planning should begin early in the juvenile justice process as part of a clear continuum throughout the course of treatment and after treatment completion. Young offenders often have a number of different probation officers and treatment counselors. Continuing care should provide consistency in personnel as well as a range of services that includes relapse prevention, intervention and treatment for at least a year or longer. The goal is to open productive avenues for youths as they work to develop positive identities, jobs, educational and social skills that can provide powerful alternatives to drug use and delinquency.

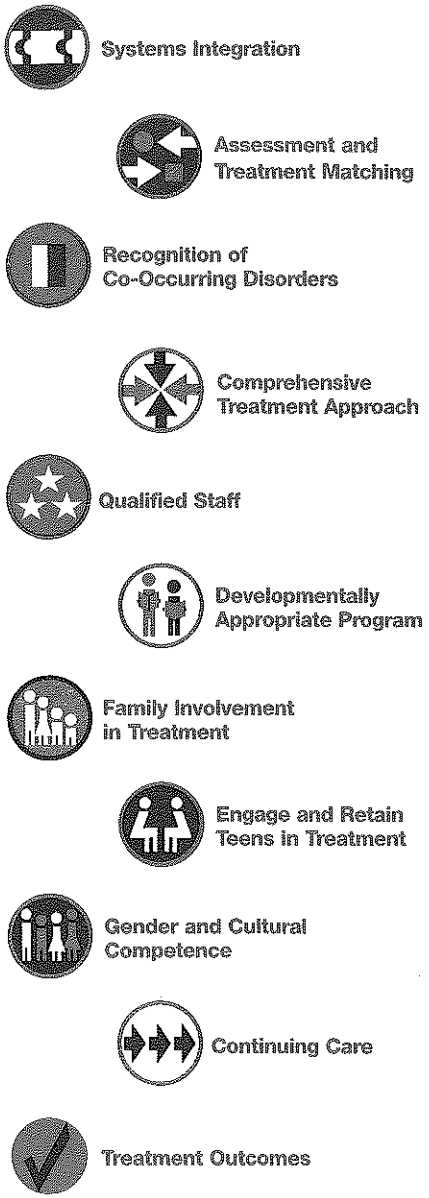
Treatment Outcomes

Research on the effectiveness of drug treatment for juvenile offenders is still limited. Several recent large-scale federally funded evaluations have found that drug treatment for adolescents, including many referred by the juvenile justice system, can produce significant reductions in substance use and related problems. These studies—Drug Abuse Treatment Outcome Studies for Adolescents (DATOS-A); Cannabis Youth Treatment Program (CYT) and Adolescent Treatment Models (ATM)—are discussed in the section on "Programs and Approaches."

Very few adolescent treatment programs conduct formal outcome evaluations, largely because they are expensive, require a high level of research expertise, and often face added obstacles when multiple systems are involved (e.g. mental health services, juvenile drug court, child welfare). Following up with juveniles after they have completed treatment or are no longer under the jurisdiction of the court can be very difficult. Nonetheless, measuring effectiveness must remain a top priority, even if programs are not able to conduct formal outcome evaluations.

In the absence of formal outcome evaluations, many programs engage in some assessment of quality assurance and treatment impact. Programs can collect a range of information that will shed light on how they are performing and whether they are achieving their goals. Programs should routinely measure clients' progress: Do regular urine tests come back clean (i.e., no drug use)? Has the juvenile violated probation or been rearrested? Are family relationships improving? Is there progress in education and employment placement? Retention rates are also valuable indicators of program effectiveness, since completion of treatment is the most consistent predictor of positive outcomes.

Programs and Approaches Illustrating the Key Elements



This section describes a wide range of programs and approaches designed to treat substance-abusing adolescents involved in the juvenile justice system. Each section highlights useful strategies and practices that illustrate one of the eleven key elements of effective treatment identified by the Expert Advisory Panel. In addition to discussing the practical application of each key element, the descriptions include a focus on program results, specific challenges faced by the program, and how these were addressed. We hope to provide the reader with a better understanding of the great diversity of current treatment efforts as well as a more detailed look at what may be involved in putting each key element into practice.

The selection of programs and approaches for this section was based on recommendations from members of the Expert Advisory Panel as well as from state alcohol and drug abuse agency directors. We recognize that there may be many other programs and approaches that might equally well illustrate the key elements, but space constraints required us to select only a few. Drug Strategies does not endorse any particular program or approach described in *Bridging the Gap*.

This section does not provide information on the cost of treating individual juveniles, although this is an important practical consideration that greatly affects treatment availability. While many programs maintain overall annual budget figures, relatively few are able to provide the actual average cost of treatment per juvenile. Two major federally funded studies, the Cannabis Youth Treatment Program (CYT) and Adolescent Treatment Models (ATM), discussed later in this section, did assess the cost-effectiveness of various programs and treatment models. Each of the CYT treatment protocols appeared to be both clinically effective and cost-effective when compared with the average cost ($365/week) for treating adolescent marijuana abusers reported in the National Treatment Improvement Evaluation Study (NTIES).

Recent studies by the University of Pennsylvania's Treatment Research Institute (TRI) provide additional perspective on costs. TRI developed standardized treatment costs by recalculating the weekly cost of adolescent and adult treatment in 2004 dollars. The TRI study found that outpatient treatment is somewhat more expensive for adolescents than for adults. TRI reported that costs for research-based adolescent outpatient programs with a median stay of 12 weeks ranged from $1,474 to $3,730 per treatment episode. Residential therapeutic community costs for clients with co-occurring disorders are relatively higher, reflecting long-term residential costs as well as more intensive services.

Incarceration remains far more expensive than treatment. Putting a juvenile in jail costs about $40,000 annually, compared to $13,000 for residential treatment and $3,000 for outpatient care (depending on geographic location, type of staff and treatment intensity).

Multidimensional Family Therapy

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Multidimensional Family Therapy (MDFT) outpatient therapy concentrates on the individual adolescent, the parents, the family and youth together, and systems that affect the youth's life, including schools, juvenile justice, peer groups and the community. Based on a strong theoretical structure of developmental psychological principles, MDFT views any interaction between the therapist and the client/family as an opportunity to provide treatment. Three-quarters of the program's clients are referred by the juvenile justice system. The program has been implemented in more than a dozen sites nationwide and six other countries. Federally funded since 1985, MDFT costs one-third less on average than standard outpatient or residential treatment.

FAMILY INVOLVEMENT

MDFT believes that a good parent/child relationship is a powerful protective factor against substance abuse. Therapists work on resolving parents' personal mental health and substance use issues, teaching parenting skills and addressing the family environment as a whole. An MDFT therapist conducts an initial assessment of various risk factors, including familial drug use, family relationships, communication and conflict. Observation, interaction and clinical interviews are used to assess individual and family functioning. In order to gain parental cooperation, therapists acknowledge participants' past efforts and encourage them to express their frustrations with their children's drug use and behavioral problems. Earlier hopes and dreams of parents for their children are discussed, which often motivate parents to try once more. Therapists refer families to any needed services, and remain in close contact with the juvenile justice system, schools, peer groups, and other community services in order to coordinate services and monitor progress.

Family sessions, individual sessions with parents and adolescents, and meetings with relevant social service agencies and the teen and parent occur one to four times a week for four to eight months, depending on the level of treatment intensity. Phone calls are used extensively both to check in on progress and to give new tips on how to effect changes between face-to-face sessions. Topics addressed in family therapy include the family's mental health and substance use, how to adjust parenting strategies based on the child's developmental level, and how family relationships can support the developmental challenges of adolescents and parents. Adolescents and families also work on relapse prevention strategies following completion of treatment.

RESULTS

Located in a research center at the University of Miami, MDFT has been found to be effective in four separate randomized clinical trials as well as several therapy process studies over the past ten years. MDFT participants in one randomized study from 2001 showed a clinically significant reduction of drug use at one year post-treatment and improvement in family functioning when compared to two alternative treatment approaches. Outcome measures were taken at 6 and 12 months post-treatment with abstinence confirmed through urinalysis. At one-year post-treatment, 45 percent of youths who had received MDFT reported clinically significant reductions in drug use, compared to 32 percent and 26 percent of adolescents in the other two groups. Grade point average (GPA) also improved significantly. At intake, 20 percent of the MDFT population had a GPA of 2.0 or better. At one-year follow-up, the percentage increased to 76 percent.

Challenges: MDFT researchers are currently seeking to facilitate the adoption of the program in a variety of non-research clinical settings. The challenges of applying MDFT in real world environments are largely related to staff training issues and providing the necessary time and resources to teach clinicians how to implement MDFT.