



**NC Division of Mental
Health, Developmental
Disabilities & Substance
Abuse Services**

Juvenile Justice Initiative

Providing Juveniles a System of Care

**North Carolina Institute of Medicine
Substance Abuse Task Force
June 23, 2008**



Juvenile Justice Initiative

Providing Juveniles a System of Care

- **The Focus**
 - **Population and Prevalence**
- **System of Care**
- **The Model**
- **Evidence-Based Practices**



The Focus

- 70% of youth in the Juvenile Justice System meet criteria for at least one mental health disorder
 - 46% disruptive disorders
 - 46% substance abuse
- Without conduct disorder and substance abuse prevalence is still over 60%



The Focus

- 79% of youth had two or more diagnoses
- 60% had three or more diagnoses
- 60% of youth with diagnosable disorders had a substance abuse disorder



NC Juvenile Population

- Of the 9,220 adjudicated youth in 2007
 - 75% screened to have mental health needs
 - 46% screened to be in need of substance abuse assessment or treatment

-NC DJJDP Legislative Report, 2007.



Providing a System of Care

- Appropriate response to this population requires:
 - Increased collaboration
 - Continuity of Care
 - Qualified provider community
 - Infusion of evidence-based treatments



System of Care

- **Child and Family Team Based**
- Family Driven and Youth Guided
- Natural Supports
- Collaboration
- Community Based
- Culturally and Linguistically Competent
- Individualized
- Strengths Based
- Persistent
- Outcome Based and Data Driven



Why are we doing this?

- Refocus services on MH/SA and co-occurring
- Need for a single point of contact
- Referrals are down
- Community Support overutilized
- Evidence-Based Treatments underutilized
- Reflect how DJJDP is organized



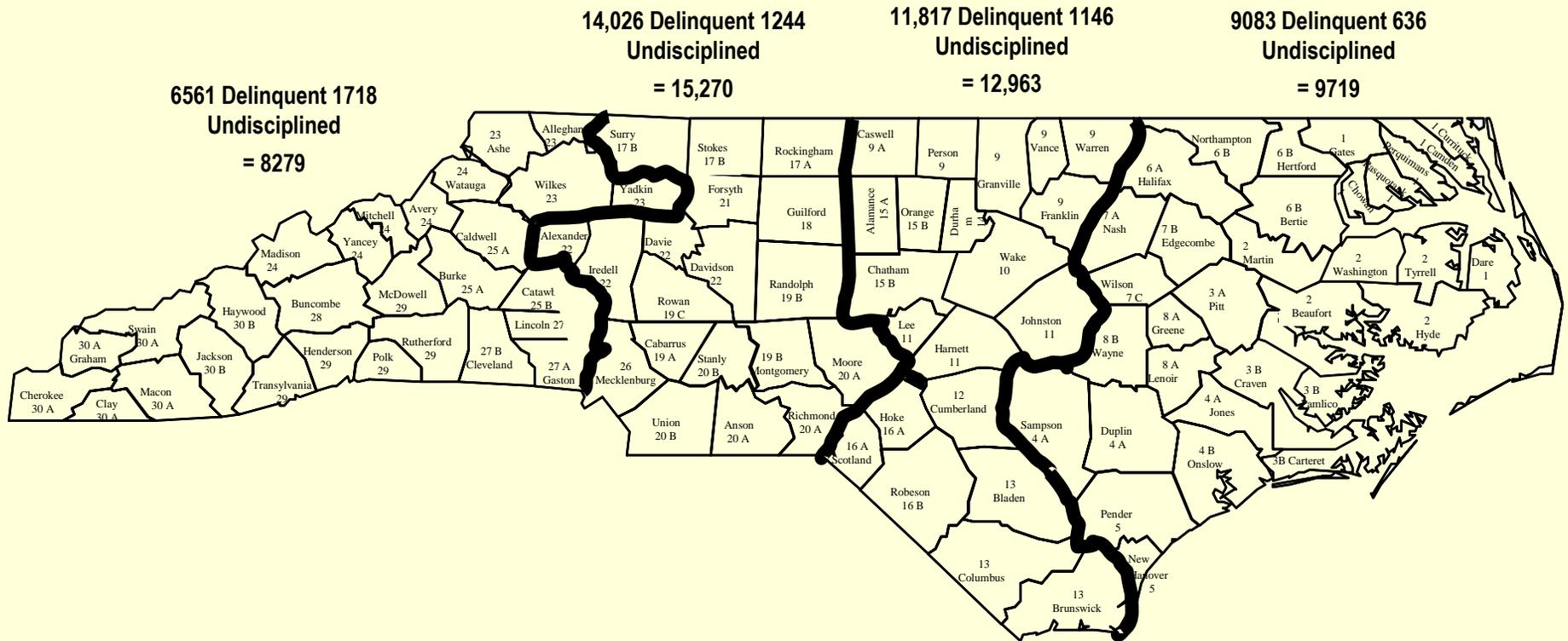
Cross-Area Service Program

- Designated by the DMH/DD/SAS to receive earmarked funding to provide services across multiple Local Management Entities
- Services are directed through a provider entity to serve an identified consumer population



Juvenile Justice Initiative

Providing Juveniles a System of Care



Juvenile Justice Initiative

Providing Juveniles a System of Care

DJJDP-DMH/DD/SAS Advisory Partnership: meets quarterly

Systems Coordination Team (per Area): meets quarterly
DJJDP Area Administrator, LME SOC Coordinator and SA Contact,
JCPC Chair(s) and Community Collaborative Chair(s),
Lead Provider Project Director

Operations Team: meets monthly, provides quarterly training
Chief Court Counselor, LME SOC Coordinator and SA Contact,
Lead Provider Project Director, Other Provider Supervisor(s)

Lead Provider Agency (per CASP): coordinator and/or provider of service array

- Receives and coordinates referrals from court, court counselors, YDCs, and detention
 - Uniform Evidence-Based Assessment
 - Monthly Child and Family Teams
- Weekly Clinical Staffing (clinical staff *and* court counselor)
 - Treatment Contract
- Strong connection to Lead LME

Community Service

Family Therapy

Parent Education

Multi-Family Group

Community Support

Intensive In-Home/ MST

Therapeutic Foster Care

SA Residential

MH/SA/Co-occurring Evidence-Based Treatments & Interventions including &/or within:



What will this accomplish?

- Support Public Safety
- Provide a single Point of Contact for DJJDP & courts
- Quality assessment and appropriate level of care
- Coordination of referral and treatment
- Ensure service dollars are expended appropriately
- Increase stability & quality of LME provider community
- Improve relationships among state & local agencies
- Infusion of EBTs into provider community



Why Evidence-Based Practices (EBPs)?

- Translate research into practice, increase the effectiveness of treatment
- Provide a framework for collecting data about treatment
- Ensure accountability to funding sources
- To encourage some consistency in practice



Global Appraisal of Individual Needs (GAIN)

- **A reliable and valid assessment that can be used:**
 - At the individual level to immediately guide clinical judgments about diagnosis/severity, placement, treatment planning, and the response to treatment
 - At the program level to drive program evaluation, needs assessment, and long term program planning



GAIN I

- **Administration Time:** Core version 60-90 minutes
- **Training Requirements:** 3.5 days plus recommend formal certification program
- **Mode:** Generally staff administered on computer (can be done on paper or self-administered)
- **Purpose:** Designed to provide a standardized bio-psycho-social for people presenting for treatment (using DSM-IV for diagnosis, ASAM for placement)
- **Scales:** 9 sections (including substance use, mental health, risk and protective behaviors, recovery environment, legal, etc.)



GAIN I

- **Main interpretative reports to support diagnosis, placement, and treatment planning:**
 - **GAIN Referral and Recommendation Summary (GRRS)**: A text-based narrative designed to be shared with specialists, staff from other agencies, insurers, etc.
 - **Individual Clinical Profile (ICP)**: A more detailed report designed to help triage problems and help the clinician go back to the GAIN for more details, if necessary.
 - **Personal Feedback Reports (PFR)**: A text-based summary to support the motivational interviewing or MET.



Motivational Enhancement Therapy/ Cognitive Behavioral Therapy

- **MET/CBTx5**

- Five-session treatment composed of two individual sessions of motivational enhancement therapy (MET)
- Three weekly group sessions of cognitive behavioral therapy (CBT)

- **MET/CBTx5 + CBTx7**

- Two sessions of MET and 10 weekly group sessions of CBT



Motivational Enhancement Therapy/ Cognitive Behavioral Therapy

- The MET sessions focus on factors that motivate adolescents to change
- In CBT sessions adolescents learn skills to cope with problems and meet needs in ways that do not involve turning to marijuana or alcohol
- Focuses on teaching techniques:
 - problem solving
 - anger management
 - improving communication skills
 - coping with cravings and urges to use marijuana
 - depression management
 - planning for high-risk situations
 - coping with relapse



Multi-Dimensional Family Therapy (MDFT)

- **MDFT**
 - 12-week treatment, composed of 12 to 15 individual, family-focused sessions plus telephone and case management contacts.
 - Depending on need or availability, therapists meet with adolescents and family members individually or together.
- **Focuses on:**
 - Integrated approach to family issues
 - Roles, problem areas, and interactions among family members
 - Effective and age-appropriate interpersonal and conflict-resolution skills
 - Helping parents establish a more effective and supportive parenting style
 - Building appropriate social supports with peers, schools, and other involved service providers



Seven Challenges

- Designed to motivate a decision and commitment to change to support success in implementing the desired changes.
- Simultaneously helps young people address their drug problems as well as their co-occurring life skill deficits, situational problems, and psychological problems.
- Provides a framework for helping youth think through their own decisions about their lives and their use of alcohol and other drugs.
- Implemented in a wide array of counseling settings (outpatient, intensive outpatient, inpatient, residential, day treatment, partial care programs, and home-based).
- Sessions can be conducted in individual or group sessions.



Seven Challenges

1. We decided to open up and talk honestly about ourselves and about alcohol and other drugs.
2. We looked at what we liked about alcohol and other drugs, and why we were using them.
3. We looked at our use of alcohol or other drugs to see if it has caused harm or could cause harm.
4. We looked at our responsibility and the responsibility of others for our problems.
5. We thought about where we seemed to be headed, where we wanted to go, and what we wanted to accomplish.
6. We made thoughtful decisions about our lives and about our use of alcohol and other drugs.
7. We followed through on our decisions about our lives and drug use. If we saw problems, we went back to earlier challenges and mastered them.

Juvenile Justice Initiative

Providing Juveniles a System of Care

DJJDP-DMH/DD/SAS Advisory Partnership: meets quarterly

Systems Coordination Team (per Area): meets quarterly
DJJDP Area Administrator, LME SOC Coordinator and SA Contact,
JCPC Chair(s) and Community Collaborative Chair(s),
Lead Provider Project Director

Operations Team: meets monthly, provides quarterly training
Chief Court Counselor, LME SOC Coordinator and SA Contact,
Lead Provider Project Director, Other Provider Supervisor(s)

Lead Provider Agency (per CASP): coordinator and/or provider of service array

- Receives and coordinates referrals from court, court counselors, YDCs, and detention
 - Uniform Evidence-Based Assessment
 - Monthly Child and Family Teams
- Weekly Clinical Staffing (clinical staff *and* court counselor)
 - Treatment Contract
- Strong connection to Lead LME

Community Service

Family Therapy

Parent Education

Multi-Family Group

Community Support

Intensive In-Home/ MST

Therapeutic Foster Care

SA Residential

MH/SA/Co-occurring Evidence-Based
Treatments & Interventions
including &/or within:



References / Resources

Abram, K.M., Teplin, L.A., McClelland, G.M., & Dulcan, M.K. (2003). Comorbid psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*, 60, 1097-1108.

Shufelt, J. & Coccozza, J. (2006). Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study. National Center for Mental health and Juvenile Justice, Research and Program Brief.

- The National Registry of Evidence-based Programs and Practices (NREPP) www.nrepp.samhsa.gov
- The Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide (MPG) www.dsgonline.com
- Chestnut Health Systems (GAIN) www.chestnut.org
- Seven Challenges www.sevenchallenges.com
- Multi-Dimensional Family Therapy www.med.miami.edu



Contact Information

- Kelly B. Crowley, LCSW
System of Care Coordinator
Community Policy Management
Prevention and Early Intervention
919-715-5989
Kelly.Crowley@ncmail.net
- Paul Savery
Project Coordinator
CSAT Adolescent Substance abuse Treatment Grant
Community Policy Management
Best Practice and Community Innovations
919-715-2774
Paul.Savery@ncmail.net