

Welcome to NCJFCJ's Adolescent-Based Treatment Database

The adolescent substance abuse treatment field is young compared to adult substance abuse treatment services. For many years, services for juveniles were merely adult models, most of which were only slightly modified to address a multitude of adolescent-specific issues. When studies examined these treatment practices, they found that such modified adult models were often ineffective with juveniles and, perhaps not surprisingly, caused more harm than good. However, in the last 15 years, researchers have successfully developed a range of validated substance use disorder treatment modalities normed for adolescents. It is important for courts and juvenile justice professionals to fully understand what treatments are available, evidence-based, and developmentally appropriate for the youth they are serving.

NCJFCJ has compiled information on validated treatment interventions and assessment instruments in **The Adolescent-Based Treatment Database**. This database will serve as a valuable tool for juvenile drug courts by detailing intervention basics; special considerations for JDCs; and engagement strategies (for treatment providers, allied agencies, youth, and families). **The Adolescent-Based Treatment Database** serves as a “one-stop-shop” for JDCs researching adolescent-focused treatment and assessment instruments.

Treatment Database Usage TIPS (for online purposes only)

- Click here to download a copy of the right-hand image, which displays the Adolescent-Based Treatment Intervention Comparison Matrix. The Comparison Matrix will help readers quickly identify brief, individual, group, and family interventions that may work in their jurisdiction.
- Click here to download a complete copy of the Adolescent-Based Treatment Database to share the thirty-three page document with additional JDC team members, stakeholders, or partners.
- Click on any of the individual interventions below to research the best fit for your jurisdiction:

Brief Interventions

Teen Intervene

Individual & Group Interventions

Adolescent Community Reinforcement Approach (A-CRA)
Matrix Model
Moral Recognition Therapy (MRT)
Motivational Enhancement Therapy (MET) and Motivational Interviewing (MI)
Motivational Enhancement Therapy & Cognitive-Behavioral Therapy (MET/CBT 5 or 12)
Multi-Systemic Therapy of Juvenile Offenders (MST-JO)
Seeking Safety

The Seven Challenges Program

Family Interventions

Brief Strategic Family Therapy (BSFT)

Family Support Network (FSN)

Functional Family Therapy (FFT)

Multi-Dimensional Family Therapy (MDFT)

Multi-Dimensional Treatment Foster Care (MTFC)

Screening Instruments

Global Appraisal of Individual Needs (GAIN-SS / GAIN Q3)

Massachusetts Adolescent Screening Instrument (MAYSI)

NOTE: Information gathered in this Database was compiled from existing sources (i.e., SAMHSA's National Registry of Evidence-Based Programs and Practices and other online resources). NCJFCJ's goal was to narrow the focus to adolescents and to add additional considerations, so JDC teams would be able to make knowledgeable decisions regarding treatment in their jurisdiction, as not all treatment options available will be a good fit for a JDC population.



Teen Intervene

Intervention Basics

Teen Intervene is an early intervention program which targets adolescents who display early signs of alcohol or drug problems, but are not yet at the stage of daily use or substance dependence.

Teen Intervene integrates the following techniques in order to eliminate their substance use:

- Stages of Change Theory
- Motivational Enhancement
- Cognitive-Behavioral Therapy

Expectation of Sessions:

There are 2 - 3 one-hour sessions. Sessions are administered in a school setting and specific goals are addressed in each session. The final session includes the family and addresses the need for the parent to demonstrate healthy attitudes and behaviors related to substance use.

Recommended Populations

- Youth ages 13 - 17
- Girls or Boys
- Outpatient / School Setting
- Urban or Suburban Setting

Special Considerations for Juvenile Drug Courts

Because this treatment modality sits on a line between prevention and early intervention for youth with a low severity of substance use, it may not be appropriate for the youth JDCs are serving. It is recommended that JDCs target youth who have both moderate to high substance abuse treatment needs **and** moderate to high criminogenic risk. In some cases, youth participating in Teen Intervene may show signs of a more severe substance abuse problem than originally assessed, which may lead to enrollment in a JDC program, but courts and case managers are cautioned to place youth into the right program the first time, rather than relying on a “controlled failure” (i.e., the team should work through any screening and assessment challenges, if youth are continually showing more severe issues after intake and then being moved to a more intense treatment program or level of supervision).

Additionally, Teen Intervene, as tested and evaluated by NREPP, was provided in a school-based setting, typically with a school guidance counselor administering the protocol.

Engagement Strategies

Teen Intervene may not need targeted engagement strategies when youth enroll in the program, given its length. One strength of the program would be that the intervention can be targeted to teens without the stigma of

“treatment” given its short duration and location of the treatment provided (i.e., school guidance counselor). Engaging the parents in this low-intensity setting (school grounds), for the final session, will likely be easier than gaining agreement to attend a session in a traditional treatment setting.

The JDC may want to take this opportunity to engage local school administrators regarding Teen Intervene. School counselors can easily be trained to provide this intervention; it is very prescriptive in nature, making the training fairly easy for school counselors with little time for additional duties.

Implementation and Training

Visit Hazelden's website to research costs and training opportunities or contact Ken Winters, Ph.D. at winte001@umn.edu for more information.

For more detailed information regarding research and replications associated with the intervention, visit: SAMHSA's National Registry of Evidence-Based Programs and Practices.

Adolescent Community Reinforcement Approach (A-CRA)

Intervention Basics

Adolescent Community Reinforcement Approach (A-CRA) is a behavioral intervention that uses a clinician and seeks to replace environmental contingencies that have supported alcohol or drug use with pro-social activities and behaviors that support recovery. A-CRA therapists choose from fifteen procedures that address the adolescent's needs and self-assessment in multiple areas of functioning.

Goals of treatment sessions are as follows:

Adolescent Sessions

- Promote abstinence
- Promote positive social activities
- Promote positive peer relationships
- Promote improved familial relationships

Caregiver Sessions

- Encourage participation in the recovery process
- Promote the adolescent's abstinence
- Provide information on effective parenting

There are twelve standard procedures and three optional procedures. Delivery of the intervention is flexible based on the individual's needs, although the manual provides guidelines regarding the general order of procedures.

Standard Procedures:

- Functional Analysis of Substance Use
- Analysis of Pro-Social Behavior
- Happiness Scale & Goals
- Increasing Pro-Social Recreation
- Relapse Prevention Skills
- Communication Skills
- Problem-Solving Skills

- Urine Testing
- Caregiver Overview, Rapport Building & Motivation
- Caregiver Communication Skills
- Caregiver-Adolescent Relationship
- Treatment Closure

Optional Procedures:

- Dealing with Failure to Attend
- Job-Seeking Skills
- Anger Management

Expectation of Sessions:

Fourteen sessions (60 minutes each) over a three-month period, ten individual sessions with adolescent, two individual sessions with caregiver and two joint sessions. Community contact is added on a case-by-case basis.

Recommended Populations

- Youth ages 12 – 18
- Girls & Boys
- American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; and White
- Outpatient; Home; Other community settings
- Urban; Suburban; Rural and/or frontier

Special Considerations for Juvenile Drug Courts

A-CRA may be helpful in engaging/involving the family in juvenile drug court because the intervention itself relies on family involvement. The judge should be clear about this element of the approach and encourage the treatment provider to use these sessions to reinforce family involvement with the youth in the juvenile drug court. A-CRA, along with MET/CBT 5, produced the lowest cost per youth in recovery at 12 months post-intake. If this intervention is chosen, it will be useful to consider also incorporating Assertive Continuing Care (ACC), which will help the JDC team to incorporate case management in a meaningful and seamless way. Advantages to this approach have been demonstrated in several clinical trials and reduce early relapse which in turn increases the chances of abstinence at 12 months post-intake. For information, visit Chestnut Health Systems' website.

The A-CRA protocol calls for a very regimented and rigorous training program for therapists to achieve certification. The treatment organization should engage in a "readiness for change" evaluation to measure the readiness of the program and the therapists to adopt this approach. The training and skill level of the therapists should be assessed to ensure a good fit with the model.

Engagement Strategies

Throughout the process, JDC team members should continue to engage youth regarding any goals associated with their treatment plans. Because A-CRA generally lasts three months, it is recommended that the judge and other team members continually speak with the youth about the ongoing commitment to the goals they have achieved.

While there are sessions for family/caregivers incorporated in the protocol, it is imperative that the court make family engagement a priority, as well. Remove barriers (i.e., alleviate any transportation issues) and provide incentives for family/caregivers to participate in treatment sessions. Families/caregivers who do engage, report satisfaction with the program and their engagement has led to better outcomes for youth in juvenile drug courts.

Implementation and Training

Visit Chestnut Health Systems to research costs and training opportunities.

*For more detailed information regarding research and replications associated with A-CRA, visit:
SAMHSA's National Registry of Evidence-Based Programs and Practices.*

Matrix Model

Intervention Basics

Matrix Model is an intensive outpatient treatment approach for substance abuse and involves relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing to motivate for change.

The Matrix Model utilizes many different forms of therapy and factors to help ensure success for those involved. Factors include:

- Motivational Interviewing
- Twelve-Step Facilitation
- Family Involvement
- Education
- Contingency Management
- Continuing Care

Expectation of Sessions:

Individual therapy, group therapy and family sessions occur over a 16-week period but can be extended up to 12 months.

Recommended Populations

- Young adults ages 18 - 25
- Male & Female
- Asian; Black or African American; Hispanic or Latino; and White
- Outpatient
- Urban; Suburban

Special Considerations for Juvenile Drug Courts

JDC teams will have to determine if this type of treatment is appropriate for their target population, as the studies only suggest positive outcomes for young adults (ages 18-25). Research indicates that this treatment does not work well for youth ages 13 – 17 (the age of most JDC participants).

Engagement Strategies

JDC teams may want to take this opportunity to work with other levels of jurisdiction to determine if an additional track may be inserted with the juvenile drug court or the adult drug court framework (i.e., a track for 18 – 25 year olds), in light of current research findings suggesting that the maturation of the brain may not happen until a person reaches the age of 24.

Implementation and Training

Contact Michael McCann, M.A., (310) 478-8305, mmcann@matrixinstitute.org to research costs and training opportunities.

***For more detailed information regarding research and replications associated with the Matrix Model, visit:
SAMHSA's National Registry of Evidence-Based Programs and Practices.***

Moral Reconciliation Therapy (MRT)

Intervention Basics

Moral Reconciliation Therapy (MRT) seeks to decrease recidivism among both juvenile and adult criminal offenders by increasing moral reasoning. MRT is systematic and implements a cognitive-behavioral approach, which positively addresses an adolescent's ego, social, moral, and positive behavioral growth.

MRT uses 12-16 objectively defined steps, which focus on seven basic treatment issues:

- Confrontation of beliefs, attitudes, and behaviors
- Assessment of current relationships
- Reinforcement of positive behavior and habits
- Positive identity formation
- Enhancement of self-concept
- Decrease in hedonism and development of frustration tolerance
- Development of higher stages of moral reasoning

Expectations of Sessions:

Individual and groups sessions. Groups meet once or twice weekly and can range in length from 3-6 months.

Recommended Populations

- 18-25 (Young adult)
- 26-55 (Adult)
- Male & Female
- Black or African American; White; Non-U.S. population
- Correctional

Special Considerations for Juvenile Drug Courts

Some of the research associated with MRT was completed on juveniles living outside of the U.S., in which the study participants lived in a non-secure facility and were allowed to leave whenever they wished. In addition, a majority of the participants studied were males and focused on young adults (18-24). It may be difficult to generalize these results out to the greater juvenile justice population and still more difficult to generalize to the juvenile drug court population.

While MRT is widely used in the U.S., there are no data submitted for review to support the use of MRT for U.S. adolescents and no data to support a reduction in substance use and/or abuse. Given that the research does not (at this current time) support using this type of treatment within a juvenile drug court, JDC teams should consider utilizing a different approach or using MRT in conjunction with a treatment that focuses on adolescent substance use and/or abuse.

Engagement Strategies

JDC teams are encouraged to ask treatment providers targeted questions regarding the use of MRT as a single therapy within a juvenile drug court program, especially since the research relies so heavily on its use with adult males. Engage treatment providers to participate in open discussions with the team to review outcomes and research.

Implementation Requirements/Recommendations

Visit Correctional Counseling, Inc. (CCI) to research costs associated with the therapy and training opportunities.

*For more detailed information regarding research and replications associated with MRT, visit:
SAMHSA's National Registry of Evidence-Based Programs and Practices.*

Motivational Enhancement Therapy (MET) & Motivational Interviewing (MI)

Intervention Basics

Motivational Enhancement Therapy (MET), initially developed to address the abuse of alcohol, has been adapted to address drug abuse. This treatment modality may work well with adolescents who do not attend therapy regularly or for only a limited number of sessions.

MET seeks to elicit behavior changes by resolving ambivalence and by utilizing intrinsic motivation, rather than the external motivation of family or treatment providers.

This treatment was built on Motivational Interviewing (MI), which strives to build intrinsic motivation to change substance abuse by resolving client ambivalence, evoking self-motivational statements, and commitment to change. MI focuses on “rolling with resistance” which responds, in a neutral way, to the client’s resistance to change, rather than contradicting or correcting the client.

Two phases are utilized during treatment sessions:

Phase One

- Eliciting self-motivational statements
- Listening with empathy
- Questioning
- Presenting feedback
- Affirming the client
- Reframing
- Summarizing

Phase Two

- Recognizing readiness to change
- Discussing a plan
- Communicating free choice
- Discussing consequences of action and inaction
- Providing information and advice in response to client questions
- Emphasizing abstinence
- Recapitulating (offering a broad summary)
- Asking for commitment

Expectation of Sessions:

Includes one or more sessions, which treatment providers give feedback in a non-confrontational style.

Recommended Populations

- 18-25 (Young adult)
- Male & Female
- American Indian or Alaska Native; Black or African American; Hispanic or Latino; and White
- Inpatient; Residential; Outpatient; School
- Urban; Suburban

Special Considerations for Juvenile Drug Courts

MET was developed for Project Match, a national research endeavor by the National Institute of Alcoholism and Alcohol Abuse. The principles of this approach are based on Motivational Interviewing, and is the precursor to a manualized, adolescent-specific intervention known as MET/CBT 5.

But, unlike MET/CBT 5 there is not a specific manual for the intervention. The intervention could be molded to address the needs of adolescents by a very skilled purveyor; however, that molding has occurred and produced successful outcomes through the use of MET/CBT 5.

JDCs should keep in mind that this is not a manualized form of treatment for adolescents and protect against its overuse (i.e., youth attending treatment sessions far longer than they should just because they happen to be in a drug court program).

Engagement Strategies

If a treatment program working within a juvenile drug court program is utilizing MET as a form of treatment for the youth in the program, the court should ask targeted questions based on the information above:

- Is the treatment program protecting against over-treatment?
- Is the JDC program driving treatment (i.e., are youth merely attending sessions based on phase structure, rather than an individualized treatment plan)?
- Would the JDC program have better outcomes if a manualized treatment was implemented?

Implementation Requirements/Recommendations

Visit the MINT website to research costs and training opportunities.

For more detailed information regarding research and replications associated with the MET intervention, visit:

SAMHSA's National Registry of Evidence-Based Programs and Practices.

Motivational Enhancement Therapy & Cognitive-Behavioral Therapy (MET/CBT 5 or 12 Sessions)

Intervention Basics

MET/CBT combines the effective use of Motivational Enhancement Therapy (MET) and Cognitive-Behavioral Therapy (CBT). The number **5 or 12** indicates the number of sessions, which include both individual and group sessions for teens and young adults. This method of treatment provides ways in which clients are motivated to change, training tips for building the skills necessary to increase social support, how to engage in non-drug related activities, and avoidance and coping mechanisms to deal with any potential relapse issues.

MET/CBT is seen as beneficial for adolescents due to its less directive, non-confrontational approach in teaching coping skills. It also incorporates the power of peer influence into group sessions, which has proven successful.

Expectations of Sessions:

5 or 12 sessions – initial two sessions are 60-minute individual sessions, focused on Motivational Enhancement Therapy (MET); the remaining sessions (either 3 or 7 sessions) are typically 75-minute group sessions which incorporate Cognitive-Behavioral Therapy (CBT).

Recommended Populations

- Youth ages of 12 – 18, but has also been used up to age 22

It is important to note that MET/CBT 5 or 12 has not been successful with adolescents who:

- Require inpatient treatments
- Demonstrate severe conduct disorder
- Possess poly-substance dependence problems
- Experience social anxiety and are unable to participate in group sessions
- Possess an acute psychological disorder that affects their participation in the sessions

Special Considerations for Juvenile Drug Courts

JDC teams should keep in mind that this intervention will require more supervision while the youth is in drug court, since there may be only five sessions (or twelve) from which teams will get feedback from the treatment provider.

MET/CBT 5 or 12 works best when delivered over a shorter period of time, so it is important for the youth to move through treatment and sessions as scheduled, rather than allowing the treatment to stretch out for long periods of time. Feedback, by case managers, to the treatment provider and the court will be essential in determining the need for additional treatment after the initial five sessions. If additional sessions are not needed, the team will need to devise ways to keep the youth engaged in continuing care or supportive services following MET/CBT 5.

Engagement Strategies

The first two sessions (focusing on MET) are critical to engaging youth in the process, so JDC teams should structure program and phase components that will enhance this process. In addition, quickly getting the youth enrolled in treatment and attending these sessions is extremely important. In practice, JDC teams should develop a flowchart (in

collaboration with treatment providers) to help this process go smoothly (i.e., take care of transportation issues before they occur).

Although MET/CBT 5 or 12 does not include a family component, during the community-based trials, many treatment providers engaged families in either a family night or a family session since involvement of the family in juvenile drug court has been proven to increase retention and positive outcomes.

If MET/CBT 5 or 12 is new to the JDC program and team, there may be some skepticism involved regarding the effectiveness of the modality (due to the shortness of the treatment). Members of the team should read the article from the Cannabis Youth Treatment study to familiarize themselves with the outcomes. The study can be found in *Journal of Substance Abuse Treatment* 27 (2004) 197–213.

Implementation and Training

Visit SAMHSA's website to research costs and training opportunities.

*For more detailed information regarding research and replications associated with MET/CBT 5 or 12, visit:
Chestnut Health Systems.*

Multi-Systemic Therapy for Juvenile Offenders (MST-JO)

Intervention Basics

Multi-Systemic Therapy for Juvenile Offenders (MST-JO) is an intensive family and home-based treatment. It was developed to address the limitations of existing mental health services for juvenile offenders, but it has been modified for use with non-offending adolescents who have substance abuse or conduct-related problems.

The primary goals of MST-JO programs are to decrease rates of antisocial behavior and other clinical problems, improve functioning and achieve these outcomes at a cost savings by reducing the use of out-of-home placements such as incarceration, residential treatment, and hospitalization. MST-JO also helps parents identify their strengths, develop a natural support system, and remove barriers. **MST-JO focuses on three interventions:**

Individual

- Institutional placement
- Individual counseling
- Life/Social skills training

Family

- Family therapy
- Parent education
- Parenting skills training

Peer

- Peer-resistance education

Once the parents have become engaged, they collaborate with the therapist to develop strategies to:

- Set and enforce curfew and rules
- Decrease the youth's involvement with deviant peers
- Promote friendships with pro-social peers
- Improve the youth's academic/vocational performance
- Cope with any criminal subculture that may exist in the neighborhood

Expectation of Sessions:

Average of 60 hours during a 4-month period. Ideal treatment cycles are 3-5 months.

Recommended Populations

- Youth between the ages of 13 - 17 years of age

Special Considerations for Juvenile Drug Courts

JDC teams should understand that MST providers (and program components) should drive treatment decisions regarding youth. Generally it is recommended, regardless of intervention, that there is little attempt made by the court to influence the treatment process; however, this approach would not work well with a JDC team that would sway or alter the treatment as prescribed by the model – **where** it is delivered (this is a home-based treatment model) or **how** it is delivered. Program developers and those providing oversight to MST therapists ensure a very high degree of fidelity to the model throughout every stage of the process. Program costs are cited by many jurisdictions as a reason for not sustaining the approach after adopting it with an infusion of grant or other time-limited funding.

Keep in mind that reduction in substance use/abuse is limited to alcohol and marijuana.

Engagement Strategies

Because this is home-based intervention, once the court has assigned a youth and family/caretakers to MST, engagement and retention is seen as a critical function of the JDC team and the MST team. JDC teams should consider providing additional incentives for treatment compliance for *both* the youth and the family/caretakers to help increase engagement and retention outcomes (i.e., implement a fish bowl or rocket docket for youth and families working hard to complete treatment goals). Given the intensity of the treatment approach, it will be helpful for the JDC team to frame program requirements for the youth and family/caretakers based on MST recommendations.

Implementation Requirements/Recommendations

Please visit www.MSTSERVICES.com to research costs and training opportunities.

*For more detailed information regarding research and replications associated with this MST, visit:
SAMHSA's National Registry of Evidence-Based Programs and Practices*

Seeking Safety (SS)

Intervention Basics

Seeking Safety is a flexible treatment intervention for clients with a history of trauma and substance abuse. The treatment focuses on building coping skills and psycho-education, rather than focusing on past traumatic events.

Seeking Safety has five key principles:

- **Safety as the overarching goal**
 - Clients should attain safety in their relationships, thinking, behavior and emotions
- **Integrated treatment**
 - Working on both post-traumatic stress disorder (PTSD) and substance abuse at the same time
- **A focus on ideal to counteract the loss of ideals in both PTSD and substance abuse**
- **Four substantive areas:**
 - Cognitive
 - Behavioral
 - Interpersonal
 - Case Management
- **Attention to clinician processes**
 - Helping clinicians work on counter transference, self-care and other issues

Expectation of Sessions:

There are 25 sessions and can be flexible (i.e., group or individual formats).

Recommended Populations

- Age range is 26 - 55
- Females
- History of Trauma
- American Indian or Alaska Native; Black or African American; Hispanic or Latino; and White
- Outpatient; Inpatient; Residential

Special Considerations for Juvenile Drug Courts

Juvenile Drug Courts should understand that much of the research regarding this treatment intervention is based on the female population, ages 26-55. There is one study based on adolescent girls that showed promising outcomes, but the sample size was very small (n=33). If the treatment agency has several treatment options available, Seeking Safety being one, the court may be able to direct some JDC participants (i.e., girl participants) to receive treatment based on that modality. This would likely be based on the recommendations of the treatment provider. But, implementing Seeking Safety as the single treatment of choice for the JDC would be problematic, as the JDC team would not be able to rely on the intervention working for all JDC participants.

Engagement Strategies

JDCs should work closely with treatment providers to make sure that there is a wide-array of treatment options available to effectively treat a number of challenges and issues that this population present with, trauma being one. The JDC team will need to screen and assess for trauma and engage the youth in treatment (i.e., this is not a "one size fits all" intervention).

Implementation and Training

Visit the [Seeking Safety website](#) to research costs and training opportunities.

For more detailed information regarding research and replications associated with Seeking Safety, visit: [SAMHSA's National Registry of Evidence-Based Programs and Practices](#).

The Seven Challenges® Program

Intervention Basics

The Seven Challenges® program works with adolescents from where *they* are at with their usage, and not where their families and counselors **WISH** them to be. Counselors create a climate of mutual respect, which allows the adolescents to communicate openly and honestly about themselves and how their behavior affects, not only themselves, but also those around them (i.e., family members; peers). The program was designed to equally address drug and mental health problems. To help youth who are initially reluctant to admit to drug problems, counselors start by helping them acknowledge problems with authorities that involve drugs, and by providing assistance in maintaining abstinence. The program works through seven prescribed challenges during the treatment process.

The Seven Challenges are:

- We decided to open up and talk honestly about ourselves and about alcohol and other drugs.
- We look at what we like about alcohol and other drugs, and why we were using them.
- We look at our use of alcohol or other drugs to see if it has caused harm or could cause harm.
- We look at our responsibility and the responsibility of others for our problems.
- We think about where we seem to be headed, where we want to go, and what we want to accomplish.
- We make thoughtful decisions about our lives and about our use of alcohol and other drugs.
- We follow through on our decisions about our lives and drug use. If we see problems, we go back to earlier challenges and master them.

The Seven Challenges® Program can be beneficial for adolescents who are dealing with co-occurring disorders and establishes success through their counselors, working as problem-solving partners, rather than agents of authority who are enforcing punishments.

Expectations of Sessions:

Sessions are not pre-scripted but are tailored to the individual's needs. Counseling sessions have been implemented in several different formats: outpatient, intensive outpatient, inpatient, residential, day treatment, partial care and home-based programs. The intervention has been used in public and private schools, treatment schools, drug courts, juvenile probation departments, and public and private juvenile justice facilities.

Recommended Populations

- Youth ages 13 - 17
- Girls & Boys
- Co-Occurring Disorders
- Tribal, Hispanic/Latino, African American, Asian and Caucasian youth and their families
- Several Treatment Settings

Special Considerations for Juvenile Drug Courts

There is no pre-set time in treatment or minimum/maximum number of sessions. All treatment is individualized and

wrapped around the needs of the youth and family. This makes the program attractive to many JDCs since the length of treatment is not pre-determined and can continue as long as needed. That being said, JDC teams need to be comfortable with the fact that treatment may end before the youth has completed all of the JDC program components. This is a difficult transition for the team to sometimes make, as their expectation can be generally stated in this way – “if a youth is participating in drug court, they need to be in treatment of some kind.” In some cases, courts have been known to have the youth simply repeat the treatment modality. JDC teams need to be cautious about over-treating adolescents. Always keep in mind that treatment providers should drive the treatment plan, which is then supported by the court – not the other way around.

Engagement Strategies

JDC teams will need to put extra time and effort into engaging the community, if the team and program utilizes Seven Challenges. Community mapping should be a regular activity among team members to compile a useful list of youth and family related services. Especially, if the youth completes treatment before he/she completes the drug court program, as the team will need to connect the youth to other pro-social activities in the community to build independence and keep the youth occupied in sober activities.

Implementation and Training

Please contact Sharon Conner, Director of Program Services for The Seven Challenges, at (520) 405-4559 or sconner@sevenchallenges.com. Visit The Seven Challenges' website to learn more about the intervention.

For more detailed information regarding research and replications associated with Seven Challenges, visit: SAMHSA's National Registry of Evidence-Based Programs and Practices.

Brief Strategic Family Therapy (BSFT)

Intervention Basics

The Brief Strategic Family Therapy (BSFT) is designed to:

- Prevent, reduce and/or treat adolescent behavior problems such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers
- Improve pro-social behaviors such as school attendance and performance
- Improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school

BSFT focuses on problem behaviors by eliminating the addiction and believes that the family plays an integral role in this process. Therapy aims to help the family identify the interactional patterns that give rise to the problematic behavior in the youth and then works to change those patterns and encourage positive family interactions.

BSFT use the following strategies:

- Reframing
- Shifting Alliances
- Building Conflict Resolution Skills
- Parental Empowerment
- Reversals
- Giving and Micromanaging Behavior Skills

Expectation of Sessions:

There are 12 to 16 family sessions but can be as few as 8 or as many as 24, which are based on individual treatment plans. Sessions typically range from 60-90 minutes and can be held at any location that is convenient to the family.

Recommended Populations

- Youth ages 13-17
- Girls & Boys
- Black or African American; Hispanic or Latino
- Outpatient / Home
- Urban

Special Considerations for Juvenile Drug Courts

This program has been used extensively and effectively with Latino and African American families, and to a lesser

extent, with Caucasian American families...research is ongoing.

BSFT is one of the few interventions that has reported adverse effects related to the use of the intervention (i.e., negative behavioral outcomes occurred during or following a treatment session):

Among 900 individuals, seven adverse events were determined to be related to the delivery of BSFT. Four events were classified as "runaway." These events were determined to be related to the intervention because the adolescent ran away from home during or immediately after a session. For two events classified as "violence (victim/exposure)," a physical altercation between at least two family members occurred during a therapy session when family members became agitated. The single "arrest" event occurred at the conclusion of one of these two events when a family member was arrested and detained by police (excerpt taken from NREPP).

BSFT was developed and is used often in the context of bullying and violence making it more available to youth and families in highly volatile situations. Working with family systems prone to violence requires very skillful therapists. There is a higher level of intensity when conducting family therapy, which may mean that the client-to-counselor ratio will be lower than in most programs.

JDC teams and treatment programs/agencies/offices need to understand that the availability of treatment providers will likely change or be different from what is customary (i.e., 8 - 5 office hours). Treatment programs will need to be open during hours that *the family is available* to attend treatment and be prepared to provide child care when necessary.

Engagement Strategies

The developers of BSFT focused on two major issues in therapy: engaging and retaining youth in treatment **and** engaging the entire family in treatment sessions. Training is provided to BSFT therapists specifically around these two crucial issues. Engaging and retaining youth and families are pressing issues for juvenile drug court teams, as well. JDC teams and treatment provider parent agencies should target challenges in this area and develop ways to increase retention and family engagement in treatment and in the juvenile drug court program. In practice, JDC teams should implement ways to incentivize families who participate and find ways to create buy-in for the program (i.e., implement family dinner night once a month).

Implementation and Training

Contact Joan Muir, Ph.D., (305) 243-6363, jmuir@med.miami.edu to research costs and training opportunities.

***For more detailed information regarding research and replications associated with BSFT, visit:
SAMHSA's National Registry of Evidence-Based Programs and Practices.***

Family Support Network (FSN)

Intervention Basics

The Family Support Network (FSN) addresses issues and challenges that adolescents with insufficient family support and structure face, as these adolescents may have a harder time with recovery. FSN focuses on dimensions of authority, roles, rules, boundaries, communication, and routines. The FSN treatment combines MET/CBT12 with a family and a case management component to encourage adolescents and their families to work together on a joint treatment and recovery effort.

Expectation of Sessions:

The family component includes:

- Six bi-weekly – multifamily educational meetings addressing beliefs, development, drug use patterns and the recovery process as it pertains to the adolescent
- Four monthly in-home visits to reinforce the family’s commitment to treatment and help facilitate the adolescent and the family utilize the learned skills

The MET/CBT12 component includes:

- Two individual session of MET which explore and address the youth’s ambivalence about changing substance abuse behaviors
- Ten group sessions of CBT that teach youth specific cognitive behavioral skills

The Case Management component includes:

- Addresses barriers to treatment participation – can include weekly phone calls
- For families with more intensive needs, case management can include services for an additional two months following their standard case management

Recommended Populations

- Youth ages 13 -17
- Girls & Boys
- Black or African American; Hispanic or Latino; and White
- Outpatient; Home
- Urban; Suburban; Rural and/or frontier

Special Considerations for Juvenile Drug Courts

This intervention has the flexibility to work in conjunction with other treatment programs, as the treatment was initially developed to compliment interventions that lacked a family component. In addition, implementation of the intervention may be modified, which can be an attractive proposition for JDC teams and treatment programs.

JDC teams will need to keep in mind that any flexibility that is allowed during implementation (implementing the model in any other way than what is prescribed in the treatment manual), may be attractive to the court and to treatment providers, but it is not based in research.

Engagement Strategies

Courts should work closely with treatment providers to determine the best option for JDC program – strict adherence during implementation **OR** a more flexible approach. Choosing a more flexible approach will require that treatment provider(s) and other staff ensure that assessments and follow-up interviews with youth and families are scheduled throughout the treatment process to monitor the efficacy of the modified intervention. Some important things to consider would be:

- Modifying the duration of the treatment, should **NOT** be automatically construed as a positive change to the intervention - further evaluation will be needed
- Keeping youth in treatment past the point where they are continuing to make personal gains can lead to poorer outcomes (i.e., just because the drug court program lasts 12 – 18 months does not mean, necessarily, that the youth needs to be receiving treatment the entire time)
- This approach relies heavily on case managers and case management principles, so JDC teams will need to determine if staffing capabilities exist.

Implementation and Training

Contact Jackie Griffin, M.S. at (727) 545-7564 ext 268 or at jgriffin@operpar.org to research costs and training opportunities.

***For more detailed information regarding research and replications associated with FSN, visit:
SAMHSA's National Registry of Evidence-Based Programs and Practices.***

Functional Family Therapy (FFT)

Intervention Basics

Functional Family Therapy (FFT) is a strength-based model and focuses on interfamilial and extra familial factors while working through the therapeutic process. The process is non-judgmental and integrates respectfulness of culture, ethnicity, and family.

FFT works through five major components:

- Pretreatment
- Engagement Phase
- Motivation Phase
- Relational Assessment
- Behavior Change Phase
- Generalizations

Expectation of Sessions:

There are 12 sessions over a 3 - 4 month period.

Recommended Populations

- Youth between 12 - 18 years of age
- Clinic or home setting
- Can be used in other settings
 - Schools
 - Child Welfare Facilities
 - Probation Offices
 - Mental Health Facilities

Special Considerations for Juvenile Drug Courts

JDC teams and judges will find the Engagement Phase of this program particularly inviting, as the treatment process focuses on attitude. Many juvenile justice professionals struggle with the “attitude” that the youth (and possibly family) display in court and find it difficult to address the issue. Incorporating this component within the treatment process would be helpful to many jurisdictions.

But, more importantly, the Pretreatment Phase allows for ample opportunity to review assessments and to make treatment connections and plans. Since we know that, for the youth and families, the first phase of a juvenile drug court can be extremely overwhelming; simply working on developing a treatment plan may take some of the pressure

off and help the youth and families get familiar with new rules and increased structure in their lives.

Engagement Strategies

Because research tells us that gaining buy-in from families and increasing participation leads to better outcomes for youth, the JDC team will want to focus efforts on engaging the family, which may include connecting the family to resources in the community, asking for their assistance in treatment planning and goal setting, and creating opportunities for their “voices” to be heard.

During the Engagement Phase, treatment providers are focusing on responsiveness and building a strength-based relationship with the youth and family. The JDC team should match this focus and build components within the court’s phase structure to accomplish this. In practice, JDC teams should work to be available and responsive reaching out to families by telephone (or email, where appropriate), provide adequate transportation to treatment and court, and by making contact with as many family members as possible.

Implementation and Training

Visit the Functional Family Therapy website to research costs and training opportunities.

For more detailed information regarding research and replications associated with FFT, visit the developer’s website: Functional Family Therapy.

Multi-Dimensional Family Therapy (MDFT)

Intervention Basics

Multi-Dimensional Family Therapy (MDFT) is solution-focused and incorporates a team approach into the treatment of adolescents. MDFT focuses on four areas to provide immediate and practical outcomes: the individual adolescent, the adolescent's family members as individuals, the family unit, and how the family unit interacts with the social environment.

MDFT targets four areas of social interaction:

- The youth's interpersonal functioning with parents and peers
- The parents' parenting practices and level of adult functioning independent of their parenting role
- Parent-adolescent interactions in therapy sessions
- Communication between family members and key social systems (e.g., school, child welfare, mental health, juvenile justice).

Expectation of Sessions:

3-6 months of treatment with varying sessions of 1-2 hours in length.

Stage 1: Building a Foundation for Change (3 weeks) – Use distress to motivate/focus, create expectations, visit school/neighborhood

Stage 2: Facilitating Individual and Family Change (5 weeks) – Mobilize, make small steps toward progress, think in stages, use mistakes as opportunities

Stage 3: Solidify Changes and Launch (4 weeks) – Appraise current status honestly, except imperfect outcomes, emphasize all changes made, assess future needs and next steps.

Recommended Populations

- 13-17 (Adolescent)
- Girls & Boys
- Asian; Black or African American; Hispanic or Latino; and White
- Outpatient; Correctional; and Home
- Urban; Suburban; and Rural and/or frontier

Special Considerations for Juvenile Drug Courts

MDFT is a family therapy approach, so it is extremely important to, not only engage and retain the youth, but to engage and retain the family as a whole unit (whatever that family may look like). Family therapy differs from an individual approach with youth, in that the normal progression during treatment is for the families to get worse before they get better. In addition, families and youth will likely improve at a much slower rate. .

JDCs will need to redefine success if the court is utilizing MDFT. In the Cannabis Youth Series, the research suggested that the initial effects of MDFT did not show the same positive outcomes (at 3 and 6 months) that

MET/CBT 12 had. But, when researchers were able to go out a year or more, a correlation between participating in MDFT condition **AND** improvement in youth and family functioning. The effects were shown to have a potential residual effect for three years out post-treatment. This literally means that JDCs will have to keep the slow progress of the youth and families in mind, and develop policies and procedures that match that same progression.

Engagement Strategies

MDFT uses an ecological model and is not pushing for perfection but change that can be recognized. The court should align itself as much as possible with the treatment providers, as well as family members, in devising incentives and sanctions that make sense within the context of both treatment and the juvenile drug court. The JDC team should work towards empowering the family with workable, agreed upon incentives (i.e., lifting curfew) and sanctions (i.e., taking away electronic devices) and help families understand that they have the power of the court behind them.

Implementation and Training

Contact Gayle A. Dakof, Ph.D., (305) 243-3656, gdakof@med.miami.edu to research costs and training opportunities.

***For more detailed information regarding research and replications associated with MDFT, visit:
SAMHSA's National Registry of Evidence-Based Programs and Practices.***

Multi-Dimensional Treatment Foster Care (MTFC)

Intervention Basics

Multi-Dimensional Treatment Foster Care (MTFC) is an alternative to group home treatment or State facilities for youth who have been removed from the home due to substance use and/or involvement in the juvenile justice system.

MTFC typically comes after previous family preservation efforts have failed. Referrals come from the juvenile courts, mental health and child welfare agencies. The treatment program works to keep the youth living successfully in their communities and helps prepare their caregivers for a successful reunification.

MTFC is based on social learning theory and has four key elements, which are targeted during foster care placement and aftercare:

- Providing youth with a consistent, reinforcing environment where they are mentored and encouraged to develop academic and positive living skills
- Providing youth with daily structure that includes clear expectations, limits, and specified consequences delivered in a teaching-oriented manner
- Providing close supervision
- Helping youth to avoid deviant peer associations while providing them with the support and assistance needed to establish pro-social peer relationships.

MTFC is a cost effective alternative to traditional foster care, group or residential treatment and incarceration for problematic adolescents. MTFC can be implemented by any agency or organizations providing services to children with serious behavior problems and their families.

Expectation of Sessions:

Number of sessions varies, dependent on the intensity of the treatment. Sessions are created to closely mirror normative life. Typically lasts 6-9 months and includes interventions conducted in the foster home, continuing care works with both the family and with the adolescent individually.

Recommended Populations

- Youth ages 13-17
- Girls & Boys
- American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; and White
- Residential; Outpatient; Correctional; Home; School; Workplace; and Other community settings
- Urban; Suburban; and Rural and/or frontier

Special Considerations for Juvenile Drug Courts

Because the criteria for inclusion in this intervention are youth who have been separated from their families, with the goal of establishing permanency or family reunification, this program would only apply to a small population of youth in juvenile drug courts. These youth are often referred as cross-over youth and would be involved in both family

dependency court and the juvenile drug court. Youth who have received/are receiving MTFC are more likely to be involved with their biological family in family dependency court and the juvenile justice system; however in a situation where a youth is involved with their family in a family dependency court *and* in a juvenile drug court, there could be a number of cross-systems issues to navigate.

Engagement Strategies

Engagement of youth involved among multiple systems can be extremely difficult and great care must be taken when coordinating services. If the JDC does accept a youth involved in multiple systems, the JDC team members will have to be cognizant of the youth's time, as there will be multiple requirements (i.e., several different court appearances, as well as treatment requirements). JDC programs are generally very intensive and require a huge time commitment, so it is important NOT to set these youth and families up for failure. In addition, there will be a tendency for families, both biological and foster, to confound the efforts of the courts and agencies involved and will want to make sure the dual process is beneficial for the youth, as well as the families.

The Department of Social Services/Child Protective Services will likely be the lead agency in decision making for these youth, and memorandums of understanding or working agreements between the court and social service agencies should be in place before the youth enters the JDC program.

Implementation and Training

JDC teams should consider visiting another court that has implemented this treatment and involved in a multi-system approach, as well as undergo an intensive training component.

Contact Gerard J. Bouwman, (541) 343-2388, gerardb@mtfc.com to research costs and training opportunities.

***For more detailed information regarding research and replications associated with MTFC, visit:
SAMHSA's National Registry of Evidence-Based Programs and Practices.***

Global Appraisal of Individual Needs (GAIN)

Instrument Basics

The Global Appraisal of Individual Needs (GAIN) family of instruments uses a progressive approach to support treatment practices from initial screenings to standardized clinical assessments used for diagnosis, placement, and treatment planning. The GAIN can be implemented in a variety of settings; outpatient, intensive outpatient, partial hospitalization, methadone, short-term residential, long-term residential, therapeutic community and correctional programs.

The GAIN Initial instrument uses eight core sections to assess the youth:

- Background
- Substance Use
- Physical Health
- Risk Behaviors & Disease Prevention
- Mental & Emotional Health
- Environmental & Living Situation
- Legal
- Vocational

Logistics

- Ages 12 & up
- Instrument Details:
 - **GAIN-Short Screener** (GAIN-SS): Screener used with the general population to quickly identify those in need of further assessment (2 pages; 5 minutes; available in Spanish)
 - **GAIN-Quick** (GAIN-Q): Brief-assessment to identify a wide range of problems among those in clinical and general populations (19-34 pages; 20-45 minutes)
 - **GAIN-Initial** (GAIN-I): Comprehensive bio-psychosocial assessment used for substance abuse diagnosis, placement, treatment planning, outcome monitoring, economic analysis, and/or program planning (56-113 pages; 60-150 minutes; available in Spanish)

Visit The GAIN Coordinating Center on Chestnut Health Systems' website to find out more about the tool, costs, and to learn about training opportunities.

Massachusetts Youth Screening Instrument (MAYSI)/ (MAYSI-2)

Instrument Basics

The Massachusetts Youth Screening Instrument (MAYSI)/ (MAYSI-2) is a brief screening instrument (52 questions) designed to identify potential mental health needs of adolescents involved in the juvenile justice system.

The instrument uses seven scales to assess the youth:

- Alcohol & Drug Use
- Angry – Irritable
- Depressed – Anxious
- Somatic Complaints
- Suicide Ideation
- Thought Disturbance (Boys Only)
- Traumatic Experiences

Logistics

- 12 - 17 years of age
- Administered in 10 - 15 minutes (Self-Report; youth answer YES/NO to questions)
- Available in English and Spanish
- Used in the Following Programs/Centers:
 - juvenile diversion programs
 - juvenile pretrial detention centers
 - juvenile probation offices
 - juvenile correctional and aftercare program

Visit *The National Youth Screening and Assessment Project's* website to find out more about the tool, costs, and to learn about training opportunities.

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