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Residential Substance Abuse Treatment for Juveniles

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Residential Substance Abuse Treatment for Juveniles

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Introduction

Despite its title, the Residential Substance Abuse Treatment (RSAT) for State Prisoners Program (42 U.S.C. § 3796ff et. seq.) also allows states and U.S. territories to fund residential substance abuse treatment programs for juvenile justice-involved youth. Like programs for adults, the RSAT programs for juveniles must be, to the extent possible, evidence-based, addressing substance use disorders as well as mental health disorders, including the effects of trauma. These requirements are particularly important for programs serving adolescents: adolescents with substance use disorders (SUDs) frequently have co-occurring mental health disorders, traumatic histories, and other risk factors that present unique challenges for the juvenile justice system.¹ Additionally, as with funding for prison and jail RSAT programs for adults, RSAT funding may be used to create and sustain continuing care in the community after release from juvenile correctional facilities.

Several years ago, the Bureau of Justice Assistance (BJA) released *Promising Practices Guidelines for Residential Substance Abuse Treatment (RSAT)*, representing promulgation of the first national standards for RSAT programs. However, these guidelines specifically concerned jail and prison RSAT programs for adult offenders. The following manual specifically focuses on RSAT programs for juvenile justice-involved youth. Although there is substantial overlap between the treatment of adult and juvenile justice-involved youth with SUDs, there are also, of course, significant differences.

Addressing SUDs in juvenile corrections is essential. Not only do half of juveniles involved in the justice system have problems with drugs and alcohol (compared to only 10 percent of juveniles in general),² but research confirms that effective intervention during adolescence has the potential to offset or mitigate the long-term course of SUDs. Studies indicate early intervention for substance use is the most effective SUD prevention strategy.³ Creating developmentally appropriate juvenile RSAT programming is necessary; this population differs from their adult counterparts in multiple ways, particularly in physical and neurological development.⁴ Minors lack the neurological maturation necessary for sound decision-making and impulse control.⁵ As the Office of Juvenile Justice and Delinquency Prevention (OJJDP) recognizes, juveniles have differences in “concrete versus abstract reasoning, expansion of pain and pleasure centers in the brain prior to the maturation of the reasoning centers, and smaller body size leading to lower tolerance,” making them “more susceptible to peer influences, victimization, and the adverse effects of substance use.”⁶ Furthermore, research suggests juvenile delinquency is significantly associated with impaired social cognitive functioning caused by early trauma, which may lead to substance use as a mode of self-medication or self-harm.⁷ These important neurological differences potentially limit the efficacy of adult-oriented SUD treatment models.

I. Major Issues That Must Be Recognized and Addressed in Treating Juvenile Justice-Involved Youth with SUDs

Trauma

Not only are rates of SUD much higher among juvenile justice-involved youth than in community samples of juveniles, but juvenile justice-involved youth with SUDs are also significantly more likely than those in the community samples to have experienced trauma.⁸ As reported in one study, over 40 percent of detained youth reported using substances as a coping mechanism for managing their trauma symptoms.⁹ Another study found detained youth had been exposed to 33 percent more traumatic incidences in childhood than had non-incarcerated juveniles. The increased rate of childhood trauma incidences means there is also a significantly higher prevalence of comorbidities, particularly SUD and mental health issues.¹⁰

If left untreated, youth involved in the juvenile justice system with co-occurring SUDs and trauma-related mental health disorders are significantly more likely to continue engaging in delinquent behavior.¹¹ Furthermore, failure to treat their trauma may lead to continued or increased self-destructive behavior, including substance use, as a form of self-punishment because their core belief about themselves is they are “worthless” and do not “deserve” to be well.¹² This revictimization in the context of intoxication can then intensify baseline traumatic symptoms, which in turn worsens SUD and deepens traumatogenic cognitions about the self as “damaged.”¹³ For all of these reasons, trauma-informed approaches in RSAT programs are an essential ingredient for addressing the needs of juvenile participants.

Family Trauma and Substance Use

Unlike the trauma experienced by veterans of war or women in abusive relationships who often populate jail and prison RSAT programs, the trauma experienced by juveniles is often associated with parental substance use. Research suggests that many youth involved in the juvenile justice system experience family-based based trauma, including neglect and physical, sexual, and emotional abuse from parents with SUDs.¹⁴ Moreover, parental substance use itself is considered an “adverse childhood experience indicator,” suggesting youth who have a parent with SUD may be using alcohol and/or drugs to cope with this trauma.¹⁵ One study found, for example, youth with at least one parent who used substances were over three times more likely to test positive for drugs.¹⁶ Similarly, if parents’ drug abuse or other behavior causes a child to be placed in child protective services custody or foster care, this too significantly increases the child’s risk for SUD.¹⁷

These familial considerations, including parental substance use, family-based trauma, and related or other mental health needs, can negatively affect participants' programmatic success. Programs must incorporate appropriate family therapy models for juvenile offenders' SUD treatment to be successful and their recovery sustained.¹⁸

Gender Responsiveness

SUD interventions and treatment for juvenile justice-involved youth have largely been designed with boys in mind, as most juveniles arrested are male.¹⁹ As a result, much of the research on youth involved in the juvenile justice system with SUDs primarily addresses males and may ignore important considerations of gender differences in effective treatment. For that reason, gender-responsive RSAT programming is important when designing treatment for SUD, as is consideration for comorbidities such as trauma and mental health.

For girls, substance use is often a coping mechanism for managing trauma symptoms from gender-based violence such as sexual abuse by family members and other trusted individuals.²⁰ While it is important to consider for all genders, paying particular attention to this issue is necessary for girls, as they experience significantly higher rates of gender-based violence (including sexual abuse) than boys.²¹ Girls are also more likely to internalize trauma responses and engage in self-harm, including substance use, while boys are more likely to engage in criminal activities with delinquent peers and externalize disruptive behaviors.²² This explains why it has been found, for example, that while 64.7 percent of girls involved in the juvenile justice system were “addicted to some drug, the percent for boys was lower at 40 percent.”²³ It also supports the need for RSAT programs for girls to specifically address the trauma and betrayal resulting from sexual abuse by parents, caregivers, and other trusted individuals.

Cultural Competencies

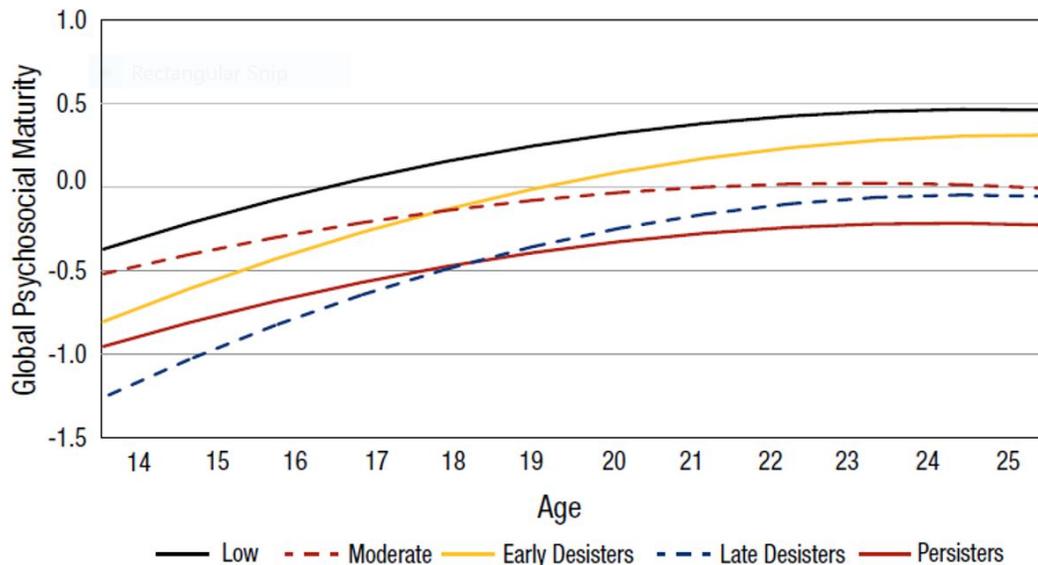
Within the context of a trauma-informed juvenile justice approach, youth of color face intersectional biases based on their race, class, and gender identities, which may result in increased trauma. For example, research indicates adults are significantly more likely to view Black girls—particularly those age 5–14—as more adult-like and less innocent than White girls.²⁴ This “adultification” eliminates “childhood innocence” as a mediating factor for adults judging Black girls' behavior. This bias toward Black girls may result in harsher sentencing and use of force within a juvenile justice context.²⁵ Similarly, Black boys face an increased risk for trauma when adhering to “the code of the street” of poor neighborhoods.²⁶ This “code” refers to young Black men's unwavering commitment to stand together with friends to assert their individual self-respect and collective sense of agency in a location where they otherwise feel vulnerable to constant threat and surveillance by law enforcement.²⁷ As a result, Black boys face an increased risk for SUD as a way to cope with ongoing traumatic stress.²⁸

Neurodevelopment

Juvenile neurodevelopment is also an important consideration for RSAT programs because increases in psychosocial maturity may explain the overall decrease in antisocial behavior, including substance use, among serious juvenile offenders as they age into adulthood.²⁹ Neuroscientific research indicates that psychosocial maturation increases as individuals age into their mid-twenties, characterized by temperance (ability to control impulses), perspective (considering others' points of view and long-term consequences), and personal responsibility (including the ability to resist others' influences).

A Pathways to Desistance Study tracked 1,354 serious juvenile offenders in two major metropolitan areas, interviewing them into adulthood.³⁰ It identified five patterns of offending: a low number of offenses remaining steady throughout adolescence and early adulthood, a moderate number of offenses remaining steady, early desistance from offending in mid-adolescence, late desistance between ages 17 and 20, and persistence into adulthood. Individuals in all five groups experienced psychosocial maturation between ages 14 and 25, but the increases were less pronounced among the “moderate” and “persister” groups. The “low” group exhibited the highest psychosocial maturity levels at all ages, but the “early desister” group reached very similar levels as they approached age 25. Similarly, the “late desister” group had much lower maturity levels than the “moderate” group at age 14 but nearly identical levels at age 25. Neurodevelopment has direct implications in both who should be admitted to RSAT programs for juveniles and how their progress should be understood.

Figure 1. Trajectories of Antisocial Behavior and Global Psychosocial Maturity



Source: Steinberg, Cauffman, & Monahan, 2015, p. 8.

II. Intake: Screening and Assessment

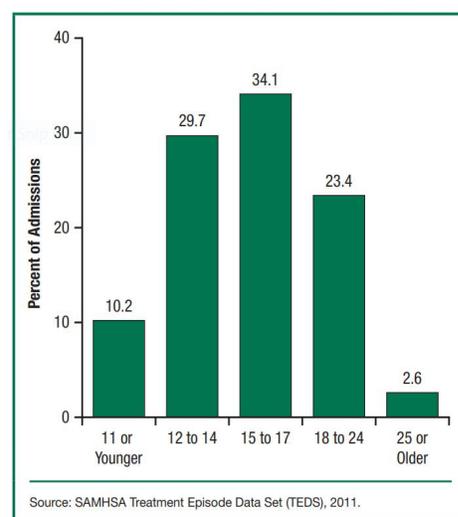
Juvenile RSAT programs should be reserved for high-risk, high-need youth who cannot be better served or accommodated in nonresidential programs. Age of initial substance use is a key indicator of individuals with high need for SUD treatment (see figure 2).³¹ For example, data from the 2012 National Survey on Drug Use and Health indicate adults who were 14 or younger when they initially tried marijuana were six times more likely to be classified with SUD than adults who first used marijuana at the age of 18 or older.³²

Admitting low-risk, low-need juveniles may result in negative outcomes. Research confirms that detention and confinement are not only costly and disruptive to education and employment opportunities, but they may also lead to increased depression and suicide attempts. Further, with proper risk assessment, alternatives to detention and confinement may be more effective at reducing recidivism and pose no increased risk to society.³³

Screening

The primary criteria for entry into a juvenile RSAT program should be (1) a diagnosed moderate- to severe-based SUD and (2) an evidence-based assessment that indicates medium to high likelihood for reoffending. Juvenile justice facilities should have protocols in place to screen for and assess SUDs and criminogenic risks.ⁱ Multiple validated screening and assessment instruments are available for use.

Figure 2. Age of Substance Use Initiation among Treatment Admissions Aged 18 to 30



ⁱ See the Substance Abuse and Mental Health Services Administration's (SAMHSA) report reviewing different screening and assessment instruments for co-occurring disorders, *Screening and Assessment of Co-Occurring Disorders in the Justice System* (2019), at <https://store.samhsa.gov/product/Screening-and-Assessment-of-Co-Occurring-Disorders-in-the-Justice-System/PEP19-SCREEN-CODJS>.

RSAT programs should also assess youth for additional criminogenic risks and needs. Reductions in recidivism are greater when programming addresses the criminogenic needs of system-involved youth.³⁴ These criminogenic needs and risk factors include:

- Mental health needs.
- History of abuse or other traumatic experiences.
- Educational history.
- Well-being needs and strengths.
- Housing stability.
- Leisure time and recreational activities.
- Parental/family SUD, parental mental health, and parenting skills.
- Peers with SUD and peers with mental health needs.

Given the neurodevelopment of juveniles, motivation should not be a factor for admission to RSAT programs. SUD treatment does not need to be voluntary to be effective. Research confirms that evidence-based intervention programs can provide the needed motivation for change for juveniles with SUD—even if the juveniles themselves are not initially interested in change.³⁵ Treatment includes motivating juveniles to change their behavior as well as providing them with the tools to accomplish the behavior change.

Assessment

Once admitted to an RSAT program, juveniles should be assessed for SUDs, criminogenic risk and need, and responsivity factors such as trauma, mental health, physical health, and literacy. As the National Institute on Drug Abuse's (NIDA) *Principles of Drug Abuse Treatment for Criminal Justice Populations* declares, assessment is the first step in treatment.³⁶

Assessments help identify SUD severity, readiness to change, recovery stage, and intensity of required supervision. These factors, along with gender, ethnicity, and culture, should be considered in assigning treatment approaches and treatment providers.

Although the limited duration of RSAT programs in juvenile detention facilities may restrict their ability to provide intensive individualized treatment, completing individualized assessments allow programs to at least define subgroups of youth with similar needs so that programming can better meet their specific needs.

The contents of the comprehensive assessment should be included in the program's policies and procedures. The American Society of Addiction Medicine (ASAM) outlines the following components of a comprehensive assessment; most are relevant for juveniles as well as adults.³⁷

- Physical exam.
- Mental status exam.
- Medical and psychiatric history.
- Detailed past and present substance use history, including assessment of withdrawal potential.
- History of the pathological pursuit of reward or relief through addictive behaviors such as gambling or exercise.
- SUD and addictive disorder treatment history and response to previous treatment.
- Family medical, psychiatric, substance use, addictive behavior, and addiction treatment history.
- Allergies.
- Current medications.
- Social history.
- Consultation with family, schools, or other appropriate collateral sources of information.
- Readiness to engage in treatment.
- Potential to continue or return to substance use or addictive behaviors.
- The recovery environment that can support or impede recovery.
- Diagnostic formulation(s).
- Facilitators and barriers to treatment engagement, including motivational level.

For juveniles, we would add assessment of literacy and education as well as emphasis on assessment of trauma, including familial and sexual trauma, violence in the community, death of parents and relatives, child protective service involvement, and the like.

While motivation is not a screening consideration, once admitted to RSAT, staff should assess the juvenile participant's readiness to change and adapt programming to match his or her stage of readiness.

III. RSAT Program Structure

Program Length and Phases

The RSAT statute requires that programs last at least 6 months. However, this may include residential continuing care in the community and other reintegration programming. Juvenile RSAT programs should be structured in different phases, allowing participants to advance based on their progress, not preset time limits. In this manner, as participants advance, they can move to less restrictive environments to minimize the negative effects of long-term removal from the community. Juvenile RSAT programming that begins in the detention facility should be considered the first part of ongoing treatment that will continue after release.

Similar to the design recommended by OJJDP in its *Juvenile Drug Treatment Court Guidelines*, juvenile RSAT programming should be designed for participants to engage with services in phases. The first phase should include orientation to the juvenile RSAT pod and program rules. Next, participants' mental health symptoms, substance-related cravings, withdrawal, anhedonia, readiness to change, and motivation should be addressed. The program should then address resolution of criminogenic needs, including criminal thinking. In the final phase before release, the RSAT program should provide services and supports to maintain treatment gains by enhancing participants' long-term adaptive functioning.

Cultural Responsiveness

The development of culturally responsive clinical skills is vital to the effectiveness of behavioral health services. According to the U.S. Department of Health and Human Services, cultural competence “refers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time.” Culturally responsive skills can improve client engagement in services, therapeutic relationships between clients and providers, and treatment retention and outcomes.³⁸

The ability to interpret a juvenile's “presenting problem” is greatly enhanced by knowledge of a culture's attitudes toward mental illness, substance use, healing, and help-seeking patterns, practices, and beliefs. Such knowledge is also essential for developing culturally competent counseling skills and formulating culturally relevant agency policies and procedures. RSAT staff should learn and understand how identification with one or more cultural groups influences each person's worldview, beliefs, and traditions surrounding initiation of substance use, healing, and treatment.³⁹

FEDERAL PROTOCOLS

The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes cultural competence as an important element to effective SUD and mental health treatment for clients, clinicians, service providers, and communities. For this reason, it developed the “Improving Cultural Competence” Treatment Improvement Protocol (TIP),⁴⁰ which outlines culturally responsive guidelines for staff, programs, and organizations. The TIP also includes a checklist to evaluate cultural competence in treatment programs and organizations, some of which is applicable to RSAT programs. The TIP includes acculturation and ethnic identity measures central to cultural competence tenets and examines how many drug subcultures exist within and across diverse ethnic and racial populations.

Daily Programming

Although RSAT participants are segregated from the general population, negative influences of other RSAT participants, especially those just entering the program who may have not yet committed to behavior change, can be further reduced if participants are involved in positive programming most of the day. Because security staff may spend more time with participants than treatment staff do, it is imperative that they also reinforce behavioral standards and activities promoted by RSAT staff. Cross-training security and RSAT staff encourages consistent positive reinforcement for treatment. Positive engagement is a key feature of the modified therapeutic communities (TCs) employed by many juvenile RSAT programs. Activity logs for tracking participants’ structured activities or tablet devices that can be monitored to measure time spent on educational or treatment programming are two options. Tablets, for example, are used in many RSAT programs to help juvenile participants obtain high school equivalency diplomas or keep up with classmates on the outside. They can be used to keep juveniles busy and productive even when confined to their rooms.

STATE DEPARTMENT OF JUVENILE AFFAIRS PROTOCOL

The Oklahoma Office of Juvenile Affairs RSAT program emphasizes academics and GED preparation. Since this increased focus began, academic achievement levels increased an average of 2 semesters, and literacy scores rose 1.8 grade levels.⁴¹

Prosocial Behavior Promotion

Reinforcing positive behavior is an important component of correctional supervision of juveniles participating in SUD treatment. Non-monetary “social reinforcers,” such as recognition for progress or sincere effort, can be effective, as can graduated sanctions that are consistent, predictable, and clear responses to noncompliant behavior. Generally, less-punitive responses

should be used for early and less-serious noncompliance, increasing in severity for continued problem behavior. Rewards and sanctions are most likely to have the desired effect when they are perceived as fair and when they swiftly follow the targeted behavior. Consequences for participants' behavior should be administered in accordance with evidence-based principles of effective, age-appropriate behavior modification. Moreover, any confrontation should focus on negative behavior and attitudes, and not on the individual.

The concept of recovery capital is worthy of emphasis here. Recovery capital encompasses the interrelated domains of social support, spirituality, religiousness, life meaning, and 12-step affiliation. Higher levels of recovery capital are associated with improved coping and enhanced life satisfaction. They predict higher quality of life, sustained recovery, and lower stress at 1-year follow-up among adults.⁴² Although much substance use research emphasizes substance use outcomes, in fact other aspects of functioning are equally critical and create the building blocks of long-term recovery. Juvenile justice professionals can use recovery capital as a framework to identify supports most relevant to an individual participant and begin to enhance these during their RSAT experience.

RELATED RESEARCH

Emerging research has demonstrated the effectiveness of treatment approaches using contingency management (CM) principles with juveniles. CM involves giving patients tangible rewards to reinforce positive behaviors such as abstinence. One study using monetary rewards* found juveniles abstained from marijuana use for 7.6 continuous weeks during treatment utilizing CM principles versus 5.1 continuous weeks for the non-CM control group.⁴³ Outcomes observed in this study were consistent with adult substance dependence treatment literature, suggesting that CM abstinence-based approaches are an effective treatment model for adolescent SUD.

*Monetary incentives were distributed as vouchers that juveniles could redeem for specific retail goods.

If the juveniles have access to tablets, rewards can include more time during which they may access movies, games, or other approved entertainment programming. On the other hand, sanctions may involve removing access time for entertainment or games on the tablets. At one RSAT program, the juveniles are rewarded for every hour they use the tablets for schooling, and they get a proportionate number of tablet hours for entertainment.

IV. Treatment Modalities and Curriculum

Almost all evidence-based substance use treatments have their origins in the community, rather than correctional settings. For evidence-based interventions to be successful, implementation science suggests, they must be delivered in a way that mirrors the original design or maintains fidelity to the intervention in complex settings.⁴⁴ The research also shows that failing to implement an intervention with fidelity to the original model can undermine the effectiveness of the intervention and may even produce harmful effects.⁴⁵

As noted in the CrimeSolutions.gov registry of evidence-based correctional programs, however, innovation requires experimentation, trying new approaches, and building on evidence-based programming to meet the evolving needs of RSAT participants and keep pace with the evolving implications of research. Thus, in the absence of specific evidence-based SUD treatment programs for juvenile corrections settings, RSAT programs should implement treatment interventions with an evidence base for youth involved in the juvenile justice system in the community. RSAT staff must then determine that all of the following conditions are met:

- The intervention is transferable to an institutional correctional setting.
- The intervention serves a similar target population (including age, gender, ethnicity and race, special needs, culture, etc.).
- The intervention can be implemented with reasonable fidelity.
- Adequate resources and capacity are available.
- Staff have needed qualifications.

Implementation of the evidence-based intervention should be aligned with existing processes and procedures within the juvenile facility, while maintaining fidelity to the original intervention as much as possible. RSAT program administrators should ensure the chosen interventions are delivered with fidelity at each stage of the implementation process: exploration and adaptation, installation, initial implementation, full implementation, and beyond.⁴⁶

Implementation has six core drivers: (1) staff selection, (2) pre-service and in-service training, (3) ongoing consultation and coaching, (4) staff and program evaluation, (5) facilitative administrative support, and (6) systems interventions.⁴⁷ RSAT programs can establish multiple checkpoints to ensure staff receive necessary training and coaching.

In general, alcohol and substance use treatment for juveniles should address motivation, problem solving, and skill building for resisting alcohol, substance use, and delinquent behavior. Lessons focused on prosocial activities and understanding the consequences of one's thoughts and actions are important. Tailored treatment interventions can facilitate healthy development and promote interpersonal relationships with family, peers, and others in the community.

Criminal Thinking

Treatment providing specific cognitive skills training to help participants recognize patterns of “criminal thinking” that can lead to behaviors linked to crime—as well as to alcohol and substance use—may improve RSAT program outcomes. The concept of criminal thinking is generally understood as a combination of attitudes and beliefs that support a lifestyle and behaviors linked to crime, including externalizing responsibility, disregarding the feelings and needs of others, feeling entitled to have things one's own way, feeling that one's criminal behavior is justified, failing to accept responsibility for one's actions, and consistently failing to anticipate or appreciate the consequences of one's behavior. Cognitive skill training should be adapted to the level of maturity of participants. Theories on moral development, for example, explain that individual's moral consciousness may begin with the basic understanding that bad behavior is wrong because it results in specific negative consequences and pain for the individual actor. As the individual matures, that understanding may expand to include the fact that bad behavior has negative consequences for immediate family members, not only the individual actor. Further developed, it may reach the level of recognition that bad behavior is wrong because it is bad for society, even if there are no harmful consequences for the individual actor.

Trauma-informed and Specific Treatment

All juvenile RSAT programming should be trauma informed, with appreciation that juvenile detention facilities present challenges for providing trauma-informed approaches. For example, juvenile justice settings may present scores of unavoidable triggers for juveniles with posttraumatic stress disorder (PTSD): shackles, overcrowded housing units, lights that are on all night, loudspeakers that blare without warning, and severely limited privacy. Pat downs and strip searches, frequent discipline from authority figures, and restricted movement may all mimic certain dynamics of past abuse. All these factors are likely to aggravate trauma-related reactions and symptoms that can be difficult for detained youth to manage.⁴⁸ Further, youth with PTSD often use alcohol and drugs to cope with trauma responses and triggers, and trauma-related symptoms may worsen with the removal of these previous coping strategies.

This may result in behavior that is perceived as violent or overly aggressive.⁴⁹ Being perceived as “out of control” is particularly problematic for girls of color because acting outside of racialized, feminine ideals of “innocence,” such as obedience, increases the risk of being labeled “deviant.”⁵⁰ It is critical for residential staff to bear in mind that trauma can manifest differently across youths and that there is no one “right way” for a traumatized young person to

act. A key tenet of trauma-informed care involves consideration for how challenging behaviors likely reflect an adaptation to trauma. This can be difficult in a busy residential milieu. It can sometimes be easier to maintain a trauma-informed lens when a young person's behavior is fearful or withdrawn, as opposed to aggressive or belligerent, but the possibility of traumatic stress should be considered in both scenarios.

Juvenile RSAT programs can make SUD treatment more accessible to juveniles who have experienced trauma by providing trauma stabilization and PTSD coping skills training. Trauma-informed juvenile RSAT programs and cognitive behavioral trauma-specific SUD interventions can support juveniles while they master recovery skills. Trauma-informed RSAT programs should include trauma-trained staff who understand the impact of trauma on SUD and the recovery process; services designed to enhance safety, minimize trauma triggers, and reduce re-traumatization in juvenile detention settings; and encouragement of relationships between staff and youth based on mutuality and healing. Trauma-informed staff can provide psychoeducation about the impact of trauma on substance use, emotion regulation, and relationships. This psychoeducation provides an alternative way for youth to understand their reactivity, interpersonal challenges, and the persistence of SUD in the context of managing their ongoing trauma symptoms.

Although there cannot be equity in relationships between staff and juveniles, RSAT participant councils can be formed as a trauma-informed approach to give participants some input into how the RSAT programs or pods operate—and in such a way that does not compromise the security and safety of the detention facility. Trauma-informed services might include specific groups and interventions aimed at coping with the aftermath of trauma, decreasing symptoms of trauma-related disorders, and trauma awareness training. Individuals should be empowered with skills and techniques to manage and lessen the effects of trauma in their ongoing recovery. Upon program completion, staff and the council can provide juveniles with information on trauma-informed SUD recovery supports, hope, and appropriate referrals upon release.

Trauma-informed SUD treatment should include strategies to address root causes of trauma (e.g., parental neglect, physical/sexual abuse) and help participants develop healthy coping strategies such as self-care and prosocial behaviors. Further, these approaches should consider gendered patterns of trauma responses, as males are more likely to externalize trauma responses through criminal or disruptive behavior and girls are more likely to internalize responses by engaging in self-harm.

RELATED RESEARCH

Results from one study of 247 youths involved in the juvenile justice system who had been sexually abused found reducing PTSD symptoms prevented or reduced substance use in this high-risk population.⁵¹ Findings suggest a positive direct effect (0.66) between PTSD symptoms and substance use in youth involved in the juvenile justice system, however, no significant relationship between sexual abuse and substance use was found in this population. Using drugs and/or alcohol as “self-medication” is one likely explanation for the relationship between sexual abuse and substance use through PTSD symptomatology.⁵²

All programming for juvenile RSAT programs should be trauma informed. For those participants who have experienced severe or prolonged trauma that has resulted in PTSD and related symptoms, programs should provide trauma-specific treatment. There are programs designed specifically to address trauma. The National Child Traumatic Stress Network Center for Trauma Recovery and Juvenile Justice and the Network Juvenile Justice Working Group developed *Evidence-Informed Interventions for Posttraumatic Stress Problems with Youth Involved in the Juvenile Justice System*, which provides descriptions of several interventions for traumatized adolescents.⁵³

The National Center for Mental Health and Juvenile Justice (2013) provides the following examples of trauma treatments for juveniles:

- Cognitive behavioral therapy (CBT) for PTSD.
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET).
- Trauma Recovery and Empowerment Model (TREM).
- Seeking Safety.

Specific Treatment Modalities

There are a wide variety of evidence-based treatment program options suitable for both group and individual programming to support and sustain recovery. Individual CBT and group TCs modified for short-term residential use have been found to be effective treatment methods for RSAT programs for adults. The National Institute on Drug Abuse (NIDA) has identified the following behavioral therapies as “helpful” for the purposes of SUD treatment engagement, abstinence incentives, attitude and behavior modification related to substance use, and increased life skills to manage relapse triggers such as environmental cues and stressful circumstances:

- CBT.
- TCs.

- CM interventions/motivational incentives.
- Community reinforcement approach (CRA), plus vouchers.
- Motivational Enhancement Therapy (MET).
- The Matrix Model.
- Twelve-step facilitation therapy.
- Family behavior therapy (FBT).⁵⁴
- Behavioral therapies, including multisystemic therapy (MST).⁵⁵

See Appendix A for detailed descriptions of these programs, as well as additional evidence-based treatment verified by SAMHSA.

NIDA also lists the use of pharmacotherapies deemed helpful in addition to behavioral-based therapies. Methadone, buprenorphine, and naltrexone are included for opioid addiction, and naltrexone, acamprostate, disulfiram, and topiramate are included for alcohol dependence.

Lastly, evidence-based treatment interventions implemented according to instruction manuals are also effective, as they offer structure and consistency. Manual-based interventions are also an accessible option that can help focus treatment sessions. However, they can be overly routinized and, therefore, rely on counselors to incorporate personal style and creativity while leading sessions.⁵⁶ Research suggests the quality of the interpersonal relationships between staff and the participants, in addition to staff skills in relaying treatment information, are just as important to risk reduction as the specific programs in which offenders participate.⁵⁷

Cognitive Behavioral Intervention

The use of cognitive behavioral intervention (CBI) in juvenile corrections helps to directly address risk factors associated with future offending. For example, distorted cognition is a characteristic of many juveniles involved in the justice system. Distorted cognition may include self-justificatory thinking, misinterpretation of social cues, feelings of dominance and entitlement, and a lack of moral reasoning. The basis for using CBI for juveniles involved in the justice system is that an individual's cognitive deficits and delinquent thinking patterns are learned, and not inherited, behavior.

CBI typically uses a set of structured techniques to build cognitive skills in areas where juveniles show deficits. CBI can also help restructure cognition in areas where patients show biased or distorted thinking. Some are designed so that a well-trained non-clinician could provide the

intervention to clients. Examples of such programs include Thinking for a Change and Reasoning and Rehabilitation.ⁱⁱ

CBT is a problem-focused set of therapeutic approaches provided by a clinical professional. It helps people identify and change dysfunctional beliefs, thoughts, and patterns of behavior that contribute to their problem behaviors, delinquent and otherwise. CBT programs emphasize individual accountability and help juveniles to understand their thinking processes and the choices they make.⁵⁸ Examples of CBT include rational emotive behavior therapy, cognitive therapy, and dialectical behavioral therapy.

To help reinforce this approach, treatment and correctional staff should teach participants to become aware of their thinking, verbalize their thoughts, stop reacting to automatic thoughts, and understand how their thoughts and beliefs can trigger delinquent and addictive behaviors. Staff should provide skills training and opportunities for modeling and behavior rehearsal. All RSAT staff should understand the program's basic CBT approach and key terms. CBT sessions should be monitored periodically to ensure that proper techniques are employed, principles or skills are being reinforced outside of CBT sessions, and other treatment tools and program rules are consistent.

Therapeutic Communities (TCs)

Juvenile justice-based TCs have been found to be an effective approach for SUD treatment.⁵⁹ TCs use a group-centered, comprehensive drug treatment program model for treating individuals by fostering changes in attitudes, perceptions, and behaviors related to substance use. Emphasis on community—which includes peers and facility staff—and recovery is the defining feature of TCs,⁶⁰ and integrating healthy individual routines and attitudes within a group setting is the program's primary goal.⁶¹

The TC theory proposes that recovery involves rehabilitation to learn healthy behaviors and “habilitation” to routinize healthy behaviors within a permissive but safe environment that supports a social learning approach.⁶² TCs use a stepping-stone model, in which participants' level of responsibility increases as they progress through each treatment level. Juvenile TC treatment also includes reentry services and aftercare to provide ongoing support and relapse prevention after leaving the TC.⁶³

ⁱⁱ SAMHSA's Evidence-Based Practices Resource Center lists more than 20 CBT-based programs. See <https://www.samhsa.gov/ebp-resource-center>. The CrimeSolutions.gov registry also lists 13 “effective” and 34 “promising” CBT-based programs for juvenile offenders.

The Treatment Communities of America, a membership organization of more than 600 SUD and mental health treatment centers, recommends the following for TCs to be most effective:

1. It is most desirable to have at least some staff or people involved in the program in some capacity who can serve as role models for long-term recovery, even as outside guest speakers, especially peers.
2. There must be a prevailing culture of positive peer pressure within the TC that counteracts the “inmate code” of social rules and values adhered to among the general population of detained juveniles to emphasize their unity against correctional staff.
3. There must be a strong sense of community, with shared language, rituals, and rites of passage, that prevents a “we-they” dichotomy.
4. There must be a shared locus of control, with residents involved in running the program but staff maintaining ultimate control and applying it with rational authority and acting as prosocial role models.
5. Cooperation and continuous communication with security and administration personnel (e.g., warden) are essential to the autonomous functioning of the TC.
6. There must be a prosocial code of morality—“right living”—that promotes empathic relations between staff and clients along with open communication, honesty, trust, positive work ethic, community responsibility, etc.
7. Members should be organized by job functions in a hierarchical structure with corresponding rewards.
8. The community must adhere to strict behavioral expectations with certain consequences and sanctions applied in a mutual effort by other members and staff.
9. To ensure there is no corruption or programmatic drifting, it is essential to have regular TC-specific monitoring and training from outside the community.⁶⁴

Motivational Interviewing

Motivational Interviewing (MI), which has been rated by CrimeSolutions.gov as “effective,” is a brief, client-centered, semi-directive psychological treatment approach that concentrates on improving and strengthening an individual’s motivation to change.⁶⁵ It incorporates four basic principles into treatment: (1) expressing empathy, (2) developing discretion (3) rolling with resistance, and (4) developing self-efficacy. When provided to individuals with SUDs, the long-term goal is to help them reduce their use of or stop using drugs and alcohol. The practice can target individuals who are less motivated or ready to change, and who may show more anger, opposition, or ambivalence. The intervention itself is brief; typically, an individual will meet with a counselor one to four times, for about an hour each session. Delivery settings may include detention and confinement facilities, aftercare/outpatient clinics, inpatient facilities, group homes, intensive supervision programs, and other community-based settings.

Medication-assisted Treatment

Medication-assisted treatment (MAT) for opioid use disorder (OUD) is the use of medications primarily for the treatment of addiction to alcohol and opioids such as prescription pain relievers, fentanyl, and heroin.⁶⁶ Although the American Academy of Pediatrics endorsed the use of MAT for youth with SUD in 2016,⁶⁷ it is not yet widely available in the general population of adolescents with OUD. It is important to note that although the incidence rate of OUD has more than quintupled in recent years,⁶⁸ research on MAT for juveniles is in its infancy. For adults, MAT is considered an effective component of standard treatment with OUD.⁶⁹ MAT among adults improves opioid abstinence and treatment retention and significantly reduces mortality risk.⁷⁰ We know less about its efficacy for juveniles.⁷¹ There are also specific risks. While buprenorphine or buprenorphine with naloxone, for example, do not produce the euphoric effect of opioids in those suffering OUD, it does produce such an effect for opioid naïve users and can promote craving for continued use. For this reason, it is essential that juveniles be carefully screened before inducing them onto such opioid medications. Buprenorphine and buprenorphine with naloxone can only be prescribed by physicians who undergo additional training and obtain a waiver through the federal Drug Enforcement Administration (DEA; see Appendix B for pharmacotherapies). Methadone cannot be prescribed for OUD treatment. It must be accessed through participation in a certified Opioid Treatment Program (OTP). This generally requires an RSAT program to partner with a community-based OTP that agrees to come into the facility to provide the medication each day. Naltrexone, an antagonist opioid medication that blocks the opioid receptors in the brain, is not an opioid and can be prescribed by any physician.

If juveniles entering an RSAT program are already prescribed opioid medication, it should be continued unless a physician and the individual determine it is appropriate to taper the person off the medication. When leaving the program, referrals should be made to physicians and programs so that opioid medications can continue to be accessed as prescribed without interruptions. Methadone and buprenorphine or oral naltrexone must be taken every day or so. There are, however, injectable buprenorphine and naltrexone medications that last for up to a month.

Psychiatric medication can also be instrumental in enabling juveniles with co-occurring mental health disorders to function successfully both in juvenile justice settings and in the community. If potential RSAT participants are prescribed antipsychotic medication, they need to continue receiving the medication pending medical and psychiatric assessments. Research suggests continuing the use of antipsychotic medication has the potential to reduce recidivism after release and mitigate the severity of symptoms of the mental disorder, the overuse of solitary confinement as a form of punishment when correctional staff perceive actions related to mental health disorders as defiant or disrespectful, and the incidence of suicide within criminal justice detention.⁷² Programs should also collaborate with families and/or guardians to help juvenile RSAT graduates obtain access to appropriate medication(s) upon release if they and their physicians and treatment providers deem it appropriate.

Please note: Methadone can only be used in specially licensed programs and must follow current U.S. Food and Drug Administration (FDA) and SAMHSA parental parameters, as well as drug-specific age restrictions. Child development and adolescent neurobiology warrants unique approaches to utilizing pharmacotherapy for juveniles with SUD.⁷³ For that reason, RSAT programs should check current FDA guidelines and drug-specific age approvals for up-to-date MAT regulations. As previously noted, research on MAT for juveniles is very limited at this time.⁷⁴ Consistent with principles of this manual, we advise an evidence-based approach that stays abreast of the emerging research base on MAT to inform policy.

RELATED RESEARCH

While juvenile MAT clinical research is nascent, one multistate study of addiction treatment and retention in care found 70.5 percent of the population studied discontinued their treatment. Compared with youths who received only behavioral health services, youth who received buprenorphine were 42 percent less likely to discontinue treatment during the follow-up period, and those receiving naltrexone were 46 percent less likely to discontinue treatment during the follow-up period. Those receiving methadone were 68 percent less likely to discontinue treatment during the follow-up period. Notably, no differences were observed in care retention according to race after controlling for receipt of medications. The same study, however, found that a relatively small number of youth received MAT.⁷⁵

Peer Support

Connections to safe and supportive peers and prosocial networks of support are important components of successful juvenile RSAT programs. Many juveniles reenter the community with very few age-group contacts who are not connected with drug and/or alcohol use. Increasing RSAT participants' connections to a prosocial peer support network begins in the treatment setting and is a key aspect of the TC approach. Recovering peers have a role in treatment settings distinct from staff. In juvenile RSAT programs, an outside peer recovery presence is desirable; however, other juveniles who have completed treatment and are awaiting release can serve a similar purpose. The unique contributions of peers fall into four categories that complement professional services:

1. **Promoting hope** through positive self-disclosure; assuring others that recovery is possible.
2. **Modeling recovery** thinking, reentry success, and educational or employment success.
3. **Sharing knowledge**, unwritten rules, resources, and prosocial “street smarts.”
4. **Engaging others** in informal networks of support that provide an alternative to antisocial companions and activities.

Examples of peer-led elements of successful RSAT programs include recovery coaching, mentoring, attendance at recovery support groups, and connections to local recovery community resources. Multiple studies have verified the effectiveness of peer support programs.

Treating Co-occurring SUDs and Mental Disorders

Co-occurring mental health conditions among juveniles with SUDs should be considered the rule rather than the exception, as evidence suggests that up to 56 percent of people with the most serious mental illnesses will experience a co-occurring SUD in their lifetime.⁷⁶ Despite the commonality of these comorbidities, the juvenile justice system may be the first exposure to treatments for both sets of disorders for most juvenile RSAT program participants. Some may have had SUD treatment but relapsed and or/recidivated due to untreated mental health issues. Still others may have accessed mental health services without their substance use problems being addressed, resulting in unsuccessful treatment.

Given the frequency of co-occurring disorders, juvenile RSAT program staff trained in SUD counseling and intervention should establish procedures for collaboration with mental health treatment staff.

Although participants are screened and assessed before and when entering RSAT programs, symptoms of mental illness or substance abuse can emerge or develop during the course of the RSAT program. When SUDs are interrupted in a controlled setting, new mental health symptoms may emerge. Conversely, a primary mental health disorder which had previously presented as only an SUD may come into clear focus. As a result, controlled settings like juvenile detention facilities are a valuable site for diagnostic clarification. For that reason, RSAT staff should know how to identify juveniles who may require further screening and assessment by a qualified mental health professional.

According to the National Institutes of Health (NIH) and SAMHSA, SUDs and mental health disorders are both brain conditions that should be treated with integrated approaches combining mental health and addiction recovery into a comprehensive treatment program. RSAT programs should offer integrated treatment geared specifically to the needs of individuals with both mental health disorders and SUDs. This can be done in different ways, all equally appropriate for at least some participants. Some juvenile RSAT programs employ mental health staff to provide youth with parallel mental health therapies and SUD treatment. Other juvenile RSAT programs deliver services sequentially, with participants completing a required course of mental health treatment to stabilize and manage their mental health symptoms prior to beginning SUD treatment. The primary goal for all juvenile RSAT program staff should be to understand how these co-occurring conditions interact so they can provide participants with tools to ensure prerelease planning facilitates connections to a full range of required services to support their recovery.

Multiple evidence-based approaches have been proven to effectively treat individuals with co-occurring SUD and mental health disorders—these include pharmacotherapies and motivational approaches such as MI, MET, CM, and illness management and recovery. The latter refers to a set of practices that teaches individuals with mental illness how to sustain their recovery through managing their SUD and working with a community of treatment providers, friends, and family. These strategies align with current SUD treatment principles, which emphasize information, tools, and resources to empower individuals to effectively manage ongoing recovery.

SAMHSA has developed the following practice principles for integrated SUD and mental health disorder treatment:

- Integrated treatment specialists are trained to treat both SUDs and serious mental illnesses.
- Co-occurring disorders are treated in a stage-wise fashion, with different services provided at different stages.
- Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage.
- SUD counseling, using a cognitive behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages.
- Multiple formats for services are available, including individual, group, self-help, and family.
- Medication services are integrated and coordinated with psychosocial services.⁷⁷

Research suggests individuals engaged in integrated treatment programs show greater improvement than individuals in non-integrated programs in multiple areas, including reduced substance use, improved psychiatric symptoms and functioning, decreased hospitalization, increased housing stability, fewer arrests, and improved quality of life.⁷⁸

STATE DEPARTMENT OF JUVENILE JUSTICE PROTOCOL

The RSAT program at the DOVES Residential Community Home serves female youth ranging in age from 13 to 24. “DOVES” stands for Developing Opportunities and Values through Education and Substance Abuse Treatment. It is the sole community-based program in New Jersey providing necessary services and support to all adjudicated juvenile girls requiring residential or secure residential placement. DOVES hosts a maximum of 16 residents, with 2 relapse beds for those who have previously completed the program. The program provides services to female youth with co-occurring behavioral health disorders and SUDs. Residents are admitted on both committed and probation status. The residents are provided evidence-based services and trauma-informed care.⁷⁹

Other Program Content

RSAT programs should include a variety of compatible social services, in addition to those described above. Although all RSAT participants are engaged in treatment for SUDs, other needs must be addressed while they are confined to prepare them for reintegrating into the community. Examples of compatible treatment and services include the following, also identified by drug court researchers:⁸⁰

- Clinical case management.
- Housing assistance, as appropriate.
- Mental health treatment.
- Trauma-informed and specific services.
- Delinquent thinking interventions.
- Family and social support and interpersonal counseling.
- Recovery community support.
- Peer recovery support.
- Prosocial and recreational activities.
- Vocational and educational services.
- Medical and dental treatment.
- Overdose prevention and reversal, including provision of naloxone to family members.

Case Management and Program Reassessments

Individual participant treatment plans must be assessed and modified as the individuals progress through the program; this includes transitional plans when participants exit the program. The adoption of an evidence-based treatment program does not guarantee the same results for all, but careful monitoring of outcomes and processes can help programs achieve their goals for more participants. While RSAT programs should adopt evidence-based practices, measures must also exist to assess and determine program effectiveness for each participant. RSAT programs should ensure that any practice involves definable and measurable outcomes, documentation of case information, and formal, valid mechanisms for measuring outcomes. RSAT programs must routinely assess participants' progress or change in cognitive development and skills and evaluate the recidivism and relapse rates of program graduates.

There should also be periodic staff performance evaluations to achieve greater fidelity to the evidence-based program design, service delivery principles, and outcomes. Staff monitoring, measuring, and reinforcing promotes overall cohesiveness and greater support to the program mission.⁸¹ Feedback is essential both for RSAT participants and for staff.⁸²

V. Staffing and Training

Ratio of Staff to Participants

The ratio of staff to juvenile participants should be less than 20 to 1 in group activities. (This is the standard for adults endorsed by SAMHSA;⁸³ it should undoubtedly be less for juveniles.) For any treatment modality, achieving RSAT program goals and objectives requires sufficient ratios of treatment staff to participants and correctional officers to participants. The RSAT pod should provide for a safe environment where participants are not distracted by extraneous commotion, and where they can think, reflect, and engage in constructive conversation with staff and their peers.

Staff Training

Whether the primary modality of treatment is a modified TC or another model, counselors and correctional officers should be trained appropriately and work as a team. Treatment staff and correctional officers should both understand RSAT standards, philosophy, benchmarks, and objectives. Each staff group should be expected to attend and participate in relevant program activities, including daily or weekly staff meetings and community meetings with RSAT participants. Both groups should be involved in participant discipline and performance reviews—including decisions on whether participants should advance to the next phase of treatment—along with assessments and clinical supervision.

Treatment staff and correctional officers should be involved in cross training (including implementation of assessment instruments), Motivational Interviewing techniques, accountability training, and SUD and mental health trainings. Treatment staff should attend correctional officer training and security-related training as appropriate, and correctional officers should be exposed to treatment training. In addition to initial training, all staff should be required to complete a regimen of in-service training to keep up with the latest evidence-based treatment.

STAFF TRAINING BEST PRACTICES

Experienced correctional officers and staff, particularly shift commanders and chiefs of security, should take a lead role in providing in-service training on trauma-informed practices. Miller and Najavits (2012) indicate juvenile justice officers tend to respect and prioritize their own lived experience over research. For that reason, validating staff intuition and skill before introducing new evidence-based information is crucial to successfully training staff. Similarly, recognizing and building on previously successful strategies is imperative. Trainers can also engage experienced staff by featuring stress management, self-care, and burnout prevention tools. Additional important trauma-informed care topics include controlling staff healthcare costs and turnover, de-escalating critical incidents, effective behavior management, safer facilities, and job satisfaction.⁸⁴

To enhance collaboration between security and treatment staff, security and other personnel assigned to the RSAT pod should be restricted to personnel committed to and interested in this assignment. To be effective, treatment programming should take up 40–70 percent of a juvenile participant's time.⁸⁵ Meeting this standard requires a collaborative effort between security officers and treatment staff so that the former can engage RSAT participants in the program beyond the limited hours counselors may be available in the institution. All personnel assigned therefore must understand RSAT programming and be as committed to treatment as RSAT counselors and administrators are.

Program Administration

Treatment providers and security and other staff should be centrally involved in RSAT program administration, operation, and direction. This holds true whether treatment staff are employed directly by the institution or contracted. The most promising RSAT programs represent collaboration among treatment staff, security officers, and administrators, where each recognizes the needs of the others.

VI. Drug-free Environments

Juvenile RSAT programs should carefully monitor participants for alcohol and substance use during confinement. Monitoring alcohol and substance use through urinalysis or other objective methods as part of treatment or juvenile justice supervision provides a basis for assessing and providing feedback on the participant's treatment progress. It also provides opportunities to intervene to change unconstructive behavior—for example, determining rewards and sanctions to facilitate change and modifying treatment plans according to progress. In detention or confinement facilities that are unable to separate RSAT participants from the general population, alcohol and other drug testing should be more prevalent.

VII. Transition and Aftercare Planning

Reintegration into the community and continuity of care is an essential component of RSAT. In 2013, BJA removed a 10 percent cap on the use of RSAT grants for this, and RSAT programs are expected to help participants connect to community resources, mobilize family and prosocial peers, and help participants develop a prosocial peer network by encouraging peer-to-peer learning, designating a peer reentry liaison, and encouraging engagement in mutual support. All of this should occur in addition to specific treatment and service referrals.

Effective continuing care in the community requires transition planning and programming, prerelease planning, and a coordinated transition with a community-based provider for SUD and mental health treatment, physical and behavioral case management, referrals for employment/education, and a first dose of medication, where appropriate. Effective aftercare also requires coordination with juvenile parole/probation.

People who complete treatment in correctional facilities and continue with treatment in the community typically show the best outcomes.⁸⁶ Research shows that providing continuing care can result in better outcomes than when aftercare is not provided.⁸⁷ Continuing SUD treatment can also help recently released individuals deal with issues that become relevant at that time, such as learning how to handle situations that could lead to relapse, learning how to live drug-free in the community, and developing a drug-free peer support network.

To facilitate connections between in-custody treatment and community-based treatment, treatment staff and correctional officers must establish information-sharing protocols with post-release case managers and treatment staff in the community. Such agreements are important to ensure seamless transfer of information about an individual's behavioral health conditions, progress in treatment while in detention or confinement, and treatment needs that should be addressed in the community.

The success of a continuing care model is contingent on whether the juvenile appears after release for admission to the community treatment program and continues to attend it. Unfortunately, studies have documented that some juveniles will not report to treatment, even in states where post-release treatment is a condition of release, parole, or probation.⁸⁸ On the other hand, efforts by various correctional departments have demonstrated that improving the process of reentry referral can result in more people entering aftercare.⁸⁹

Connecting juveniles and their families to resources within and outside juvenile justice facilities is key to preparing juveniles for reentry into the community. Best practices indicate contact

should be established with community-based juvenile SUD treatment within one week of release from juvenile justice custody. However, lack of support service follow-through and lack of staff follow-up are major obstacles faced by many reentry programs. For that reason, recommending and establishing contact with support services prior to release is paramount. This process also includes creating and maintaining ongoing communication with treatment staff, providers, and community corrections personnel. Some necessary tasks are:

- Making aftercare appointments prior to release.
- Having multidisciplinary meetings at regular intervals during treatment.
- Reassessing criminogenic needs at regular intervals.
- Collaborating with community corrections and community-based treatment staff (including transferring treatment records) to ensure continuity of treatment and other services.

If youth will not be under juvenile justice supervision after release, RSAT programs must encourage and motivate graduates to continue their own treatment and recovery and support them in creating a service and assistance plan to maintain recovery post-release.

SUD is a chronic, relapsing illness that requires management throughout the life span. Relapse is to be expected and is thus a major target for treatment. For that reason, multiple episodes of treatment may be required. Effective treatment engages participants in a therapeutic process, retains them in treatment for a substantial length of time, and supports them in recovery. Community-based treatment providers, social service agencies, and supervision agencies can play a role in improving outcomes for juveniles with SUD by monitoring drug and/or alcohol use and by encouraging continued participation in treatment.

RELATED RESEARCH

Researchers identified six effective transition practices for juveniles reentering their communities.⁹⁰ These interventions begin in juvenile detention facilities and continue in the community, with a focus on increasing employment and continuing education, both during incarceration and post-release. Principles include:

1. Transition team led by transition coordinator (starting early and communicating).
2. Effective youth records and vital information transfer.

3. Individualized transition plan including academic, behavioral, social-emotional, and career and technical goals.
4. Research-based programming including social-emotional development, behavior management, and mental health treatment.
5. Regular monitoring and tracking of individual, system, and community outcomes data.
6. Adequate funding to provide transition service resources.

Health Insurance

Without access to health services immediately upon release, the physical and mental health conditions of recently released juveniles may deteriorate. Research suggests that providing access to health insurance upon release can promote more timely access to care, which may reduce the risk of such deterioration, particularly for individuals with chronic physical or mental health conditions.⁹¹ In addition, continuous access to health care immediately after release may reduce the risk of rearrest and detention.⁹²

Although youth in juvenile detention or confinement facilities are ineligible for the Children's Health Insurance Program,⁹³ their eligibility for Medicaid is unaffected. In 2004, the Centers for Medicare & Medicaid Services issued guidance reminding states that people "who meet the requirements for eligibility for Medicaid may be enrolled in the program before, during, and after the time in which they are held involuntarily in secure custody of a public institution." Federal law requires states to allow individuals to apply for Medicaid at any time. In all states, juveniles in detention or confinement facilities may be enrolled in available subsidized or unsubsidized insurance plans offered through their state's market exchanges.

Enrollment is just the first step. The second is appropriate utilization of the treatment and services covered. This medical assistance can help facilitate easier access to treatment and help reduce recidivism as part of a comprehensive reentry effort.⁹⁴

Best practices include referrals to Federally Qualified Health Centers (FQHCs), referrals to Medicaid Health Homes for eligible individuals with multiple conditions, and standard procedures for transmitting correctional health records to community providers.⁹⁵

- Helpful resources may include:
- American Correctional Association. (2016). *Health Care Reform: A Practical Guide for Corrections and Criminal Justice Professionals*.⁹⁶
- Milbank Memorial Fund. (2016). *Coordinating Access to Services for Justice-Involved Populations*.⁹⁷
- Council of State Governments Justice Center. (2017). *Critical Connections: Getting People Leaving Prison and Jail the Mental Health Care and Substance Use Treatment They Need*.⁹⁸

Probation and Parole Collaboration

To improve the success of drug treatment and reentry, RSAT personnel should work with participants' post-release supervisors to plan for the participants' transition to community-based treatment and linkage to appropriate post-release services. Abstinence requirements may necessitate a rapid clinical response, such as more counseling, targeted intervention, or medication. Ongoing coordination between juvenile corrections and treatment providers is important in addressing the complex needs of those reentering the community.

Youth involved in the juvenile justice system with SUDs should be offered testing for infectious diseases and receive counseling to modify risky behaviors, as outlined in federal and state laws. Individuals with SUDs and histories of juvenile justice system involvement and community supervision are at higher risk than the general population for infectious diseases such as hepatitis, tuberculosis, and HIV/AIDS.⁹⁹ Juvenile RSAT programs should link graduates to appropriate healthcare services and encourage them to comply with medical treatment and reestablish their enrollment in health services (e.g., Medicaid, local health department services) before their release from juvenile justice facilities. Programs should inform participants and their families of the availability of naloxone and its use to prevent overdose deaths. Where naloxone is available, participants and their families should be encouraged to have it on hand in case of emergency.

VIII. Measuring Results

Strong data collection standards and standard time frames for analyzing data are essential for measuring the effectiveness of RSAT at the individual and program levels. In addition to performance measures required by BJA, many RSAT programs include measures in their data collection processes as required by the treatment model. Although no evidence-based program can be implemented with the exact same population or circumstances as the model, these measures help ensure that the key components of the model are implemented without compromising their integrity.

Juvenile RSAT program measures should include participation and completion rates, information on urine tests, the percentage of slots in TCs that were used for individuals who were at medium to high criminogenic risk, and other relevant data. Measured outcomes should also include rearrests, reincarcerations, initiation and retention in treatment, abstinence or length of time to relapse, drug overdoses, emergency room visits, and drug overdose deaths.

Juvenile RSAT program performance, otherwise known as program outputs, does not determine the juveniles' behavior once released from juvenile justice facilities. Juvenile RSAT programs should track individuals' program outcomes—how program graduates reintegrate into their communities and families after they are released—to determine long-term program efficacy. Recidivism, including new arrests and reincarcerations, is the most easily obtained outcome measure. SUD relapse, generally associated with length of time in treatment, is another important outcome. Deaths from overdoses and emergency room treatment for overdoses are obviously the most critical relapse outcomes.

The best outcome evaluations involve comparisons with equivalent populations. This allows a program to be able to better interpret its impact. Otherwise, if the outcome data, for example, reveal that 30% of the youth remain drug free for six months, it is difficult to say if that is a terrific or lackluster result. On the other hand, if only 10% of the comparison group remained drug free for six months (without the program), this suggests the program triples the recovery rate of its participants. The best comparison groups come from assignments of subjects from the same pool with some randomly assigned to the program under study and some not. However, random assignment would be both ethically and legally problematic in studies involving incarcerated youth.

A lot of evaluations rely on “before and after” comparisons. The problem with these studies is that it may be difficult to attribute any outcomes found to the program's effectiveness or simple

the result of maturation or other factors having little to do with the program being evaluated. These evaluations cannot control for external factors.

Generally, sophisticated evaluative research requires an independent researcher with no conflict of interest. However, independent researchers require a full understanding of the program, the population studied, and the juvenile justice context. They must also allow program officials to comment on the findings to ensure the researchers have adequately interpreted the data. For example, some RSAT program graduates may be arrested following their release, but for charges that arose prior to their RSAT participation. Researchers must know how to read criminal records to decipher such circumstances.

Evaluations should include all individuals initially referred to the RSAT program, including those who may drop out or be terminated before completing the program. Although an RSAT program might show a perfect record among those who successfully complete the program, it might be the case that the vast majority of individuals who entered the program never completed it. Furthermore, an analysis of non-completers might reveal that the completers are only those with the lowest risk/need scores of those admitted into the program or are disproportionately represented by one racial or ethnic background over another, suggesting that the program lacks the cultural competence to respond to diverse populations. An intention-to-treat analysisⁱⁱⁱ will tell the program whether it should limit its admission to those for whom it is most effective or change its program to accommodate more diverse participants.

In addition, shorter follow-up periods tend to overstate the program's effectiveness. Many juvenile justice interventions reduce recidivism at 6 months but have significantly diminished effects over longer periods. Generally, follow-up should be at least 1 year.¹⁰⁰ Finally, RSAT programs periodically should conduct internal reviews of performance data to measure progress and make incremental adjustments as indicated. Although BJA aggregates data by state, individual RSAT sites are encouraged to maintain and track data to compare performance measures and review changes for better or worse as key components of substance use disorder treatment for juvenile justice-involved youth programs evolve and change over time and as staff, correctional officers, facility policies, and participant populations change.

ⁱⁱⁱ An intention-to-treat analysis is a type of study design in which every subject is included in the randomization, regardless of the intervention received or adherence to the intervention.

IX. Examples of RSAT Programs for Juveniles

Adobe Mountain School, Arizona Department of Juvenile Corrections (Phoenix, Arizona)

The RSAT program serves 25 youth aged 14–18 with co-occurring mental illness and substance abuse. The program is modeled on a therapeutic community (TC) and implements the Seven Challenges¹⁰¹ curriculum. Serving youth with 6 months or more of detention remaining, Adobe Mountain helps youth transition through five phases: *acknowledgment* of problem behaviors, *understanding* of the reasons for those behaviors, *application* of prosocial skills, *demonstration* of skills within a relapse prevention plan, and *reentry* after all requirements have been met. Other available interventions include Aggression Replacement Training (ART)¹⁰² and Eye Movement Desensitization and Reprocessing (EMDR).¹⁰³

Regional Youth Detention Centers, Georgia Department of Juvenile Justice (Augusta and Eastman, Georgia)

The Georgia Department of Juvenile Justice uses RSAT funding in multiple locations to provide RSAT services to 34 youth up to age 21. The RSAT programs serve youth with 6 months or more remaining in detention, using a TC model and the Seven Challenges curriculum. Youth participate in four 60-minute group sessions per week, along with individual sessions every 2 weeks and family sessions every month. Successful completion of the program requires 4–6 months of group, individual, and family sessions; Seven Challenges journal assignments; a relapse prevention plan; and transition exercises. The department coordinates with the state’s behavioral health agency to ensure aftercare, including Seven Challenges-based aftercare, is available.

Developing Opportunities and Values through Education and Substance Abuse Treatment (DOVES) Residential Community Home, New Jersey Juvenile Justice Commission (Hopewell, New Jersey)

The DOVES Residential Community Home operates an RSAT program in the former estate of famed aviator Charles Lindbergh, serving up to 16 female youth aged 13–24 who have co-occurring disorders. The program is a TC using the New Freedom substance abuse¹⁰⁴ curriculum, incorporating CBT and MET. The RSAT program links these youth to community resources, including Dress for Success, community colleges, programs for sex trafficking victims, and a juvenile parole officer who coordinates follow-up care.

The Ferris School for Boys, Delaware Division of Youth Rehabilitative Services (Wilmington, Delaware)

The Ferris School's RSAT program serves 18 boys aged 13–18 using the Seven Challenges curriculum and a TC model. Successful completion of the program requires 6 months of group and individual/family sessions, Seven Challenges journal assignments, and transition exercises. At completion and release from the facility, care transfers to the youth's parole officer and a youth advocacy worker, who both provide 6 months of follow-up care in the community.

Henry Wade Juvenile Justice Center, Dallas County Juvenile Department (Dallas, Texas)

The RSAT program serves 12 youth aged 13–17. It includes three phases: *orientation* (assessment of history, strengths, and family issues and determination of goals and treatment plans), *active treatment* (identification of triggers, coping skills, effects of drug use on body and family, criminal thinking patterns and maladaptive behaviors, and trauma narratives), and *transition* (relapse prevention, discharge planning, family involvement, prosocial activities, and education planning). The programs offer multiple groups, including peer group, skills group, parent psychotherapy, and crisis de-escalation.

Illinois Youth Center Harrisburg, Illinois Department of Juvenile Justice (Harrisburg, Illinois)

The Illinois Youth Center Harrisburg's RSAT program serves 20 males aged 13–20, with a capacity of 32. The program requires a minimum of 4 months for participation. It is a modified TC providing 15 hours of substance use services per week. The youth move through the following phases: *orientation* (1–3 weeks consisting of screening, assessment, and development of treatment goals), *intensive treatment* (including academic and life skills, counseling, and recreational activities), and *prerelease* (1–2 months of care planning, skills reinforcement, connection to community resources, connection-building with family and peers, and educational/employment activities).

Juvenile Relapse Avoidance Project (JRAP), Oklahoma Office of Juvenile Affairs (Cleveland County, Oklahoma)

JRAP serves a total of 36 youth in four group homes. The 6- to 12-month program includes trauma-informed CBT; weekly assessments; team meetings with youth, family, therapist, and aftercare providers; transition to community providers; and academic and career planning.

Pine Hills Youth Correctional Facility, Montana Department of Corrections (Miles City, Montana)

The Pine Hills program combines a strong 6- to 12-month residential program with a cognitive behavioral approach and a closely coordinated aftercare component. The RSAT programming continues to strive to improve efforts to reduce SUD among juvenile program participants. The facility conducts cognitive behavioral and chemical dependency training for treatment and security staff assigned to the treatment unit, transition staff, and juvenile parole officers. All youth released from the Pine Hills RSAT program are placed in an established aftercare program in or near their home community.

Rhode Island Training School (RITS), Rhode Island Department of Children, Youth and Families (Cranston, Rhode Island)

The RSAT program currently serves three youth, with a service population of male and female youth aged 13–18. The program is a modified TC emphasizing relapse prevention and offering CBT. For 4 months, participants attend four group sessions and one individual session each week. After the 4 months, they continue weekly individual sessions but attend only one to two groups per week. Groups include CBT, MI, emotion regulation, life skills, psychoeducation, and relapse prevention planning.

Postscript and Additional Resources

This collection of promising practices guidelines is designed to be a working document. These guidelines will be updated and revised as more research is completed and as more feedback is received from juvenile RSAT programs across the nation and U.S. territories. These guidelines are intended to complement the work already done by frontline staff. Research suggests staff skill levels and the quality of the interpersonal relationship between staff and juvenile justice-involved youth are as important or more important to reducing SUD risk than specific programs.¹⁰⁵ In other words, there will never be a substitute for the work of dedicated counselors, correctional officers, and other program staff who make up juvenile justice RSAT programs.

To learn of the latest research establishing evidence-based SUD treatment and correctional treatment programming, a few of the resources of particular value include:

The CrimeSolutions registry
National Institute of Justice, U.S. Department of Justice
www.crimesolutions.gov

Evidence-Based Practices Resource Center
The Substance Abuse and Mental Health Services Administration
www.samhsa.gov/ebp-web-guide

Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)
National Institute on Drug Abuse, National Institutes of Health
<https://www.drugabuse.gov/download/675/principles-drug-addiction-treatment-research-based-guide-third-edition.pdf?v=87ecd1341039d24b0fd616c5589c2095>

Juvenile Drug Treatment Court Guidelines
Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice
<https://ojjdp.ojp.gov/programs/juvenile-drug-treatment-court-guidelines>

To learn of updates to *Promising Practices Guidelines for Residential Substance Abuse Treatment*, including trainings and technical assistance around its implementation and continued discussion, please follow the RSAT Training and Technical Assistance Project at www.rsat-tta.com.

Appendix A: Description of Evidence-based SUD Treatment Programs for Juveniles

Family Behavior Therapy (FBT)

FBT focuses on addressing SUD problems as well as co-occurring issues such as conduct disorders, child mistreatment, depression, family conflict, and unemployment. Therapy includes both the patient and at least one family member or significant other. Skills taught in therapy are aimed at improving patients' home environment.

For more information, *Principles of Drug Addiction Treatment: A Research-Based Guide* (Third Edition) pg. 47 (<https://www.drugabuse.gov/download/675/principles-drug-addiction-treatment-research-based-guide-third-edition.pdf?v=87ecd1341039d24b0fd616c5589c2095>).

Community Reinforcement Approach and Family Training (CRAFT)

The CRAFT intervention is an evidence-based program that works with family members and significant others of individuals who refuse to seek SUD treatment. This strategy was created based on a family/couples therapy model that recognizes the important role family members and significant others play in the lives of individuals with SUD, even if the individual refuses to seek SUD treatment. Evidence suggests family members and significant others do affect the motivation of individuals with SUD for change despite initial refusal to receive treatment.

For more information, see <https://www.robertjmeyersphd.com/craft.html>.

Behavioral Therapies for Adolescents/Multisystemic Therapy (MST)

One adaptation of behavioral therapy for drug-using adolescents is MST. MST examines the factors associated with antisocial behavior in children and adolescents and typically provides its treatment in natural environments—such as home or school—addressing factors such as the child's characteristics, family, peers, school, and neighborhood, in an effort to reduce drug use and incarceration.

For more information, *Principles of Drug Addiction Treatment: A Research-Based Guide* (Third Edition) pp. 47-48 (<https://www.drugabuse.gov/download/675/principles-drug-addiction-treatment-research-based-guide-third-edition.pdf?v=87ecd1341039d24b0fd616c5589c2095>).

Moral Reconciliation Therapy (MRT)

MRT is a treatment strategy aimed at reducing reincarceration among juveniles by increasing moral reasoning. Through group and individual counseling, MRT addresses ego, social, moral, and positive behavioral growth. It focuses on seven basic treatment issues: (1) confrontation of beliefs, attitudes, and behaviors; (2) assessment of current relationships; (3) reinforcement of positive behaviors and habits; (4) positive identity formation; (5) enhancement of self-concept; (6) decrease in hedonism and development of frustration tolerance; and (7) development of higher stages of moral reasoning.¹⁰⁶

For more information, see <https://ncjfcj-old.ncjfcj.org/moral-reconciliation-therapy-mrt>.

Correctional Therapeutic Community

This program for clients with SUDs provides for an isolated community of participants to promote recovery and prevent relapse. The program separates participants from the general prison population to enhance the effectiveness of the rehabilitative communities.

For more information, see <https://whatworks.csgjusticecenter.org/intervention/therapeuticcommunities>.

Appendix B: Pharmacotherapies

Buprenorphine

Buprenorphine is a synthetic opioid medication that acts as a partial agonist at opioid receptors—it does not produce the euphoria and sedation caused by heroin or other opioids, but is able to reduce or eliminate withdrawal symptoms associated with opioid dependence and carries a low risk of overdose. Buprenorphine is currently available in two formulations that are taken sublingually: (1) a pure form of the drug, and (2) a more commonly prescribed formulation called Suboxone, which combines buprenorphine with the drug naloxone, an antagonist (or blocker) at opioid receptors. Naloxone has no effect when Suboxone is taken as prescribed, but if an addicted individual attempts to inject Suboxone, the naloxone will produce severe withdrawal symptoms.

Buprenorphine treatment can be provided in office-based settings by qualified physicians who have received a waiver from the Drug Enforcement Administration (DEA).

Naltrexone

Naltrexone is a synthetic opioid antagonist—it blocks opioids from binding to their receptors and thereby prevents their euphoric and other effects and reduces cravings for opioids. It can be taken orally, either daily or three times a week, or injected for 28 days (Vivitrol). Patients must be opioid free 7 to 10 days before an injection. Naltrexone also blocks receptors that are involved in the rewarding effects of drinking alcohol and the craving for alcohol. It can be taken daily as a pill or injected which lasts for 28 days.

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