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System-level effects of integrating a promising treatment into juvenile drug courts

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Abstract

This study examined the system-level effects of implementing a promising treatment for adolescent substance abuse in juvenile drug courts (JDCs). Six JDCs were randomized to receive training in the experimental intervention (contingency management–family engagement [CM-FAM]) or to continue their usual services (US). Participants were 104 families served by the courts, 51 therapists, and 74 JDC stakeholders (e.g., judges, prosecutors, defense attorneys). Assessments included repeated measurements of CM-FAM implementation by therapists and therapist and stakeholder perceptions of incentive-based interventions and organizational characteristics. Results revealed greater use of CM and family engagement techniques among CM-FAM relative to US therapists. In addition, therapists and stakeholders in the CM-FAM condition reported more favorable attitudes toward the use of incentives and greater improvement on several domains of organizational functioning relative to US counterparts. Taken together, these findings suggest that JDC professionals are amenable to the adoption and implementation of a treatment model that holds promise for improving youth outcomes.

Keywords: Contingency management; Substance use; Drug court; Adolescent; Family

1. Introduction

The primary purpose of this report is to examine the system-level effects of integrating a promising treatment for youth substance abuse (contingency management–family engagement, CM-FAM) into several juvenile drug courts (JDCs). A previous report (Henggeler, McCart, Cunningham, & Chapman, 2011) described the favorable reductions in juvenile offender substance use and criminal behavior resulting from the CM-FAM intervention. The achievement of improved clinical outcomes, however, is only one factor in the successful transport of evidence-based treatments to field settings (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). For effectiveness and sustainability, therapists must learn to implement the treatment with fidelity, stakeholders must come to view the intervention favorably, and the organization in which the intervention is embedded must adjust to the integration of the new treatment methods. The present report evaluated these changes using a design in which several JDCs were randomized to receive training in CM-FAM or not. Before the specifics of the study are presented, however, the broader context in which this study fits into the JDC field and the validation of the CM-FAM protocol (Henggeler et al., 2012) are described.

Juvenile offenders with substance abuse problems represent a large and underserved population that is at high risk of presenting significant deleterious outcomes and long-term costs for themselves, their families and communities, and society (Belenko & Dembo, 2003; Chassin, 2008). Based, in part, on the success of their adult drug court counterparts (General Accountability Office, 2005), JDCs were developed in the early 1990s to address the significant treatment needs of juvenile offenders with substance abuse problems. Indeed, with considerable local, state, and federal

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support, more than 500 JDCs are currently operating in the United States (Bureau of Justice Assistance Drug Court Clearing House, 2009), and stakeholders hope to further increase the availability of the JDC model across the nation ("Record funding for drug court!!!," 2009).

As is often the case in the field of juvenile justice, however, the proliferation of promising interventions, JDCs in the present case, has preceded rigorous evaluation of their effectiveness (Howell, 2003; Greenwood, 2006). Unfortunately, meta-analytic reviews of JDC evaluations have produced mixed results (Aos, Miller, & Drake, 2006; Shaffer, 2006), with a reported mean effect size of only .05 favoring JDC. However, these studies also reported significant variability in the observed effect size estimates, suggesting that some courts are more successful than others at reducing youth substance use and delinquent behavior. In examining this literature, several reviewers (e.g., Belenko & Logan, 2003; Chassin, 2008; Henggeler, 2007; Hills, Shufelt, & Cocozza, 2009) have suggested that the effectiveness of JDCs has been attenuated by their general difficulty in involving parents and caregivers in the treatment process (see, e.g., Salvatore, Henderson, Hiller, White, & Samuelson, 2010) and by a failure to adopt and integrate evidence-based substance abuse treatment practices into the treatment component of JDC. Indeed, the importance of caregiver involvement in effective treatment for adolescent substance abuse is well established (e.g., Waldron & Turner, 2008; Williams & Chang, 2000), and the science–service gap is substantial in the field of substance abuse treatment (Carroll, Martino, & Rounsaville, 2010; Compton et al., 2005; Institute of Medicine, 1998).

In an effort to test and enhance the effectiveness of JDC by integrating an evidence-based family treatment, Henggeler et al. (2006) conducted a four-condition clinical trial in which substance-abusing juvenile offenders were randomized to family court, usual JDC, JDC with an evidence-based family treatment (i.e., multisystemic therapy [MST]; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009), or JDC with MST + CM integrated as the treatment component. Supporting the view that increased family involvement and integration of evidence-based treatments could improve JDC outcomes, the two JDC conditions with the evidence-based substance abuse treatments were more effective than usual JDC (and family court) at decreasing adolescent substance use. Although these results were promising, the complexity and cost of MST programs (e.g., a minimum of two full-time therapists and a half-time supervisor, extensive quality assurance procedures) serve as barriers to the wider transport of this intervention model to JDCs, many of which serve only small numbers of youths. Clearly, a family friendly and more efficient approach is needed—ideally, one that can be integrated into a range of existing JDC treatment services.

CM with enhanced strategies for family engagement (CM-FAM) might represent a logical choice to fill this need. CM and its variations have strong empirical support in the adult substance abuse literature (Higgins, Silverman, & Heil, 2008) and very promising outcomes in the adolescent substance abuse literature (Stanger & Budney, 2010); and, as noted previously, CM enhanced youth substance use outcomes in the aforementioned JDC study (Henggeler et al., 2006). Moreover, because of its relative simplicity, low cost, and compatibility with current JDC practice (i.e., frequent drug testing with consequences), CM seems more amenable to adoption (Rogers, 1995) by JDC professionals than are other evidence-based treatments of adolescent substance abuse such as MST, multidimensional family therapy, and brief strategic family therapy. Indeed, Henggeler et al. (2007) and Henggeler, Chapman et al. (2008) demonstrated widespread interest in and adoption of CM by public sector practitioners in substance abuse and mental health when provided appropriate training and support. To promote family participation in CM, the effective family engagement strategies used in MST (Henggeler, 2011) have been integrated into the CM protocol. The resulting intervention is labeled *CM-FAM* and specified in a treatment manual (Henggeler et al., 2012).

As indicated previously, the present article is the second report from a larger study that is evaluating the integration of CM-FAM into JDCs. The first report (Henggeler et al., 2011) focused on the effects of CM-FAM on youth outcomes. Six JDCs were randomized to a condition in which therapists were trained to deliver CM-FAM or to continue their usual services (US). Participants included 104 juvenile offenders, 86% of whom met criteria for at least one substance use disorder. Results showed that CM-FAM was significantly more effective than US at reducing youth marijuana use, based on urine drug screens, and at reducing crimes against persons and property offenses. The present article examines the effects of integrating the CM-FAM intervention on the participating therapists, stakeholders, and organizations.

Reviewers and researchers (e.g., Aarons, Fettes, Flores, & Summerfeld, 2009; Beidas & Kendall, 2010; Fixsen et al., 2005) have noted that an organization's transition to an evidence-based practice likely involves change in practitioner behavior, stakeholder attitudes, and organizational processes—changes needed to support the implementation of the new treatment. To the best of our knowledge, however, few studies have examined such changes resulting from the integration of an evidence-based practice into an organization. One important exception is a recent study conducted by Aarons, Fettes et al. (2009) and Aarons, Sommerfeld, Hecht, Silovsky, and Chaffin (2009) in which integration of an evidence-based practice into case management teams reduced staff turnover and emotional exhaustion in comparison with teams providing usual case management services. Aside from this study, the literature has focused almost exclusively on identifying those practitioner and organizational variables that are conducive (or serve as barriers) to the adoption of evidence-based practices. This study, which randomizes JDCs to conditions and includes a longitudinal design, provides a rare opportunity to examine