

Alternatives to Detention for African American Adolescents with Substance Use and Co-occurring Disorders

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Juvenile justice services, disproportionate minority contact, and alternatives to detention for African American adolescents with substance use and co-occurring disorders continue to be areas of concern for juvenile justice, substance abuse, and mental health administrators. Additionally, salient is the question regarding the purpose of the juvenile justice system. Whether its focus is “punishment or rehabilitation” impacts on outlook, services, approaches, and outcomes. This article will examine disproportionate minority contact and alternatives to detention for African American adolescents with substance use and co-occurring disorders along with evidence-based and community-based alternatives to detention.

KEYWORDS *Alternatives to detention, African-Americans, adolescents, co-occurring disorders, juvenile detention*

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Characteristics of delinquents

Delinquent and antisocial behavior can be defined as recurrent violations of socially prescribed patterns of behavior, often characterized by hostility, aggressive behavior, defiance of authority, and violations of social norms and mores (Simcha-Fagan, Langner, Gersten, and Eisenberg, 1975). First described by Cleckley (1976), antisocial behavior patterns are marked by risk taking, sensation seeking, and involvement in criminal activity. Socially these individuals may be described as egocentric, manipulative, grandiose, and forceful (Lyman, 1996), often evidencing shallow emotions, lack of empathy, and little remorse for wrongdoing (Gresham, 2002). Adolescents with antisocial and aggressive behavior patterns who excessively violate social norms constitute between 35 percent and 50 percent of referrals to mental health clinics, making it the most cited reason for bringing adolescents to the attention of mental health providers (Rogers, Johansen, Chang, and Salekin, 1997).

Adolescents who are at high risk for developing lifelong pernicious patterns of antisocial and delinquent behavior continue to be a significant concern among the community-based residential treatment population, particularly those who are highly resistant to intervention (Kemp and Center, 1999). Antisocial behaviors are increasingly more common in adolescents in community-based residential treatment programs as compared to their counterparts in public schools. They are three times more likely to report committing acts of vandalism, hitting or assaulting, shoplifting, gang involvement, and carrying a weapon on school property within the past twelve past months than are their public school counterparts (Fulkerson, Harrison, and Beebe, 1997). Furthermore, in reviewing the characteristics of delinquents in general, a variety of delinquency

typologies have been proposed through the years (Underwood, Barretti, Storms, and Strumolo, 2004). In examining patterns of delinquent behaviors and attitudes in time, this suggests a common progression from fewer, less serious types of offending to furthermore serious offending (Loeber, Stouthamer-Loeber, VanKammen, and Farrington, 1991). Loeber et al (1991) have identified an empirically identified seven groups of delinquent offenders over time (e.g., beginning, persistence, and ending):

- Stable non-delinquents;
- Starters (e.g., those who made the transition from no delinquency to involvement in minor delinquency);
- Stable moderately serious offenders (e.g., those who consistently participate over time);
- Escalators (e.g., those escalating in seriousness of offense over time);
- Stable highly serious offenders (e.g., those involved in frequent and serious offending over time);
- Deescalators (e.g., those who deescalated in the seriousness of their offenses over time); and
- Desisters (e.g., those who cease offending (Loeber et al, 1991)).

Research identifies the following risk factors for delinquency and mental illness (Rutter, 1990):

Delinquency:

Individual –	Substance abuse Mental health problems, particularly ADHD and depression Poor social problem-solving skills
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	Learning difficulties Cognitive impairments especially affecting verbal abilities
Family -	Poor parental supervision Ineffective discipline practices Exposure to domestic violence
School -	Truancy Poor academic achievement Untreated learning disabilities
Peer -	Association with delinquent peers Gang membership
Community -	Exposure to violence Exposure to drug dealing
Poverty -	Low self-esteem Limited choices Limited resources

Mental Illness:

Family -	Large family size or overcrowding Paternal criminality Maternal psychiatric disorder Severe marital discord
Community -	Poverty

Disproportionate minority contact for African American Youth with substance use disorders

For many youth becoming subjects of the juvenile justice system is highly associated with their low socioeconomic status (Kaminer and Winters, 2011). According to the National Survey on Drug Use and Health (National Center on Addiction and Substance Abuse, 2004a), juvenile arrestees are significantly more likely than other youth to come from poverty. Youth who come from families with sufficient economic resources are

generally better able to afford private legal representation and to subsequently avoid involvement in the judicial system for all but the most serious criminal acts (Kaminer and Winter, 2004). Those living in poverty, however, typically perceive, if not experience in reality, that they will be able to obtain (or certainly afford) such treatment only after becoming involved in the judicial system and often only when ultimately incarcerated. This speaks to the importance of actively providing early intervention services to urban communities, to culturally appropriate service delivery involving clinicians indigenous to local sub-populations (Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 1999). Adolescents of color, particularly African American and Latino, are increasingly at risk for entry in juvenile justice systems rather than treatment systems (Bilchick, 1999; Elliot, 1994; Elliot, Huizinga, and Menard, 1989; Tolan and Guerra, 1994). Delinquent behavior, substance abuse, and emotional disorders by adolescents of color stem from complicated social, medical, and psychological factors (Bilchick, 1999; Canino and Spurlock, 1994). Correlations with delinquency among adolescents of color include lack of legitimate job opportunities, increasing social isolation, poor schools, and weak community organizations (Boyd-Franklin, 1991). The disproportionate representation of youth from lower socioeconomic groups overlaps with a disproportionate representation of black youth in the juvenile justice system (Kaminer and Winters, 2011). Additionally, substantial evidence exists that adolescents of color are often treated differently than white adolescents within the mental health and juvenile justice system (Boyd-Franklin, 1991; Isaacs, 1992; Underwood and Rawles, 2002). Approximately two-thirds of studies examined showed that racial, ethnic status or both influence decision making in at least some urban jurisdictions (Underwood et al., 2004).

Although case rates have increased for all racial groups in all offense and mental health categories during the last decade, rates for African American adolescents remained well above rates for whites and other races. Even after controlling for offense, it is nearly twice as likely that cases involving African American adolescents will result in detention in correctional facilities than cases involving white adolescents (Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 1999).

Substance use characteristics

Catalano, Hawkins, and Miller (1992) identify the following seventeen risk factors for adolescent substance abuse:

- Laws and norms favorable toward behavior
- Availability of drugs
- Extreme economic deprivation
- Neighborhood disorganization
- Physiologic factors
- Family alcohol and drug behavior and attitudes
- Poor and inconsistent family management practices
- Family conflict
- Low bonding to family
- Early and persistent problem behaviors
- Academic failure
- Low degree of commitment to school
- Peer rejection in elementary grades

- Association with drug-using peers
- Alienation and rebelliousness
- Attitudes favorable to drug use
- Early onset of drug use

Domains of functioning consistently linked to substance abusing adolescents who engage in delinquent activity include family functioning, school functioning, and peer relationships (Henggeler, Schoenwald, Borduin, Rowland, and Cunningham, 1998). Adolescents in residential facilities are much more likely than adolescents in public schools to report the use of alcohol, drugs, and illegal substances and are more likely to initiate substance use at an earlier age (Underwood, et al, 2004).

In recent years, it has been concluded that adolescents who abuse substances present with higher rates of co-morbid psychiatric problems, such as depression and conduct disorder (Greenbaum, Johnson, and Petrila, 1996; Waldron, Slesnick, Pearson, and Turner, 2001; Weinberg, Rahdert, Colliver, and Glantz, 1998) and that adolescents who abuse substances are at especially high risk of co-occurring, mental health, and substance use disorders (Capaldi, 1992; Coccozza, 1997; Thompson, Riggs, Mikulich, and Crowley, 1996). A 1999 study regarding psychiatric co-morbidity among substance abusing adolescents demonstrated that adolescent substance abuse with distinctive degrees of co-morbidity, such as internalizing (i.e., affective disorders) and externalizing (i.e., conduct disorder), impacts adolescents differently than substance abuse alone and that it may be linked with differential longer-term treatment outcomes (Drake, Muesser, Clark, and Wallach, 1999; Randall, Henggeler, Pickrel, and Brondino, 1999). For example, adolescent substance abuse with co-morbid externalizing disorders predicted

high-school dropout (Kessler, Foster, Saunder, and Stang, 1995) and inpatient treatment failure (Abram and Teplin, 1991), whereas co-morbid internalizing disorders predicted completion of inpatient treatment for substance abusing adolescents (Kaminer and Frances, 1991). Concluding, substance abusing adolescents with co-morbid external disorders are even more delinquent than are their substance abusing delinquent counterparts, engaged in higher rates of delinquent activity and illicit drug use, use more marijuana and alcohol, and exhibit less family cohesion, greater conformity to antisocial peer pressure, and decreased school competence (Randall et al., 1999). Consistent with previous investigations (Kessler et al., 1995) co-morbidity predicts worse treatment outcomes than substance abuse alone and co-morbid externalizing disorders, such as conduct disorder, offer the poorest treatment outcome (Randall et al., 1999).

Disproportionate minority contact (DMC)

Suman Kakar (2006) describes disproportionate minority contact as a disproportionately large number of minority youth coming into contact with the juvenile justice system in relation to their representation in the general population. The groups referred to as minorities are African American, Native American, Asian American, Pacific Islanders, Hispanic/Latinos, or any other non-Caucasian group (Gilespe, Wilson, & Yearwood, 2000). Disproportionate minority contact is defined as a ratio of the share of the juvenile population that is minority relative to the share of the at-risk population that is minority. It is believed that considerations of police practices such as targeting patrols in low-income neighborhoods, locations of offenses, differences in delinquent behavior by

minority and white youth, differential reactions of crime victims to offenses committed by white or minority youth, and racial bias by decision makers in the system lead to DMC.

Kakar (2006) lists the following components of the DMC:

- DMC exists and is on the increase.
- DMC is widespread and present at all stages of the juvenile justice system.
- Some studies attributed overrepresentation to over-involvement in crime.
- Some studies attribute juvenile crime to community risk factors.
- Education and educational resources related to DMC.
- Lack of adequate resources leads to DMC.
- Socioeconomic status and family structure along with the minority status leads to DMC.
- System is biased against minority offenders.
- Causes and mechanisms of DMC are much more complex than just system bias.

Cabaniss, Frabutt, Kendrick, and Arbuckle (2007) review the following best practices for reducing disproportionate minority contact in the juvenile justice system:

- Data review and decision-point mapping
- Cultural competency training
- Increasing community-based detention alternatives
- Reviewing decision-making subjectivity
- Reducing barriers to family involvement
- Cultivating state leadership to legislate system-level change

Juvenile Justice Prevention Programs

Greenwood (2008) articulates that the strongest and most promising school- and community-based interventions must be used before the demands of public safety require a residential/detention placement.

Private prevention programs target the general population of youth and include efforts to prevent smoking, drug use, and teen pregnancy. Secondary prevention programs target youth at elevated risk for a particular outcome, such as delinquency or violence, a group that might include those in disadvantaged neighborhoods, those struggle in school, or those exposed to violence at home.

Greenwood (2008) reports the following principles and promising prevention programs for reducing delinquency and alternatives to detention:

- The first opportunity for prevention is with pregnant teens or at-risk children in early childhood.
- Numerous school- or classroom-based programs have proven effective in preventing drug use, delinquency, anti-social behavior, and early school dropout, all behaviors that can lead to criminal behavior. The programs vary widely in their goals, although they share some common themes: collaborative planning and problem-solving involving teachers, parents, students, community members and administrators; grouping of students into small self-contained clusters; career education; integrated curriculum; and student involvement in rule-setting and enforcement; and various strategies to reduce drop-out.
- Bullying Prevention Program – developed with elementary and junior high school students in Bergen, Norway. It involves teachers and parents in setting and enforcing clear rules against bullying. Two years after the intervention, bullying

problems had declined 50 percent in treated schools. Furthermore, other forms of delinquency declined as well, and school climate improved. The Bully Prevention Program is one of the eleven Blueprints model programs and is listed as promising by the Surgeon General.

- Social-emotional Learning Programs/After-school Programs
- Early Head Start/Head Start
- Multisystemic Therapy
- Functional Family Therapy
- Home-based Treatments
- Faith-based Programs
- Mentoring

Conclusion

Adolescent African American youth should have access to the same services as white youth with substance use and co-morbid disorders, but discrepancies in policy and practice remain prevalent in the delivery of services for this population. It is improbable that adolescent substance abusers with co-occurring disorders will receive the exact treatment and services in detention that address both disorders. The focus for substance abuse administrators, juvenile detention, mental health administrators should be on early prevention, assisting at-risk families, identifying risk factors, strengthening protective factors, and connecting youth to caring and supportive adults, so that their futures are not in being locked up but rather in being productive and contributing adults making a difference in their communities.

REFERENCES

- Abram, K.M. and Teplin, L.A. (1991). Co-occurring Disorders among Mentally Ill Jail Detainees. *American Psychologist*, 46(10), 1036-1045.
- Bilchick, S. (1999). Minorities in the Juvenile Justice System. National Report Series, Juvenile Justice Bulletin, Washington, D.C., U. S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.
- Boyd-Franklin, N. (1991). Culturally Sensitive Treatment of the Inner-city African American Adolescent. A Multisystemic Model. In W. Snyder and T. Ooms (Eds.) *Empowering Families, Helping Adolescents: Family-centered Treatment of Adolescents with Alcohol, Drug Abuse, and Mental Health Problems* (pp. 34-48). Washington, D.C.: U.S. Department of Health and Human Services.
- Cabaniss, E.R., Frabutt, J.M., Kendrick, M.H., and Arbuckle, M.B. (2007). Reducing Disproportionate Minority Contact in the Juvenile Justice System: Promising Practice. *Aggression and Violent Behavior*, 12, 393-401.
- Canino, I., and Spurlock, J. (1994). *Culturally Diverse Children and Adolescents: Assessment, Diagnosis, and Treatment*. New York, NY: Guilford Press.
- Capaldi, D.M. (1992). Co-occurrence of Conduct Problems and Depressive Symptoms

in Early Adolescent Boys: II. A 2-year Follow-up at Grade 8. *Development and Psychopathology*, 4:125-144.

Catalano, R.E., Hawkins, J.D., and Miller, J.Y. (1992). Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention. *Psychological Bulletin*, 112(1), 64-105.

Cleckley, H. (1976). *The Mask of Sanity* (5th Ed.), St. Louis: C.V. Mosby.

Cocozza, J.J. (1997). Identifying the Needs of Juveniles with Co-occurring Disorders. *Corrections Today*, 147-149.

Department of Justice, Office of Juvenile Justice and Delinquency Prevention (1999). Minorities in the Juvenile Justice System, 1999 National Report Series, *Juvenile Justice Bulletin*, Washington, DC: Juvenile Justice Clearinghouse.

Drake, R.E., Mueser, K.T., Clark, R.E., and Wallach, M.A. (1999) The Course, Treatment, and Outcomes of Substance Disorder in Persons with Severe Mental Illness. *American Journal of Orthopsychiatry*, 66(1), 42-51.

Elliott, D.S. (1994). Serious Violent Offenders: Onset, Developmental Course, and Termination: The American Society of Criminology, 1993 Presidential Address,

Criminology, 32, pp. 1-21.

Elliott, D.S., Huizinga, D., and Menard, S. (1989). *Multiple Problem Youth: Delinquency, Drugs, and Mental Health Problems*. New York, NY: Springer.

Fulkerson, J.A., Harrison, P.A., and Beebe, T.J. (1997). Residential Behavioral Treatment Facilities: 1996 Minnesota Student Survey, Rockville, MD: Substance Abuse and Mental Health Services Administration.

Gillespie, T., Wilson, M., and Yearwood, D. (2000). *A Closer Look at Disproportionate Minority Confinement in the North Carolina Juvenile Justice System*. Bulletin. Washington, D.C., U.S. Department of Justice.

Greenbaum, P.E., Foster-Johnson, L., Petrila, A. (1996). Co-occurring Addictive and Mental Disorders among Adolescents. Prevalence Research and Future Directions. *American Journal of Orthopsychiatry*, 66(1), 52-60.

Greenwood, P. (2008). Prevention and Intervention Programs for Juvenile Offenders. *The Future of Children*, 8(2), 185-210.

Gresham, F.M. (2002). Co-morbidity of Conduct Problems and ADHD Identification of Fledgling Psychopaths. *Journal of Emotional and Behavioral Disorders*, 14(2), 1-19.

Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D., and Cunningham,

P.B. (1998). *Multisystemic Treatment of Antisocial Behavior in Children and*

Adolescents. New York, NY: Guilford Press.

Isaacs, M. (1992). Assessing the Mental Health Needs of Children and Adolescents

of Color in the Juvenile Justice System: Overcoming Institutionalized Perceptions

and Barriers. In J. Coccozza (Ed.), *Responding to the Mental Health Needs of*

Youth in the Juvenile Justice System (pp. 141-163) Seattle, WA: National

Coalition for the Mentally Ill in the Criminal Justice System.

Kakar, S. (2006). Understanding the Causes of Disproportionate Minority Contact:

Results of Focus Group Discussions. *Journal of Criminal Justice*, 34(4), 369-381.

Kaminer, Y., & Frances, R.J. (1991). Inpatient Treatment of Adolescents with

Psychiatric and Substance Abuse Disorders, *Hospital and Community*

Psychiatry, 42, 894-896.

Kaminer, Y., and Winters, K.C. (2011). *Clinical Manual of Adolescent Substance*

Abuse Treatment. Washington, DC: American Psychiatric Publishing, Inc.

Kemp, D., and Center, D., (1999). *Troubled Children Grown Up: Antisocial Behavior*

in Young Criminals. Paper presented at 23rd Annual Conference of Teacher

Educators for Children with Behavioral Disorders Conference on Severe Behavior Disorders of Children and Youth, Scottsdale, AZ.

Kessler, R.C., Foster, C.L., Saunder, W.B., and Stang, P.E. (1995). Social Consequences of Psychiatric Disorders. *American Journal of Psychiatry*, 152, 1026-1032.

Loeber, R., Stouthamer-Loeber, M., VanKammen, W.B., and Farmington, D.P. (1991). Initiation, Escalation, and Desistance in Juvenile Offending and their Correlates. *Journal of Criminal Law and Criminology*, 82:36-82.

Lymen, D. (1996). Early Identification of Chronic Offenders: Who is the Fledgling Psychopath? *Psychological Bulletin*, 120, 209-234.

National Center on Addiction and Substance Abuse (CASA) at Columbia University: CASA Analysis of the National Survey on Drug Use and Health (NSDUH). Rockville, MD, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2004a.

Randall, J., Henggeler, S.W., Pickrel, S.G., and Brodino, M.J. (1999). Psychiatric Co-morbidity and the 16-month Trajectory of Substance Abusing and Substance Dependent Juvenile Offenders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(9), 1118-1124.

Rogers, R., Johansen, J., Chang, J.J., and Salekin, R.T. (1997). Predictors of

- Adolescent Psychopathy: Oppositional and Conduct-disordered Symptoms.
Journal of the American Academy of Psychiatry and Law, 25, 261-271.
- Rutter, M. (1990). Psychosocial Resilience and Protective Mechanisms. In A. Rolf, A. Masten, D. Cicchetti, K. Nuechterlein, and S. Weintraub (Eds.), *Risk and Protective Factors in the Development of Psychopathology* (pp. 181-214). New York, NY: Cambridge University Press.
- Simcha-Jagan, O., Langner, T., Gersten, J., and Eisenberg, J. (1975). *Violent and Antisocial Behavior: A Longitudinal Study of Urban Youth (OCD-CB-480)*. Unpublished manuscript, Office of Child Development, Washington, DC.
- Thompson, L.L., Riggs, P.D., Mikulich, S.K., and Crowley, T.J. (1996). Contribution of ADHD Symptoms to Substance Abuse and Delinquency in Conduct Disordered Adolescents. *Journal of Abnormal Child Psychology*, 24, 325-347.
- Tolan, P.H., and Guerra, N.G. (1994). *What Works in Reducing Adolescent Violence: An Empirical Review of the Field*. (Monograph, available from the Center for the Study and Prevention of Violence.) Boulder, CO: University of Colorado.
- Underwood, L.A., and Rawles, P. (2002). Screening and Assessing African American Youth Involved in the Juvenile Justice System: Practical Considerations. *Juvenile Correctional Mental Health Report*, 2(4), 49-50, 56-62.
- Underwood, L.A., Barretti, L., Storms, L.T., Strumolo, N.S. (2004). A Review of Clinical Characteristics and Residential Treatments for Adolescent Delinquents with Mental Health Disorders: A Promising Residential Program. *Trauma, Violence, and Abuse*, 5(3), 199-242.

- Waldron, H.B., Slesnick, N., Peterson, T.R. and Turner, C.W. (2001). Treatment Outcomes for Adolescent Substance Abuse at 4- and 7-Month Assessments. *Journal of Consulting and Clinical Psychology*, 69, 802-813.
- Weinberg, N.Z., Rahdert, E.Q., Colliver, J.D., and Glantz, M.D. (1998). Adolescent Substance Abuse: A Review of the Past 10 Years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 252-261.

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