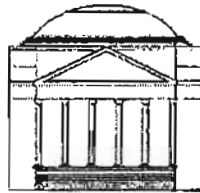


Juvenile Justice Fact Sheet

**SUBSTANCE ABUSE AND DEPENDENCE IN JUVENILE
OFFENDERS**

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Substance abuse presents concerns for juvenile offenders because of the long-term risk of addiction, its association with other physical and mental health disorders, and its relationship to delinquency and conduct disorder behaviors. Substance abuse is also the single strongest risk factor for violent behavior.

PATTERNS OF ABUSE

There is great variability among juveniles in their patterns of abuse, how they begin to abuse substances, and whether or not they progress from experimental use to chronic use or addiction. Much depends on psychosocial factors, psychobiology, and underlying mental illness. Less serious drug abusers tend to follow a distinct pattern of initiation to drugs, usually beginning with alcohol, then extending to experimentation with marijuana and more illicit substances. When asked why they use alcohol, juvenile offenders have reported reasons related to coping with their problems and seeking relief from unpleasant or unmanageable feelings.

In contrast, more serious drug users may use marijuana before alcohol, and other illicit drugs before marijuana. More serious drug use is linked to more serious delinquency, and

certain patterns of drug use tend to be associated with certain types of offenders. Teenagers who use alcohol have a lifestyle of general delinquency, rather than one of specific criminal activity. Adolescents who abuse pills, cocaine or amphetamines are more likely to be violent and commit a greater number of offenses.

RISK FACTORS FOR SUBSTANCE ABUSE

The causes of substance abuse and delinquency are regularly debated, with researchers saying that each causes the other. Risk factors for both substance abuse and delinquency include family and peer influences. Some studies show that juveniles may model alcohol or drug use from parental behavior and that poor parenting skills may contribute to substance abuse. Two generations (parents and grandparents) with alcohol abuse or dependence problems tend to produce greater delinquency at an earlier age and more severe drug abuse. The most recent research suggests that a poor relationship with parents, particularly the father, may be a substantial risk factor for drug abuse. Children whose parents are involved in their lives and who provide positive influences by modeling anti-drug attitudes and behaviors are less likely to abuse substances.

Peer relations can profoundly influence substance abuse and delinquency in juveniles. Greater marijuana use by an adolescents' peer group results in greater drug use, possibly because the adolescent sees other important individuals using drugs. Drug use at younger ages also results in decreased contact with prosocial peers and involvement in desirable activities, and greater contact with delinquent peers engaged in delinquent activities. Early drug use may also be related to personality characteristics of classic psychopathy such as emotional shallowness, lack of empathy and guilty, and interpersonal manipulateness.

There is no consensus among researchers on whether some drugs (like marijuana) are stepping stones for the use of more serious drugs, but there is some research supporting this theory. It is clear, however, that the juveniles most at risk for becoming abusers are those who begin using drugs at an early age (before about age 13).

MULTIPLE DIAGNOSES

Conduct Disorder (CD), Attention Deficit Hyperactivity Disorder (ADHD) and Depression are associated with substance abuse among juvenile offenders and non-offenders alike. The occurrence of multiple diagnoses is high within juvenile offenders who have substance abuse problems. As the number of symptoms of psychopathology increase, so does the severity of alcohol or substance abuse, and adolescents with multiple diagnoses are more likely to abuse multiple substances. Juveniles with serious mental illness are more likely to abuse many different substances in a disorganized pattern of abuse.

Because of the similarity of behaviors seen in substance abuse or dependence and CD and ADHD, it is often difficult to determine exactly what is contributing to delinquent

outcomes. Attentional problems such as ADHD can lead to later delinquency, and boys with ADHD are likely to have more CD symptoms at an earlier age as well as substance dependence, anxiety and depression. However, some studies have found that attention problems do not account for delinquency or substance abuse when other problems (e.g., conduct disorder, low IQ, social disadvantage) are taken into consideration.

Conduct problems may not be accurate predictors of substance abuse or delinquency because many conduct problems are drug-related or mimic the symptoms of substance abuse. After treatment for substance abuse, a diagnosis of conduct disorder may no longer be valid. But if the conduct disorder continues after drug treatment, or predates the substance abuse, then criminal recidivism is more likely to occur.

EFFECTIVE TREATMENTS AND INTERVENTIONS

Treatment for substance abuse in juvenile offenders may be complicated by a lack of available resources. For example, the limitations of evaluation and treatment services in detention facilities may hinder the detection of juveniles with substance abuse problems, resulting in medically risky withdrawal and a lack of preparation to avoid future relapse. Many substance abusing youth are also physically dependent, and detoxification may be necessary. Therefore, it is desirable to have youths evaluated and medically cleared as soon as possible after intake. The development of effective treatment plans requires knowledge of the juvenile's drug abuse patterns, coexisting mental illnesses, and psychosocial characteristics.

Treatment modalities for adolescent substance abuse include inpatient programs, outpatient programs, multisystemic therapy, adventure based residential programs, and behavioral family therapy.

Behavioral family therapy involves teaching other family members to change their reward patterns toward desired and undesired behaviors of the adolescent, to improve cooperation and reduce social acting-out and drug abuse. The premise of the method is that drug abusing adolescents often receive more attention from parents, albeit negative attention, when they are embroiled in substance abuse crises. The method teaches parents to assign basic responsibilities (such as household chores and prosocial behavior) with contingent privileges, including bonuses for superior performance and punishment for inferior performance. Families work together to identify what behaviors the parents desire and what rewards the adolescents prefer. Negotiation skills are taught as part of the process, as well as record-keeping skills to monitor the adolescent's behavior.

Multisystemic therapy (MST) may provide the most effective treatment approach for substance abusing juvenile offenders, as demonstrated by several studies that clearly show impressive results with this population. MST conceptualizes adolescent drug abuse and problem behaviors as a product of several related systems, including home, school, neighborhood, and the larger community. Drug abuse often arises from dysfunctions in these systems. Intervention requires engagement with family members, teachers, social service agencies and others having contact with the adolescent. For further information on MST, see

Henggeler et al. (1996), Pickrel and Henggeler (1996), Pickrel, Hall, and Cunningham (1997), and the MST FACT SHEETS distributed previously.

Adventure based programs have been found to improve social skills, problem-solving abilities, and relapse prevention awareness. Clients are usually given a chance to engage in physically challenging activities that previously seemed impossible or improbable for them to attain, for the purpose of gaining experience in success through the support and encouragement of others. Groups participate in problem-solving activities that require minimal verbal skills for resolution, since substance abusing delinquent adolescents are frequently more skilled in non-verbal problem-solving. This setting provides an opportunity for effective interpersonal interactions with peers and supervisors in a prosocial environment. Some portion of the program includes review of the components of addiction and relapse prevention.

Inpatient treatment would seem to be desirable for young offenders because so many exhibit low motivation to change and poor social functioning, and come from distressed homes. Isolating juveniles from these problems appeals to common sense. But outpatient programs may be more effective, especially when compared to inpatient programs that do not support extensive aftercare planning and programming. However, some juveniles (particularly those with significant physical or psychological dependence) will require detoxification and inpatient treatment in residential programs, followed by intensive outpatient aftercare.

Key elements contribute to program effectiveness. Comprehensive treatment programs providing a range of ongoing services are the most effective. Presenting program material through a medical care venue can provide families with access to services through more familiar and less threatening health care settings. Consistent relationships between staff members and adolescent patients promotes interpersonal skill-building with adults and may facilitate relationships with probation officers. Identifying special needs, such as educational and vocational rehabilitation, may also help families receive support from a variety of community resources.

Treatment dropout for families of substance abusing or dependent juvenile offenders is a persistent problem. Strategies for improving completion rates include earlier acceptance into treatment programs, higher levels of involvement with treatment providers, and concrete program planning. Incorporating these services with multisystemic therapy, including family-directed goal planning, individualized treatment and round-the-clock access to service providers, can be both outcome- and cost-effective, as compared to traditional treatment services.

EFFECTS AND ADDICTION RISKS OF COMMONLY ABUSED SUBSTANCES

SUBSTANCE	ADVERSE EFFECTS	ADDICTION RISK	WITHDRAWAL SYMPTOMS
Alcohol	Motor impairment, blackout, loss of body heat, fetal alcohol syndrome, cirrhosis of liver, kidney damage, heart failure, unconsciousness, and death.	Very high risk for physical and psychological addiction.	Irritability, sleeplessness, tremors, sweating, hallucinations, seizures, delirium, tachycardia, and low-grade fever.
Marijuana	Irritation of throat and lungs, cardiovascular complications, possible damage to immune system, psychomotor impairment.	Potential for addiction depending on frequency and amount of use.	Anxiety, panic, short-term memory loss, thought disturbance, attentional impairment, lapses in attention, depersonalization, mental confusion, paranoia.
Cocaine	Tremors, convulsive movements, respiratory and cardiac failure hallucinations, paranoid delusions; insomnia, weight loss.	Rapidly increasing tolerance; very high risk for psychological addiction.	Desire for drug, irritability, physical exhaustion, severe depression, suicidality.
Opiates (Heroin, Codeine, Morphine, Darvon, Dilaudid, Percodan, Talwin, Methadone, Demerol)	Hepatitis, blood poisoning, dizziness, headache, and possible coma or death.	Very high risk for physical and psychological addiction.	<p>12-24 Hours: Restlessness.</p> <p>24-48 Hours: dilated pupils, anorexia, restlessness, irritability, and tremors.</p> <p>48-72 hours: increasing irritability, insomnia, marked anorexia, yawning, sneezing, weakness, vomiting, diarrhea, chills & hot flashes.</p>

SUBSTANCE	ADVERSE EFFECTS	ADDICTION RISK	WITHDRAWAL SYMPTOMS
Stimulants (Benzedrine, Ritalin, Dexdrine, Ritalin, Methamphetamine, Methadrine, etc.)	Headaches, palpitations, delirium, circulatory collapse, vomiting, paranoia, GI disorders.	Increasing tolerance, high psychological risk, mild physical dependence.	Desire for drug; acute fatigue; severe depression; occasional suicidality.
Hallucinogens (LSD, Mescaline, Psilocybin)	Hallucinations, paranoia, "bad trips," accidental death.	Psychological addiction possible.	
PCP	Anxiety, depression, sporadic outbreaks of violent behavior, and accidental death.	Psychological addiction possible.	
Minor Tranquilizers (Librium, Miltown, Serax, Valium)	Apathy, illogical fears. Fainting, chills, upset stomach, disorientation, blurred vision, insomnia, potentially fatal if taken with alcohol.	Potential for addiction depending on frequency and amount of use.	Anxiety, insomnia, headache, fever, nausea, vomiting, abdominal cramps, sweating, convulsions, possible death.
Sedative-Hypnotics (Barbituates, Nembutal, Seronal, Tuinal)	Dizziness, confusion, nausea, fever, delirium, convulsions.	Potential for addiction depending on frequency and amount of use.	Sweating, insomnia, vomiting, tremors, paranoia, irritability, nightmares, hallucinations and seizures.

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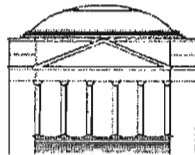
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