Motivational Interviewing With Dually Diagnosed Adolescents in Juvenile Justice Settings

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Recent empirical investigations have gathered data regarding the rates of psychiatric comorbidity within juvenile justice populations. Data from these studies detail the prevalence of risk-taking behavior, substance abuse and dependence, posttraumatic stress disorder, and sexual risk taking. In addition to reviewing these findings, this paper explores the use of motivational interviewing (MI) with adult offenders and adolescent substance users. The efficacy of MI in these areas indicates the potential fit of MI with juvenile justice populations. Although the application of MI with this population is theoretically indicated, research is needed to garner empirical support for this application of MI. [Brief Treatment and Crisis Intervention 6:218–233 (2006)]

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Entry into the juvenile justice system is a significant moment for many children and adolescents as it crystallizes the shift from isolated delinquent acts with friends and peers to more serious involvement with the legal system. For some youth, interactions with the juvenile justice system will not extend beyond their adolescence; for others, the first youth arrest marks the commencement of a lifetime of interface with the legal system. “Teachable moments,” including entry into the emergency room (i.e., Barnett, Monti, & Wood, 2001; Monti et al., 1999; Spirito et al., 2004; Tapert et al., 2003) and into the juvenile justice system, are times during which the negative consequences of specific behaviors may be particularly salient. Amidst the myriad negative aspects of these moments, one of the positive attributes of teachable moments is that they provide an opportunity to intervene, and hopefully to reduce, maladaptive behaviors. This paper explores the prevalent diagnoses of adolescents within juvenile justice settings, as well as outlines a brief intervention, motivational interviewing (MI), that has shown efficacy in reducing disruptive behaviors during teachable moments. In addition, MI is proposed as a potential intervention for some of the concomitant mental health issues of youthful offenders. Although theoretical support is offered for MI, this paper also highlights the need for empirical evaluations of MI in juvenile justice settings.

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**Etiology of Delinquency**

“Juveniles” are all individuals under the age of 18 years (Snyder, 2005). Fortunately, only a small proportion of this population becomes involved in the juvenile justice system. When looking at the trajectory toward risk-taking behaviors and potential juvenile justice system involvement, indications of future aggressive and disruptive behaviors have been found to be apparent as early as age 7 (Farrington & Loeber, 2000; Loeber & Farrington, 2000). Not only do risk-taking behavior and justice involvement frequently co-occur, but children who engage in these behaviors also tend to display several other types of disruptive behavior, including risky substance use or precocious sexual behavior (French & Dishion, 2003; Zuckerman & Kuhlman, 2000). This cluster has been conceptualized as a syndrome of antisocial actions (Donovan, Jessor, & Costa, 1991).

Although these activities may peak and subside after adolescence for many, other youth find themselves on a path toward persistent and frequent offending (Farrington & Loeber, 2000; Loeber & Farrington, 2000). Risk factors for continued criminal involvement include contributions by the various systems in which an adolescent lives. For example, persistent delinquency has been correlated with myriad individual factors (i.e., high impulsiveness, low intelligence), family factors (i.e., poverty, neglectful or abusive parenting, large and/or disrupted families, parental criminality), peer factors (i.e., membership in a deviant peer group), and community factors (i.e., residence in an urban and/or high-crime area) (Farrington & Loeber, 2000).

**The U.S. Juvenile Justice System**

The juvenile justice system in the United States is enormous. During 2003, 2.2 million juveniles were arrested by local law enforcement agencies, representing 16% of all arrests that year (Snyder, 2005). Although a higher percentage of racial and ethnic minorities and lower socioeconomic level tend to be found within the American justice system (Snyder, 2005), in 2003, the racial composition of the American juvenile justice population surprisingly mirrored the general U.S. population (juvenile justice system = 78% Caucasian, 16% African American, 4% Asian American/Pacific Islander, and 1% Native American youth; general U.S. population = 75% Caucasian, 12% African American, 4% Asian American/Pacific Islander, and 1% Native American; Snyder, 2005; United States Census Bureau, 2000, respectively). However, upon closer inspection, the rates support differing arrest rates. According to Snyder (2005), police arrested African American juveniles at twice the rate of Caucasian and Native American juveniles for property crimes and at four times the rate of Asian American juveniles. Similarly, police arrested African American juveniles at four times the rate of Caucasian and Native American youth for violent crimes and eight times the rate of Asian American youth.

In addition to ethnic differences, the gender differences that have historically existed within the juvenile justice populations are decreasing. Even though there are still a significantly lower percentage of females in the juvenile justice population (females = 29%, males = 71%), since 1994, police have been arresting females at increased rates for simple assault; violations involving driving, alcohol, and other drug abuse; and disorderly conduct (Snyder, 2005). Snyder (2005) noted that the increase (or lack of a decrease) of female-propagated crimes was evident in juvenile and adult justice populations, indicating that the societal factors driving this phenomenon are not unique by age group.

Once arrested, juveniles may have one of several outcomes. In 2003, 20% of the arrests were contained within law enforcement agencies, 71% were processed within juvenile court, and 7% were referred to criminal court (Snyder,
Despite the decline in juvenile arrest rates, court referrals have increased by 13% during the past 23 years (Snyder, 2005).

Mental Health and Risk-Taking Behavior Within the U.S. Juvenile Justice System

Although the overall rates of juvenile crimes have been decreasing, the last decade witnessed a 19% increase in drug abuse violations (Snyder, 2005). The correlates of drug use are also evident in the mental health issues of the juvenile justice population. Abram, Teplin, McClelland, and colleagues recently completed a large-scale survey of the rates of mental disorders as classified by the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev. [DSM-III-R], American Psychiatric Association [APA], 1987, DSM-IV, 1994, DSM-IV-TR, 2000), derived from a sample of youth aged 10–18 years old interviewed within 2 days of intake at the Cook County (Chicago) Juvenile Temporary Detention Center.

Prevalence of DSM Diagnoses

Within this sample, Abram, Teplin, McClelland, and Dulcan (2003) examined the prevalence of DSM-III-R diagnoses (APA, DSM-III-R, 1987), including major depression, dysthymia, mania, psychotic disorder, panic, separation anxiety, obsessive-compulsive disorder, attention-deficit/hyperactivity disorder (ADHD), conduct disorder (CD), oppositional defiant disorder, and substance-use disorders (SUDs). They found that the minority of juveniles met the diagnostic criteria for one disorder (females = 17%, males = 20%), whereas the majority met the diagnostic criteria for at least two disorders (females = 57%, males = 46%). In a previous study, these researchers found that the most prevalent disorders among male and female juveniles were SUD (females = 47%, males = 51%) and disruptive behavior disorder (i.e., oppositional defiant disorder and CD [females = 46%, males = 41%; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002]). Similarly, in their most recent study, Abram et al. (2003) found that most of the individuals in their sample met the diagnostic criteria for an SUD and a disruptive behavior disorder or ADHD. Interestingly, when compared with the juveniles who did not meet the diagnostic criteria for a major mental disorder (defined by the authors as psychosis, mania, or a major depressive episode), juveniles with a major mental disorder had significantly greater odds (1.8–4.1) of having a co-occurring SUD (Abram et al., 2003).

Even after excluding SUD and disruptive behavior disorder, 34% of female and 24% of male juveniles still met diagnostic criteria for two or more disorders (Abram et al., 2003). These disorders included affective disorders (females = 28%, males = 19%), anxiety disorders (females = 31%, males = 21%), ADHD (females = 21%, males = 17%), and psychotic disorders (females = 1%, males = 1%; Teplin et al., 2002).

Independent of the Chicago research group, the Patterns of Youth Mental Health Care in Public Services System study, which includes Garland, Aarons and colleagues, has been evaluating 1,715 youth (ages 6–17) in five sectors of San Diego public care. Those sectors include alcohol and drug services, child welfare, juvenile justice, mental health services, and public school services for youth with serious emotional disturbance. Within this sample, Garland et al. (2001) found similar rates of DSM-IV diagnoses as found in the Chicago studies. Across their juvenile justice system, 52% of their sample met diagnostic criteria for one or more disorders. Specifically, 30% of their sample met the diagnostic criteria for CD, 15% for oppositional defiant disorder, 13% for ADHD, 9% for anxiety disorders (separation anxiety = 4%, posttraumatic stress disorder [PTSD] = 3%), and 7% for mood disorders (major depression = 5%; Garland et al., 2001).
**Substance Abuse and Dependence**

To understand the prevalence of substance use within this sample, McClelland, Elkington, Teplin, and Abram (2004) examined further the manifestation of related diagnoses. As measured by the Diagnostic Interview Schedule for Children, version 2.3 (DISC version 2.3), youth reported relatively low rates of substance abuse (less than 1% to 6%) and high rates of substance dependence (2%–38%) during the 6 months prior to intake. In their sample of over 1,700 youth, when the authors combined abuse and dependence into the broader category of SUDs, 50% of males and 45% of females met diagnostic criteria for at least one SUD. In addition, 20% of males and females had two or more SUDs. Although the prevailing SUDs were marijuana abuse and dependence, alcohol use was not far behind. Approximately 40% of the sample reported both alcohol and marijuana SUDs.

In collaboration with the San Diego public sector study, Aarons, Brown, Hough, Garland, and Wood (2001) investigated the prevalence of substance use in a juvenile justice sample, finding similar rates of SUDs to those reported in the McClelland et al. (2004) sample. In the Aarons et al. (2001) sample, 62% of the youth met DSM-IV diagnostic criteria for any SUD during their lifetime, whereas only 37% met diagnostic criteria for SUDs during the past year. Similar to the findings of McClelland et al., Aarons et al. found that most justice system juveniles were using marijuana (lifetime prevalence = 45%, past year prevalence = 15%) and alcohol (lifetime prevalence = 49%, past year prevalence = 28%). Aarons et al. found much lower rates for the use of amphetamines (lifetime = 23%, past year = 10%), hallucinogens (lifetime = 9%, past year = 3%), cocaine (lifetime = 2%, past year ≤ 1%), and opiates (lifetime ≤ 1%, past year ≤ 1%).

**Posttraumatic Stress Disorder**

Abram et al. (2004) also investigated the prevalence of (PTSD within the Cook County Temporary Juvenile Detention Center. They found that the vast majority of the sample had experienced at least one trauma (93%). Traumas included, but were not limited to, “having seen or heard someone get hurt very badly or be killed” (reported by 75% of males and 64% of females), having been “threatened with a weapon” (reported by 59% of males and 47% of females), or having been in a situation where “you thought you or someone close to you was going to be hurt very badly or die” (reported by 54% of males and 49% of females). Despite the high frequency of traumatic incidents ($M = 15$, $Mdn = 6$), the rate of PTSD in this sample was a mere 11%. The authors found no significant age or gender differences in the prevalence of PTSD diagnoses.

**Sexual Risk-Taking Behavior**

Along with substance use and externalizing behaviors, sexual risk-taking behavior is often seen as another component in the cluster of delinquent behavior. Although it is not diagnosable within the DSM, risky sexual behavior is clinically significant due to its serious health implications. Through the self-report instruments of the AIDS Risk Behavior Assessment and items from the DISC version 2.3, Teplin, Mericle, McClelland, and Abram (2003) examined the sexual behavior of the Chicago youth. Across ages, the majority of the youth were sexually active (females = 87%, males = 91%). Most males (61%) and a quarter of the females (26%) reported having had more than one sexual partner within the past 3 months (Teplin et al., 2003). In addition, over 95% of this sample engaged in at least 3 and 65% in at least 10 HIV/AIDS-related risk behaviors (i.e., unprotected vaginal or anal sex, vaginal or
anal sex with a high-risk partner; Teplin et al., 2003).

**Age Considerations**

Throughout these studies, clear differences between the younger (age 13 and under) and older (age 14 and older) youth emerged. As can be predicted by increasing age and experience, older youth reported symptoms consonant with higher rates of DSM diagnoses (Teplin et al., 2002), more traumatic events (Abram et al., 2004), greater sexual activity, and risky sexual behavior, such as unprotected sex (Teplin et al., 2003).

**Gender Considerations**

In addition, several gender differences became apparent. Significantly more females than males met diagnostic criteria for DSM-III-R disorders (Teplin et al., 2002), even after excluding SUD and CD (met criteria for two or more disorders: females = 34%, males = 24%; Abram et al., 2003). Within the PTSD study, significantly more males (93%) than females (84%) reported traumatic experiences (Abram et al., 2004). In addition, the qualitative nature of the traumatic events was different whereby males more frequently experienced “having been in a bad accident” and females more frequently reported having been “forced to do something sexual that you did not want to do” (Abram et al., 2004). In addition, Teplin et al. (2003) found that significantly more males engaged in sexual risk-taking behaviors, including having more than three partners within the past 3 months (females = 5%, males = 37%) and having sex when drunk or high (females = 52%, males = 68%). In contrast, males and females reported equal rates of unprotected intercourse, when sober, drunk, or high (sober: females = 41%, males = 35%; drunk/high: females = 33%, males = 33%) (Teplin et al., 2003). Together, these data indicate that whereas females reported greater overall mental health concerns, males experienced more traumatic events and sexual risk-taking behavior. Interestingly, the rates of PTSD and unprotected sex did not differ by gender.

**Racial/Ethnic Considerations**

Throughout these studies, there were also multiple racial and ethnic differences. Caucasian juveniles reported the highest rates of psychiatric comorbidity, whereas African American juveniles reported the lowest (Abram et al., 2003). In addition, within this sample, more Caucasian and Hispanic than African American juveniles (particularly females) met diagnostic criteria for one or more SUDs (Abram et al., 2003; McClelland et al., 2004). In contrast with African American youth, Caucasian and Hispanic youth reported higher use of illicit drugs other than marijuana (McClelland et al., 2004).

In addition, racial and ethnic differences emerged in the types and rates of traumatic experiences. Specifically, Caucasian males and Hispanic females were more likely to have experienced actual and threatened violence (Abram et al., 2004). Yet, African American males reported having witnessed more violence than Caucasian males (Abram et al., 2004). However, the discrepant experiences did not manifest into significantly different rates of PTSD (Abram et al., 2004). Teplin et al. (2002) summarized their paradoxical finding that although most of the juveniles in the justice system are from minority cultures, Caucasian juveniles had the highest rates of the DSM disorders reported. Teplin et al. posit that on average, Caucasian youth in the justice system may have greater psychological difficulties than minority youth.

**Potential Intervention: MI**

Abilities, skills, and psychosocial functioning continue to develop throughout adolescence
(Schulenberg & Maggs, 2002). Although some juveniles demonstrate responsibility and emotional maturity in employment or academics, many operate in ways that are consistent with middle childhood. Specifically, executive functioning generally develops during early to late 20s, leaving many adolescents to function with relatively immature forms of reasoning, impulse control, and planning (Cicchetti & Rogosch, 2002). Unfortunately, not all juveniles will develop mature reasoning, impulse control, and planning capacities. However, there are therapeutic approaches and interventions, such as MI that may be flexible enough for work with this range of adolescent ability and functioning. Specifically, throughout the theoretical literature, MI has been posited as a potentially effective approach for use with children and adolescents (in general with child and adolescent clients: Baer & Peterson, 2002; DiGiuseppe, Linscott, & Jilton, 1996; Miller & Sanchez, 1994; in pediatric practice: Sindelar, Abrantes, Hart, Lewander, & Spirito, in press; with respect to decreasing substance use and related risks with children and adolescents: Baer, Peterson, & Wells, 2004; Breslin, Li, Sdao-Jarvie, Tupker, & Ittig-Deland, 2002; Colby, Lee, Lewis-Esquerre, Esposito-Smythers, & Monti, 2004; D’Amico & Fromme, 2000; Dishion, Kavanagh, Schneiger, Nelson, & Kaufman, 2002; Hawkins, Cummins, & Marlatt, 2004; Masterman & Kelly, 2003; Myers, Brown, & Kelly, 2000; Myers, Brown, & Vik, 1998; Rivers, Greenbaum, & Goldberg, 2001; Waldron & Kaminer, 2004; Winters, 1999; with late adolescent and college students: Barnett et al., 2004; Larimer & Cronce, 2002; Neal & Carey, 2004; Saunders, Kypri, Walters, Laforge, & Larimer, 2004; Tevyaw & Monti, 2004; with respect to safer sexual behavior: Brown & Lourie, 2001; Cowley, Farley, & Beamis, 2002; in school settings: Lambie, 2004; in juvenile justice settings: Coll, Juhnke, Thobro, & Haas, 2003).

The Spirit of MI

Ambivalence is the state in which a person feels two ways about something. Ambivalence is believed to play a role in most psychological difficulties (Miller & Rollnick, 2002). Rather that interpreting ambivalence as “wishy-washy” or pathological, MI hinges on addressing and resolving ambivalence, which is believed to help move a person toward change (Miller & Rollnick, 2002).

In contrast to communication styles that elicit client resistance, MI operates through client and practitioner collaboration (Miller & Rollnick, 2002). MI’s guiding approach draws upon clients’ inherent desire and ability to move toward change (Miller & Rollnick, 2002). As defined by its developers, MI is a “client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller & Rollnick, 2002, p. 25). More than a set of techniques, MI is a “style of being with people.” This style involves exploring ambivalence about a target behavior by examining an individual’s relevant values, interests, and concerns (Miller & Rollnick, 2002).

Although developed 2 decades ago, the foundational beliefs of MI are supported by 3 decades of research. Specifically, in the early 1970s, Truax and colleagues found that certain therapist characteristics, such as openness, genuineness, and empathy facilitated therapeutic gain with juvenile delinquent clients (Truax, 1971; Truax, Wargo, & Volksdorf, 1970). Moreover, they found that less collaborative efforts, such as persuasion, did not promote change with this same population (Truax & Lister, 1970). Replicated across demographic categories, confrontational practitioner behaviors have been found to decrease collaboration and increase resistance (DiCicco, Unterberger, & Mack, 1978; Miller, Benefield, & Tonigan, 1993; Miller & Wilbourne, 2002; Patterson & Forgatch, 1985). MI emerged from the research indicating that
confrontation, education, and authority elicit client resistance, whereas collaboration, evocation, and autonomy facilitate therapeutic alliance and foster an environment ready for positive change (Miller & Rollnick, 2002).

Specifically from these data, the foundation approaches of MI have been established as empathy, development of discrepancy, “rolling with resistance,” and support of self-efficacy. Consonant with the work of Rogers (1980), empathy within MI (Miller & Sanchez, 1994) is the skillful and deliberate ability to convey a sense of being present, as well as an understanding of the client’s words, emotions, and underlying meaning.

In addition to providing a genuine expression of empathy, MI practitioners help their clients develop discrepancy between their current behavior and their treatment goal, by supporting the client’s self-efficacy and inherent abilities and without being distracted by resistance (referred to as “rolling with resistance”) (Miller & Rollnick, 2002). Through reflective and empathic listening, the practitioner conveys a sense of collaboration with the client, through acceptance, understanding of ambivalence, and ultimate support of their autonomy to change or not change (Miller & Rollnick, 2002).

Review of Related Research

The vast majority of research regarding MI, as well as other empirically validated approaches, has been conducted with adult samples. Due to the paucity of research on effective treatments with adolescents (DiGiuseppe et al., 1996), many practitioners have had to rely on a combination of non-empirically based approaches, personal, and professional experience to guide their interactions with juveniles in the justice system. Although some of the anecdotal and descriptive literature on therapeutic work with adolescents supports the use of methods that resemble MI, empirical research remains necessary to determine the fit of MI with juvenile justice settings.

With juvenile samples, the areas with the most empirical support include interventions targeting the use of tobacco, alcohol, marijuana, and polysubstance use. Although the majority of the following studies report extensive training of their practitioners in MI techniques and spirit, no practitioner training measures such as the Motivational Interviewing Skill Code or treatment fidelity measures (such as the Motivational Interviewing Treatment Integrity Manual) were reported. As a result, it is difficult to determine whether the practitioners assigned to use MI employed “true” MI or adaptations such as techniques or components of MI but not the full approach (i.e., using reflective listening and open questions but without being directive, using importance and confidence rulers but being confrontational; Rollnick & Miller, 1995).

Tobacco Use

Many youth believe that substance use is normative and henceforth find it neither necessary nor desirable to cease (Lawendowski, 1998). If an adolescent smoker does not wish to change his/her smoking behavior, then it is important to attend to the client’s position. Rollnick and Miller (1995) posit that intervening in a manner that moves ahead of the client is likely to increase the client’s resistance to treatment. Thus, with overt risk behaviors like smoking, it may be tempting for practitioners to highlight the potential risks of the behavior (e.g., “Don’t you know how dangerous smoking is?”). Yet lecturing about the potential harmfulness of smoking to adolescent smokers is unlikely to be an effective intervention and may even produce iatrogenic effects. In contrast, MI requires attending to the client’s statements, reinforcing their self-efficacy and autonomy, and collaboratively exploring the
pros and cons of the behavior (Rollnick & Miller, 1995).

As a brief intervention for adolescent smoking as administered in inpatient units and emergency departments, MI has shown small effects (Brown et al., 2003; Colby et al., 1998; Colby, Monti, & Tevyaw, 2005) in comparison with brief advice. However, the reduction of tobacco use in the MI condition has rarely yielded statistically significant findings (Brown et al., 2003; Colby et al., 1998). However, youth who have received MI focused on their smoking have reported greater ambivalence about their smoking and greater self-efficacy in their ability to quit (Brown et al., 2003), as well as higher abstinence rates (Colby et al., 2005). However, some of these differences have not been supported by biochemical assays (Colby et al., 2005).

Alcohol Use

As most juveniles do not self-refer for alcohol treatment (Tevyaw & Monti, 2004), they are a distinctly different group than the adult samples who seek treatment. However, many adolescent alcohol problems are likely to emerge in other settings (Tevyaw & Monti, 2004), such as closed custody settings. Commonly referred to as opportunities or “teachable moments,” entry into the justice system may provide an opportunity for intervention with adolescent alcohol use.

In another teachable setting, the team of researchers at Brown University has researched the effectiveness of MI in reducing alcohol use with adolescents (aged 13–19) receiving emergency health services (Barnett et al., 2001; Monti et al., 1999; Spirito et al., 2004; Tapert et al., 2003). With their late adolescent sample (aged 18–19), their studies have found that patients who received both MI and standard hospital care display reductions in alcohol use (Barnett et al., 2001; Monti et al., 1999).

However, at a 6-month follow-up, the MI recipients demonstrated significantly greater reductions in alcohol risk behavior, including decreased episodes of drinking and driving, lower levels of alcohol-related injuries, and fewer alcohol-related problems (i.e., with parents, friends, police, and school). Unfortunately, those same differences were not found within the younger adolescents (aged 13–17; Barnett et al., 2001; Spirito et al., 2004). However, the authors posit that the more attentive (and less harried) standard of care in the pediatric versus adult emergency room may have obscured treatment effects (Barnett et al., 2001). In addition, Spirito et al. (2004) suggest that in order to effect change in alcohol-related behaviors with younger adolescents, it may be integral to involve the child’s parents. Spirito et al. hypothesize that increasing parental communication and monitoring may be the best way to achieve alcohol use reduction with younger clients.

Marijuana and Polysubstance Use

Currently there are several new areas in which the efficacy and effectiveness of MI is being evaluated. This includes emergent prevention and intervention programs for marijuana use and polysubstance use (Dennis et al., 2002; Diamond et al., 2002; Doyle, Swan, & Roffman, 2003; McCambridge & Strang, 2004a, 2004b, 2004c; Stephens, Roffman, & Fearer, 2004).

With a sample of 16 through 20 year olds engaged in polysubstance use (i.e., alcohol, tobacco, and marijuana), McCambridge and Strang (2004c) found harm-reduction effects with MI. Given the choice of which substances they preferred to discuss during their MI, participants most frequently discussed their marijuana use. This drug also demonstrated the most impressive effect size (Strang & McCambridge, 2004). Rather than choosing abstinence as their goal, adolescent participants
who received MI moderated their substance use. The result was a significant decrease in use. As the authors indicate, the true benefit of MI is that it has been efficacious in initiating substance-use reduction with traditionally unreachable adolescent populations (McCambridge & Strang, 2003, 2004c).

In their large, randomized controlled trial comparing short-term (90 days or less) outpatient treatments, including the MI-based therapy, Motivational Enhancement Therapy (MET) with Cognitive Behavioral Therapy, Family Support Network, the Adolescent Community Reinforcement Approach, and Multidimensional Family Therapy with mid-adolescent, predominantly Caucasian male marijuana users, Dennis et al. (2004) found that all five treatments demonstrated effectiveness. Specifically, adolescents receiving all forms of therapy increased days of abstinence during the following 12 months, though effect sizes were small (Dennis et al., 2004). A combination of MET with CBT (MET/CBT5 and MET/CBT12, meaning with 5 or 12 sessions of CBT) and Adolescent Community Reinforcement Approach emerged as the most cost-effective brief interventions.

Summary of MI Approaches With Adolescent Samples

In comparison with the extensive research evaluating MI and brief interventions with adults, there have been fewer studies with adolescents. However, this is becoming an increasingly prolific field. Specifically, several U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration grants have included explorations of the efficacy of MI with adolescent risk populations, including but not limited to the Arizona Practice Improvement Collaborative, North Carolina Practice Improvement Collaborative, Oregon Practice Improvement Collaborative (www.csat.samhsa.gov), the Increasing Treatment Access and Retention in New Orleans, and the Linkage Interaction Knowledge Exchange Project (www.samhsa.gov). Until the publication of the results of the projects underway, several studies (i.e., Brown et al., 2003; Larimer & Cronce, 2002; Tevyaw & Monti, 2004) provide preliminary data that support MI’s ability to affect positive change with adolescents, possibly due to MI’s fit with the developmental stage of adolescence. As a supportive, flexible, idiographic, brief, and autonomy-based intervention, MI overlaps well with adolescents’ individual needs, competing attentional demands, developing identities, and desire to assert independence (Berg-Smith et al., 1999; Channon, Smith, & Gregory, 2003), possibly catalyzing maturation and development (Tevyaw & Monti, 2004).

MI in Adult Justice Settings

Aside from overlapping well with the needs of adolescents, MI has also been recommended for use with adult criminal justice clients. Like their juvenile counterparts, adult offenders show high rates of substance abuse and dependence and other DSM disorders. Moreover, many adult offenders also exhibit deficits in executive functioning, critical reasoning, and impulse control. In fact, Andrews and Bonta (2003) discussed antisocial cognitions and personality (e.g., self-control deficits), parenting practices, substance abuse, and intelligence in their coverage of the “Big Eight” predictors of recidivism, which overlap with the etiological factors of juvenile delinquency. As many parallels exist between the juvenile and adult offender populations, the evidence supporting the use of MI with adult offenders is informative.

Although comprised primarily of nonoffenders, Project MATCH Research Group (1993) provides evidence that indicates the potential fit of MI with juvenile and adult justice clients.
A multisite comparison of Twelve-Step Facilitation, Cognitive Behavioral Therapy, and MET (MI with the provision of feedback; U.S. Department of Health and Human Services, 1995), Project MATCH explored potential “fits” between client characteristics and alcohol treatment. Findings indicated that outpatients with high anger ratings had better posttreatment drinking outcomes following MET (Project MATCH Research Group, 1997). Mattson (1998) cited the nonconfrontational nature of MET as a potential source of success with angry individuals. As adult and juvenile forensic clients frequently display anger, the efficacy of using MET (and likely MI) with angry clients is highly relevant.

MI has been used with adult offenders, but its history in this capacity is brief and its use is sparse. Much of the literature in this area consists of recommendations rather than empirical research. For example, McMurran and Hollin (1993) suggest using MI with alcohol-abusing young offenders. In addition, Annis and Chan (1983) question the value of highly intensive and confrontational group treatment for substance-abusing offenders.

Similar recommendations exist for treating sexual offenders (e.g., Garland & Dougher, 1991; Kear-Colwell & Pollock, 1997). The field was brought a step closer toward implementing MI-based interventions with the work of the National Organization for the Treatment of Abusers (Mann, 1996). This group developed a practice manual guiding the use of MI in the assessment and treatment of sexual offenders. Moreover, Mann and Rollnick (1996), in their case study of a sexual offender who believed that he was innocent despite his conviction of sexual assault, also support the MI approach. Focusing on assessment alone, Mann, Ginsburg, and Weekes (2002) discuss the use of MI in collaborative risk assessment. Across assessment and treatment approaches, MI may help change a potentially adversarial forum into a more active, meaningful, and pleasant experience for the offender.

Moving from sexual offending and assessment, Ginsburg, Mann, Rotgers, and Weekes (2002) provide a review of the use of MI with substance abuse. Overall, they found that research findings have been mixed. Although some studies have found modest results favoring the use of MI, others have not yielded significant differences between MI and other approaches. Methodological factors such as insufficient statistical power, questionable practitioner expertise, and treatment fidelity may explain some of the findings. However, clearly, more research is needed prior to drawing definitive conclusions.

For practitioners interested in clinical applications of MI, Jamieson, Beals, Lalonde and Associates, Inc. (2000) provide a curriculum for delivering an “MI friendly” group intervention to substance-abusing offenders. Moreover, Ginsburg, Farbring, and Forsberg (in press) discuss a protocol used in the Swedish criminal justice system. This protocol includes multisession individual intervention, based heavily on the spirit and techniques of MI. In addition, MI and relevant adaptations have been built into correctional treatment programs targeting other mandated clients (e.g., Lincourt, Kuettel, & Bombardier, 2002).

In recent years, a major thrust has been directed toward delivering large-scale MI training initiatives to program delivery staff and probation and parole personnel in various jurisdictions in Canada, the United States, Britain, and Sweden. Organizational change might be an even greater challenge than changing behavior at the client or micro level. However, it is a foundational step toward realizing the potential efficacy of MI with adult and juvenile clients. In the context of managing sexual offenders within the criminal justice system, Birgden (2004) addresses this organizational challenge by advocating for the use of
motivational techniques (including MI) by legal and correctional practitioners to maximize the therapeutic effects of the law. This “therapeutic jurisprudence” minimizes the antitherapeutic consequences of the law.

Working with adult offenders has also taught us that any effort to intervene early, thereby disrupting a possible trajectory toward lifelong criminal conduct and recidivism, is important. Despite treatment approaches that may work with adult samples, prevention and early treatment strategies effective with juveniles may yield the most psychosocially valuable results.

Conclusion

Children and adolescents involved in the juvenile justice system are faced with multiple challenges, including meeting criteria for one (and frequently several) mental health diagnosis. Although possible brief interventions for some of these diagnoses remain to be explored (i.e., brief interventions for PTSD), there is evidence indicating the efficacy of a brief (one to three sessions) MI intervention in reducing adolescent substance use. Four points indicate support for the adaptation of MI to juvenile justice setting. First, the research indicates robust support for MI’s ability to help adolescents reduce their marijuana use, which is the most predominant substance used within the juvenile justice population. Second, during a brief MI session administered upon entry into emergency rooms, MI has demonstrated efficacy in reducing other substance use, as well as in increasing feelings of self-efficacy. This finding provides support for using MI during the teachable moment of entry into the juvenile justice system. Third, MI has shown promise as an intervention with adult offender populations, indicating its probable efficacy with a comparable, although younger, population. Fourth, MI appears to be an appropriate developmental match for adolescents, overlapping well with adolescents’ cognitive and emotional abilities and limitations.

MI provides an excellent theoretical match with juvenile justice populations. However, rigorous empirical evaluations are needed in order to evaluate the efficacy of this intervention with juvenile justice populations. Finally, although early intervention with adolescent clients is not prevention, it does provide the opportunity to alter what could be a trajectory toward more persistent and longer term adult offending.

Acknowledgment

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References


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