IMPROVING RESULTS:

Guidance for the Collaboration of Criminal Justice and Substance Abuse Treatment Services

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Prepared by
Alice Dickow, M.A.

With Assistance from Denna Vandersloot, M.Ed.
and Mid-Valley Behavioral Care Network
Criminal Justice/Substance Abuse
Collaboration Group

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Criminal Justice / Substance Abuse Collaboration Group

The CJ/SA Collaboration Group comprised of substance abuse and criminal justice staff guided these efforts. This document benefited from the participation of:

Ric Bergey – Director, Linn County Parole & Probation

Sue Blayre – Marion County Sheriff's Office, Parole & Probation

Shawn Clarke - Workforce Development Manager, Oregon Addictions and Mental Health Division

Trish Davis – Director, Bridgeway/Cascadia Behavioral Health

Tony Howell -Program Manager, Linn County Alcohol & Drug Treatment Program

Bonnie Malek – Community and Provider Services, Marion County Health Department

Bob Miller - Evidence-Based Practices Manager, Oregon Addictions and Mental Health Division

Paul Potter - Vice-President, Organizational Development, Cascadia Behavioral Health

CJ Reid - Policy & Program Development Specialist, Oregon Addictions and Mental Health Division

Jim Russell - Executive Manager, Mid-Valley Behavioral Care Network

Barbara Seatter -Vice President, Addictions Treatment Services Cascadia Behavioral Health

Richard Sly – Director, Yamhill County Community Corrections

Keith Urban – Manager, Yamhill County Chemical Dependency Services
County Chemical Dependency Services

EXECUTIVE SUMMARY

BACKGROUND

The initial impetus for this document came as a result of the Mid Valley Behavioral Care Network (MVBCN), on behalf of the members of both criminal justice and substance abuse agencies, convening the Criminal Justice / Substance Abuse Collaboration Group in the summer of 2005. The Criminal Justice/Substance Abuse Collaboration Group had identified the need for additional dialogue and clarification around evidence based practice implementation as it is understood across various systems. The result was a systematic inquiry to fully explore the issues and challenges related to implementing evidenced based practices. This inquiry resulted in the development of a variety of recommendations to address these issues that could be implemented at the local level.

METHODS

Using focus groups and interviews, questions were developed to assess how key informants from each system perceived the issues related to working with the other system and/or working with substance using offenders. Responses were merged into three overarching categories: 1) Communication; 2) Continuum of Care and Transition and; 3) Evidence Based Practices. These categories were selected as they seemed to provide the clearest way to view the issues, challenges and opportunities that the key informants were facing. As such, they represent the issues which are currently of greatest concern for the respondents.

SUMMARY OF RECOMMENDATIONS

Communication and Information Management

Information management is critical to effectively supervising and delivering services to this population. Basic information gathered about the offender should follow him/her through all aspects of the system, while civil liberties and confidentiality laws must be considered whenever information is shared.

Procedures to improve information flow, some of which have received national support through SAMHSA (2005) include:

1. Ensure that information flows in both directions: from treatment providers to criminal justice staff, and from criminal justice staff to treatment providers.
2. Increase awareness and sensitivity to the confidentiality requirements and political concerns of criminal justice agencies and treatment providers.
3. Provide opportunities for cross discipline/cross system trainings.
4. Utilize liaisons from each system to coordinate information flow.
5. Use local Memorandums of Agreement (MOA) to establish clear roles and procedures and address the topics above.
6. Seek to further automate data sharing by either using existing information systems or purchasing new ones that would allow for timely collection and reporting of information.
7. Implement regular quality control procedures to maximize completeness, accuracy, and consistency of data.
8. Establish consistent definitions of the data/information elements between the participating agencies.

Continuum of Care/Transitional Planning

Length of stay in treatment has been found to be a critical variable in reducing recidivism and substance abuse. Providing for a continuum of care is one systemic process to increase the length of time in treatment by having offenders participate in different phases of treatment. The concept of a continuum extends the length of treatment while adjusting the intensity of the services based on the progress of the client. To achieve a seamless continuum, the following are recommended:

1. Development of appropriate policies and procedures.
2. Develop a universally accepted definition of aftercare and its components.
3. Improve case management for offenders.
4. Improve job training/readiness services for offenders in the community.
5. Explore ways to improve access to safe, affordable housing for offenders
6. Place an increased emphasis on providing life skill development for offenders in the community
7. Provide training for criminal justice personnel on the patient placement criteria (developed by the American Society of Addiction Medicine, ASAM)
8. Increase the availability of peer recovery/mentoring programs

Evidence Based Practice

The original question proposed by the Collaboration Group in regards to evidence-based practices was how do we integrate Department of Correction's (DOC) evidence-based practices with Addiction and Mental Health Division's (AMH) evidence-based practices (EBPs). While several state and national initiatives have succeeded in pushing the criminal justice and substance abuse treatment systems forward in moving towards the use of evidence-based practices, significant challenges and barriers remain. To address these challenges it is recommended that:

1. Treatment providers should select AMH approved practices that have been shown to be effective with offenders.
2. Provide appropriate cross trainings between systems to assist treatment clinicians and probation officers in developing an understanding of each others concepts and/or practices.
3. Follow the recommendations from the DOC and AMH EBP agreement.
4. Successful implementation and adoption of evidence-based practices such as Motivational Interviewing and Cognitive Behavioral Therapy require on-going training, coaching and clinical supervision.
5. When selecting an evidence-based practice use a change process that examines the needs of the agency and customers to determine the best fit for the program.

OTHER RECOMMENDATIONS AND FINDINGS

The report also addresses the issue of workforce development. Advancing the implementation of evidence based principles for criminal justice supervision and substance abuse treatment of offenders requires concurrent changes in policies and procedures, and operational standards. Changes in hiring, training, and performance measurement will, over time, produce a critical mass of employees and staff well versed in the "new" system and ways of doing things. All systems and policies must be consistent with and supportive of the new way of doing business. Policies for recruitment and hiring, training, job descriptions, performance measurement, promotional decisions, and reward systems must be aligned with the new model and this alignment must be reinforced throughout the system in written documents and practice.

In addition, the strongest recommendation made is to encourage members of the Collaboration Group to convene cross-system, collaborative brainstorming meetings and creative problem solving sessions designed to fully explore the issues and recommendations made in this document.

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INTRODUCTION

The intent of this document is to provide guidance as to how the collaborative relationship between the substance abuse and criminal justice systems might be improved and strengthened. The initial impetus for this document came as a result of the Mid Valley Behavioral Care Network (MVBCN), on behalf of the members of both criminal justice and substance abuse agencies, convening the Criminal Justice / Substance Abuse Collaboration Group (henceforth known as the "Collaboration Group") in the summer of 2005. The Collaboration Group had identified the need for additional dialogue and clarification around evidence based practice implementation as it is understood across various systems. However, after further discussion it became apparent that while evidence based practices are an area of considerable focus of the two systems; it would be insufficient to focus exclusively on this area. The Collaboration Group felt that the benefit of these discussions could be extended to a broader audience by this document.

This assumption was confirmed as more information was gathered to develop this document. The issues that

emerged in the data collection conducted for the development of this document identified collaboration and communication across systems, evidence-based practices, and organizational change as being the three key issues essential to improving the ability of the two systems to work together effectively. A review of the literature indicated that currently, no suitable model representing this process of systems integration existed within the substance abuse field. While the substance abuse field has done extensive work documenting the integration with mental health services, with the exception of drug courts, little has been produced with regard to the criminal justice system. Therefore, one must look to the criminal justice system to provide a useful framework for discussing the Collaborative Group's work.

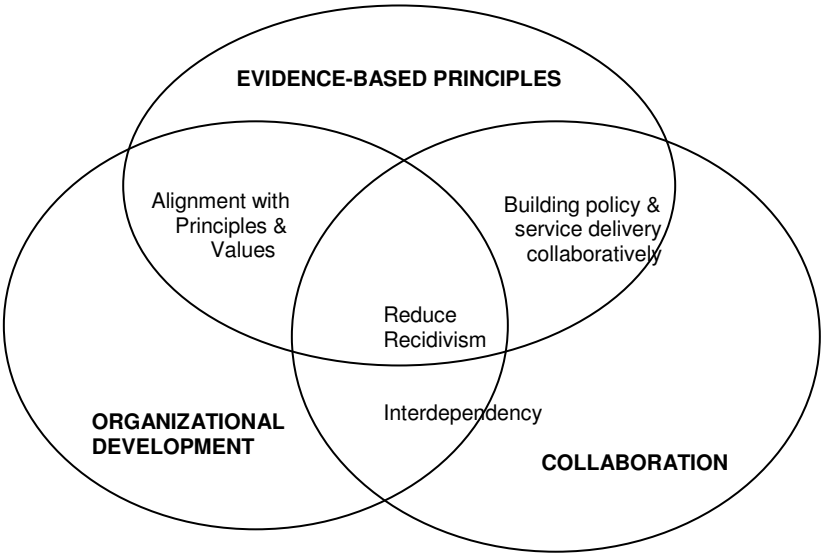
A model developed by the National Institute of Corrections (NIC) and the Crime Justice Institute (CJI) in 2004 addresses the process of improving treatment services for offenders. *Implementing Effective Correctional Management of Offenders in the Community: An Integrated Model* is based on an extensive pilot project (utilizing 4 sites in total, including Oregon) that sought to develop an integrated approach to implementation of evidence-based principles in community corrections. NIC and CJI

had recognized that many organizations, despite successfully implementing components of evidence-based principles fell short of realizing their goals of reducing recidivism and making more efficient use of limited resources. As such the NIC concluded that:

"Many organizations were not able to achieve the depth necessary to change organizational culture and attain desired outcomes. As a result, change efforts often lose focus, stagnate, and are not institutionalized. An integrated approach to implementation provides the depth and breadth necessary to ensure lasting change." (NIC, 2004).

The project's resulting Integrated Model is based therefore on the premise that successful implementation of evidence based principles can only be achieved when integrated with corresponding organizational development and collaboration.

Implementing Evidence Based Practice: The Integrated Model



These three components form an integrated model for system reform. Each component of the integrated model is essential. Evidenced based principles form the basis of effective supervision and treatment provision. Organizational and system development is required to successfully move from traditional supervision and treatment to evidenced based practices. Organizations and systems must rethink their missions and values; gain new knowledge and skills; adjust their infrastructure to support their new way of doing business; and transform their organization and system culture. Collaboration with system stakeholders increases the likelihood of internal buy-in and creates a more holistic system change. The unique and defining feature of this model is its insistence that systemic change cannot be fully implemented or sustained without equal and integrated focus

on evidence-based principles, organizational or systems development, and collaboration.

This model builds on the work being done by the criminal justice and treatment systems within several counties within Oregon.

As the diagram above suggests, developing a truly responsive collaboration between these systems to effectively treat the substance abusing offender requires that the systems consider the relationships between various service categories and practices and how they interrelate to form an entire delivery system. To that end, questions were developed to assess how key informants in each system saw the following issues as the related to working with the other system and/or working with substance using offenders: 1) Funding; 2) Administration; 3) Communication; 4) Technology; 5) Culture; 6) Workforce; 7) Services/Service delivery; 8) Evidence Based Practices and; 9) Evaluation.

Analysis of the responses again confirmed how deeply interrelated these issues were. Much of the same information and similar responses would consistently reappear in each subsequent area. For example, the issue of timely access of information was mentioned in reference to funding, administration, technology, and culture and service delivery. Similarly, the issue of assessing motivation was referenced in

questions involving funding; communication, culture, workforce, service delivery and evidence based practices. Given this frequent overlap, these nine discrete categories were merged into three overarching categories: 1) Communication; 2) Continuum of Care and Transition and; 3) Evidence Based Practices.

These categories were selected as they seemed to provide the clearest way to view the issues, challenges and opportunities that the key informants were facing. As such, they represent the issues which are currently of greatest concern for the respondents. The state of Oregon has been devoting a tremendous amount of time, energy and resources to addressing the needs of both the criminal justice and treatment systems with regard to effectively working with the substance using offender. While there has been a steep learning curve for both systems, a great deal of progress has been made. It can not be stated strongly enough that the issues, concerns and recommendations offered in this document represent merely a starting point for further discussion and problem solving.

DOCUMENT ORGANIZATION

The first three chapters are organized in such a way as to represent a brief overview of the subject based on the literature followed by a general discussion of challenges and barriers faced by the systems in working effectively together. In many cases, these challenges are ones that systems nationally typically experience. In some cases, specific reference is made to challenges faced by Oregon.

The next section provides a summation of specific issues that were brought up during the focus group/key informant interview process (for a more detailed reporting of these results, please see refer to the Appendix. These issues were selected as respondents from each system brought them up. In some cases both systems have identical issues or concerns; in others each system had a differing perspective about the same issue.

Participants in the focus groups and key informant interviews were recruited from pre-selected lists of representatives of the both systems. While the participant list for each group certainly does not include all key members throughout the state, the pool of participants was designed to provide a

reasonably representative group of individuals. The results from focus group research should never be considered representative of either population segment. The nonrandom method of recruitment and the small size of the sample do not permit this type of generalizability. Nevertheless, results of the focus groups reported here can provide a great deal of rich insight into the relevant aspects of the issues discussed and should be used accordingly.

The recommendations that follow the focus group result section are based on information gleaned from, either national model or best practice programs, or, from recommendations generated by the Collaboration Group. Lastly, the chapters conclude with implications related to funding around this issue are discussed.

The fourth chapter provides recommendations for workforce development that can assist with advancing the implementation of evidence based principles for criminal justice supervision and substance abuse treatment of offenders.

The final chapter concludes with overall recommendations for next steps to be taken by the Collaborative Group and other key stakeholders.

DOCUMENT ORGANIZATION

COMMUNICATION & INFORMATION MANAGEMENT

OVERVIEW

Successful collaboration often requires communication between multiple individuals across organizational lines. If communication is effective, coordination efforts are also likely to be effective. The purposes of communication include sharing, persuading others, clarifying and understanding, and decision making (Koehler and Sisco, 1981).

CHALLENGES & BARRIERS

Communication appears in the literature frequently as a widely discussed issue related to improving collaboration between systems. The barriers to effective communication and sharing information are well documented. These may include (American Probation and Parole Association and National Association of State Alcohol and Drug Abuse Directors, 1992):

- Misunderstanding respective roles;
- Conflicting goals;
- Confidentiality;

- Control issues; and
- Misconception of other professional perspectives.

Another challenge is that of finding an effective and timely means to share information. Currently the two systems rely heavily on "low-technology" (i.e. phone contacts, faxes, etc.) means of communication to share information, make referrals, follow up on clients etc. Low-technology communication is a labor intensive process and frequently untimely.

Over the last several years, great strides have been made in automating information gathered within a system (i.e. databases, tracking, electronic records, etc.). However, criminal justice and treatment agencies typically have separate automation systems with little ability or protocol to share data. Important events, behaviors and outcomes may be tracked electronically, but they are shared manually by phone, fax or in a written report. The challenge therefore is to allow the automation to facilitate sharing data across agencies. The end product is a tool which builds information developed by both systems and minimizes redundancy in data collection and allows for both systems to send and receive information without having to leave repeated telephone messages and emails.

RECOMMENDATIONS

As mentioned previously, information management is critical to effectively supervising and delivering services to this population. While basic information gathered about the offender should follow him/her through all aspects of the system, civil liberties and confidentiality laws must be considered whenever information is shared.

Procedures to improve information flow, some of which have received national support through SAMHSA (2005) include:

1. Ensure that information flows in both directions: from treatment providers to criminal justice staff, and from criminal justice staff to treatment providers.

Both substance abuse treatment providers and criminal justice personnel report not having the information they need to effectively work with a client available on a timely basis, if at all. Reasons cited for this often involve:

- Issues of confidentiality that do not allow criminal justice staff to share pre-sentencing reports or allow treatment providers to share parts of a client's psychosocial history

- Inmates not signing information releases and treatment staff feeling reluctant to share information,

such as trauma or abuse histories, with criminal justice staff.

2. Increase awareness and sensitivity to the confidentiality requirements and political concerns of criminal justice agencies and treatment providers.

This may most effectively be achieved through joint training on federal confidentiality mandates (42-CFR) and the Health Insurance Portability and Accountability Act (HIPAA). Substance abuse treatment providers are typically socialized to maintain strict confidentiality and nonporous professional boundaries between themselves and criminal justice authorities. Conversely, criminal justice staff is used to getting information on clients, particularly if program participation is a condition of the disposition of a criminal proceeding, probation, parole, or conditional release from prison or jail. As such, joint training is needed where each system can gain a better understanding of the applicable laws and mandates each system must adhere to.

3. Utilize liaisons from each system to coordinate information flow.

It is recommended that each corrections agency consider having a liaison to assist in the implementation of the dictates of Senate Bill 267 Evidence Based Crime Prevention Programs. Ideally this individual should be familiar with both the

treatment and the criminal justice systems. This individual would oversee program evaluations, implementation of evidence based practices, mediate between systems and, focus on relationship building.

A liaison is now being used by effectively in both Yamhill and Marion Counties. The liaisons serve as the point of contact between systems in matters involving scheduling for referral, intake or admission to treatment as well as communicating other pertinent information about the offender to ensure that "the ball is not dropped" between systems or that offenders do not "fall between the cracks." For example, a common challenge described by treatment providers is having an offender, under supervision or soon to be released from prison, fail to show up for a scheduled intake appointment and not knowing who in community corrections to contact to report the client's failure to attend. As a result, criminal justice personnel do not receive the information that the offender failed to attend in a timely fashion and cannot respond accordingly. Liaisons also reduce the time spent by both treatment and criminal justice personnel attempting to get the "right" person on the phone to get information that they need.

4. Provide opportunities for cross discipline/cross system trainings.

Several of the interviewees talked about needing to develop more effective models for communication between substance abuse providers and criminal justice professionals. Another strategy used locally to help substance abuse and criminal justice professionals build personal relationships and gain a clearer understanding of each other's system is the use of the curriculum entitled "*Criminal Justice and Substance Abuse: Working Together for Change*" (ATTC , 2005). This three-day cross-training is designed to facilitate a process in which professionals from both systems come together in a forum where they can learn from each other and gain a greater appreciation of how they can improve offender services by working together. Cross-training emphasizes familiarization with roles and procedures of the other system and allows participants to develop personal contact and build relationships that will ultimately lead to improved communication.

5. Use local Memoranda of Agreement (MOA) to establish clear roles and procedures and address the topics above.

Memoranda of Agreement (MOA) are used locally to establish clear roles and procedures to guide the work of probation and parole officers and substance abuse providers. These agreements can be used to clearly define each agency's specific roles, expectations, and

responsibilities, type of information to be shared, monitoring procedures, and timing of tasks, and confidentiality requirements. The process used to create interagency agreements is as important as the agreements themselves. Yamhill County reports regular use of MOA's.

6. **Seek to further automate data sharing by either using existing information systems or purchasing new ones that would allow for timely collection and reporting of information.**

If a "gold standard" in automated information sharing between treatment and criminal justice exists, it likely is the one developed through The Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA). The HIDTA Automated Tracking System (HATTS) includes functions of the treatment agency and criminal justice system. The system offers flexibility to allow each agency to: 1) operate separately within its own environment or 2) share information across agencies. HATTS creates an environment where information is readily available but only disseminated when appropriate confidentiality releases and policies are available. The HATTS system incorporates confidentiality regulations by providing specific functions to give consent to client level information. The different components of HATTS include such elements as:

1. Program inventory

2. Client intake process

3. Referrals and appointments

4. Confidentiality and releases

5. Assessment

6. Service units

7. Probation/Parole notes

8. Treatment tracking

9. Graduated sanctions

10. Drug testing

As a result of the success of HATTS, modified versions of this system have been created by drug courts that incorporate some of the functions of HATTS. Drug courts need to receive data from treatment provider(s) in a timely fashion, and treatment providers also need information from the drug court. Given that, is advisable to explore using or sharing software that is being used in Drug courts in Oregon counties as a cost effective means of sharing information.

Providers with sophisticated information systems will need to arrange for an interface between the court system and their own (not a simple task) and will probably need

to negotiate the permissible limits of data sharing in light of the confidentiality of some of the information. Treatment providers who do not have automated information systems will need to develop expectations and guidelines about the appropriate use of email or other means of communicating information and time frames for communication (i.e. discharge summary sent within 24 hours of completion, phone calls returned by the next business day, etc.).

7. Implement regular quality control procedures to maximize completeness, accuracy, and consistency of data.

Policies and procedures regarding timeliness and necessary data/information should be established. In addition, supervisors (or other designated quality assurance personnel) need to review documents (or a sample of documents as appropriate) to ensure that information being sent out is timely, accurate and complete. This will also afford supervisors the opportunity to identify training and/or supervision issues with staff, as well as, troubleshoot potential information sharing issues/concerns between systems.

8. Establish consistent definitions of the data/information elements between the participating agencies.

Develop consensus between the systems as to what and how much data/information is needed to be shared for each system to "do their job". Achieving consensus may require use of forums to determine the necessity and relevance of information to be shared (i.e. probation officers receiving information about past trauma, etc.). Once consensus on the information is achieved, forms and other documents should be standardized to reflect the common data/information elements.

FUNDING CONSIDERATIONS

The lack of sufficient funding does seriously impact the ability of the two systems to effectively communicate. The major funding issues related to communication include:

1. Automated Management Information Systems (MIS) are essential to developing a system of "real-time" communication and information access. However, these systems can be extremely expensive and the costs often prohibit the use of these types of systems. If finances permit, different systems and agencies often purchase their own management information systems. However this can result in agencies and systems lacking compatibility between systems and so even if they have an automated system they can't connect with other agencies and systems. Funding and coordination is

needed at a county or state level to facilitate the adoption of a common MIS system that could significantly improve the two systems ability to communicate with one another.

2. Providers in both systems report being seriously understaffed and having very high client case loads. Communication takes time, a resource practitioners in both systems are often seriously lacking. Increased funding is needed to reduce client case loads.

3. Case management is one clinical intervention that can significantly improve communication between the two systems; however this service is not usually a reimbursable service for treatment providers.

RESOURCES &ADDITIONAL CONTACTS

Versions of the liaison model are being used in Yamhill County, Linn County, and Marion County. Contacts for finding out more about these local models include;

Marion County: Sue Blayre, Marion County Probation & Parole Division, SBlayre@co.marion.or.us

Yamhill County: Keith Urban, Manager Yamhill County Chemical Dependency Services, keith_u@co.yamhill.or.us

Richard Sly, Director Yamhill County Community Corrections, slyr@co.yamhill.or.us

Linn County: Tony Howell Program Manager, Linn County Alcohol & Drug Treatment Program, thowell@co.linn.or.us

Cross Training Curriculum "*Criminal Justice and Substance Abuse: Working Together For Change.*" For more information contact the Northwest Frontier Addiction Technology Transfer Center at (503) 373-1322. Curriculum can be downloaded at: http://www.nattc.org/reentry/resources/index.

Continuum of Care/Transitional Planning

OVERVIEW

Addiction treatment has been plagued with perceptions of ineffectiveness due to the high percentage of individuals who relapse following treatment. This problem is not unique to addiction treatment; relapse and regimen non-adherence also influence outcomes for other chronic conditions, including asthma, diabetes, and hypertension. What is unique to addiction treatment is the limited attention addiction treatment programs have been able to give to treatment "continuing care." Other health care fields have been focusing on this issue for the past 10 years through chronic disease management programs that improve regimen adherence and minimize the cost of disease. Chronic disease management appears to have its place in addiction treatment. McKay (2005) noted that effective continuing care in addiction treatment can improve abstinence rates, disease risk, and consequences of use.

In other chronic care fields, there has been recognition that interventions will be ongoing and that success will require the

client or patient to co-operate and partner with the health-care system to address the pertinent aspects of the illness. A continuing care approach requires coordination and integration of the substance abuse intervention into the broader spectrum of health or social services.

Length of stay in treatment has been found to be a critical variable in reducing recidivism and substance abuse. Researchers have supported the proposition that offender populations, due to the societal harm of criminal behavior, should participate in a minimum of one year of treatment (Lipton, 1995). Providing for a continuum of care is one systemic process to increase the length of time in treatment by having offenders participate in different phases of treatment. The concept of a continuum extends the length of treatment while adjusting the intensity of the services based on the progress of the client. The continuum of care model provides the client with longer stays in treatment (up to 12 months), while reducing the costs of delivering services.

From the individual offender's perspective, leaving prison, particularly after lengthy incarceration, can be an intimidating experience. Many people become adapted, or "institutionalized," to highly structured environments. In general terms, the process of institutionalization involves the incorporation of the norms of prison life into one's habits of thinking, feeling, and acting (Maruna, 2001). Upon release

from prison, institutionalized individuals struggle with such things as decision making, assuming responsibility, adhering to a self imposed routine, etc. Further, individuals with mental health and/or substance abuse issues appear to have relatively more difficulty readjusting to community living after highly structured environments. If institutionalized prisoners have had the benefit of participating in some sort of therapeutic programming during their incarceration, these individuals often have difficulty transferring learning from one situation to another. Institution programs start a recovery process in an environment whose structure helps the change process begin, and that does not possess a risk to the community. However given that level of structure, it is difficult for prisoners to fully anticipate or prepare for the stressors that they will face upon release to the community. As a result, what they learn in the institution program does not easily transfer to the community. Recovery and self management skill learning begun in prison-based therapeutic programming needs reinforcement and some degree of relearning in the community follow up program. Without coordination between the programs the offender's substance use disorder, anxiety, or both are likely to weaken treatment gains and complicate the transition process. In addition, lack of continuity creates a level of stress that can contribute to relapse.

CHALLENGES & BARRIERS

The most frequent and strongly stated challenge faced by the two systems in providing a seamless continuum of care is lacking the funds necessary to provide treatment services to all offenders who are assessed as needing some level of treatment. Although treatment providers may have several contracts with Federal and state agencies to provide treatment to those who lack insurance or other means to afford it, most of these funds are designated as to whom they may be used for. While some agencies receive funding to provide services to offenders exiting prison, often the funding is not sufficient to cover all the offenders eligible for treatment. Additionally, some agencies do not have contracts providing dedicated funding for offenders.

Similarly, substance abuse treatment agencies using the Corrections Program Checklist (CPC) face other financial burdens. The CPC requires treatment programs to provide services that segregate the low from medium risk offenders. To achieve this, community based agencies would need more staff (and in some cases physical space) to offer additional groups and programming, making it cost prohibitive for even the largest treatment agencies.

In addition to funding challenges, conflicting priorities and practices of the criminal justice and treatment systems can

adversely affect the offender's ability to access treatment programs or placement in appropriate treatment programs. Historically, the attitudes and values of the treatment system often precluded prioritizing different populations for services (Duffee & Carlson, 1996). With the exception of pregnant women, IV drug users, and HIV positive substance users, the first come first served model of treatment services typically prevails in the treatment system. Under this model, everyone is viewed as equally in need of care. Substance users appearing at the treatment program door are accepted based on substance abuse symptom severity and program-specific criteria, which often do not include societal harm (e.g. criminal behavior) posed by the client.

In addition to the Federal government requirements for pregnant women, HIV positive substance abusers, IV drug users, Oregon Department of Human Services (DHS) asserts in contracts with treatment agencies that referrals from the DHS Child Welfare System are to receive first priority for admission. Thus, treatment agencies are primarily concerned about the risk that active substance use and/or relapse to substance use pose to the individual, the individual's children and the potential public health threat in terms of infectious disease.

Conversely, it is the job of the corrections system to protect the public by reducing the risk that offenders pose to the

community. Risk in this case speaks to the relative likelihood of offenders committing new offenses. Research indicates that high and medium risk offenders benefit most from correctional interventions; therefore, supervision and treatment resources should focus on this group to achieve the greatest reduction in recidivism. Thus, the criminal justice system is concerned that high to medium risk offenders are a priority in receiving substance abuse treatment as a means of reducing their risk to re-offend.

Furthermore, despite the growing number of females in the criminal justice system, in terms of sheer numbers men still represent the largest segment of offenders transitioning back into the community. As stated above, unless the male is HIV positive, agencies may have little or no funding to ensure that he receives a treatment slot – regardless of his risk to re-offend and/or relapse.

Besides a differing perspective on risk, each system also emphasizes addressing different things at different times. For example, employment for offenders leaving prison is a top priority for criminal justice personnel while treatment staff might place a greater emphasis on relapse prevention planning or support system building. As such, each system has a different perception on the need for treatment agencies to provide educational and vocational training programs for substance abusers. Treatment agencies frequently do not

receive supplemental funding to provide vocational or educational training. Most treatment programs have historically focused their efforts on alcohol and drug education and recovery/sobriety skill building and relied on other community agencies to provide vocational and educational services. In addition, some treatment agencies philosophically adhere to traditional tenants of recovery which place 'focusing on recovery" above all else. In this case, offenders who are either attempting to work and/or receive educational/vocational training may not receive adequate support from the treatment program to do so. For example, some programs may have treatment schedules that put working/going to school and participating treatment in direct conflict. In others, no groups or classes are designed to address issues of vocational preparedness. Programs who recognize the need to incorporate educational and vocational programming into treatment often report not having sufficient funding to do so.

This population is in great need of these services as a general lack of problem-solving skills exists among addicts. This lack of problem-solving skills may only exacerbate the stress and anxiety experienced by the addict which may subsequently result in work failure and/or relapse for the individual in recovery (Platt, 1995). By making resources available to individuals in recovery through client-centered vocational

interventions in substance abuse treatment, outcomes can be improved (Comerford, 1999).

While much attention and resources have been devoted to the more intensive spectrum of the continuum (i.e. residential, intensive outpatient) far little attention has focused on the other end of the continuum (i.e. aftercare). Aftercare's contribution to reducing recidivism has been reported by several large studies (Inciardi, et al., 1997; Knight et al., 1997; Pelisser, et al., 1998). Further, therapeutic community (TC) evaluations typically find significant positive treatment outcomes from a prospective follow-up, particularly among inmates who completed both in-prison TC and aftercare. However despite aftercare's clear importance, it is often an underutilized, under funded level of care. One reason for this may be a lack of a universally accepted definition of what aftercare is. According to the American Society of Addiction Medicine (ASAM), aftercare would be considered Level 1 treatment which is an "organized nonresidential service that provides professionally directed aftercare, individual and other addiction services to clients according to a predetermined regular schedule of fewer than nine contact hours a week" (PPC, 2003). Given this broad statement, a tremendous amount of variability exists between the aftercare programs provided by treatment agencies.

Further, an essential ingredient of aftercare services is case management. However, many programs that provide aftercare often do not have the resources to provide case management. Aftercare instead, is often ONLY a process/support group that is designed to assist clients with relapse prevention.

Offender Concerns

Focus groups with former offenders provided valuable insight as to how the offender population experienced the transition process and continuum of care. Chief concerns were as follows:

There is a Large Gap Between Release from Prison to Other Services: Offenders often found themselves waiting for typically a month or more after release from prison to transition into other services (including probation). While the former offenders were not certain as to exactly why delays existed, they speculated that "it took that long for them to get all their paperwork in order." This wait time is fraught with anxiety and uncertainty for former offenders as they "are stuck, waiting for everyone around them to get it together." In addition, offenders reported this placed them in a difficult situation in terms of "making things happen" while on the outside. Many clients also reported not knowing where they are going "up until the last minute before release" causing significant discharge planning challenges. This observation of

problematic discharge planning was confirmed by several treatment staff. While the offenders were unclear as to why these problems arose, correctional treatment staff however, often felt that this situation was due to the reluctance of offenders to sign the proper releases and consents necessary to expedite the discharge planning process.

During the Transition Phase (first month) Offenders Seem to be "Always waiting": similar to the above stated concern, offenders report waiting, sometimes for hours, for appointments and/or their appointments are cancelled/ rescheduled after a lengthy wait. Reasons cited for this often relate to probation/parole officers having high case loads and miscommunication with various providers about appointment times. As one former offender stated, "I showed up at an interview (for treatment) and the worker didn't even know I was showing up. She never got the paperwork." In addition to the frustration that the waiting caused, former offenders also described at length how this contributed to increasing their anxiety as well as eroding a sense of esteem and efficacy.

Getting Basic Needs Met can be a Challenge: Many offenders reported being put in a dilemma between participating in treatment and getting/maintaining employment. While offenders acknowledged the value and need for treatment, many also stated that they felt that they had received adequate treatment in prison and would be better served

focusing on employment and becoming financially stable. "I had enough (treatment) in prison and what I really need out here is help getting on my feet… getting a job… making money. It's hard to do that when you have to show up for treatment three times a week with no car."

RECOMMENDATIONS

1. Development of appropriate policies and procedures.

Since most treatment and correctional systems are organized around episodic treatment experiences, policies are required to create the continuum of care practices at the program level**.** A succession of acute care episodes or acute interventions such as detox, residential treatment, intensive outpatient care, or low intensity outpatient care is not the same as a continuing care strategy. From the chronic care perspective, key elements of our current "system" of care – its priorities, allocation of resources, training of professionals, and the incentives inherent in its financing -- appear out of kilter.

It is not sufficient to have an array of services without the supporting policies to move offenders through the continuum. Providers from both systems frequently refer to their wish to "not reinvent the wheel". These polices need to address the following:

- Establishing a reservation system to alert community based programs of the expected date of placement in their program;
- Ensuring that while incarcerated, offenders sign appropriate consents and release that would create a more seamless continuum of care and transition process.
- Creating a transition plan to inform the offender of the likely continuum and associated time lines;
- Establishing criteria for placing offenders in community based treatment programs based on progress that has been made in the previous treatment program (to include prison based treatment);
- Establishing treatment polices that step up or step down the level of care based on progress.

It should be noted that a tremendous step in this direction has been taken with Governor Ted Kulongoski's recent executive order creating the Governor's Re-Entry Council, a statewide leadership group to work collaboratively on improving the success and safety of inmates' transitions back into society after they complete their sentences. The order instructs the Re-Entry Council to create a common vision for transition and re-entry of offenders upon their release, including:

- Reviewing existing policies and practices, with specific recommendations for improvement, including such as institutional case planning, institutional transition planning

and preparation, information sharing, the continuum of services following release, housing and employment with specific recommendations for improvement;

- Coordinating state re-entry initiatives across Oregon;
- Removing barriers that impede successful transition and reintegration; and
- Recommending changes in funding to support the reformed transition process.

2. Develop a universally accepted definition of aftercare and its components.

A supportive aftercare program should be structured to enhance the progress made in treatment toward early recovery. Additionally, aftercare should provide, either directly or indirectly, the necessary support services to maintain recovery in the community. While there is no one single formula for the development of a successful aftercare program, an understanding of some of the research on the guiding principles, core components and variables that affect outcomes, are useful in the design of an effective aftercare program. Although programs are encouraged to modify strategies as needed to implement an effective aftercare program, the guiding principles and core components must be evident in successful aftercare programs. The following is based on the presupposition that addiction is a chronic disorder and that lapses into use (or even multiple relapses)

are often common, especially during stabilization and early recovery.

Guiding Principles:

1. A compatible treatment philosophy should exist across all levels of care.
2. Aftercare should have objective and articulated goals.
3. Aftercare should incorporate motivational enhancement strategies that parallel stages of recovery.
4. Aftercare services should be provided for at least a year post discharge. Six to nine months post discharge is considered to be the most critical period for relapse.
5. Adequate frequency of contact with professional services is necessary to maximize outcomes.
6. Aftercare should foster and help develop a positive support network for clients.
7. Aftercare should encourage and/or support self-help involvement.
8. Aftercare should include an on-going evaluation and assessment process.
9. The frequency and intensity of individualized services is dependent on the presence of high-risk relapse factors.
10. Aftercare should include transitional management to *bridge the gap* for clients during periods of transition. This may include such things as providing ongoing support, addressing institutionalized behavior and helping the offender learn or

relearn skills appropriate for functioning outside of prison, etc.

11. Aftercare services should include consideration of: *Housing, Job, Transportation, and Childcare*.

12. Aftercare should be capable of outreach and provision of services in order to keep clients engaged who might tend to drop out prematurely.

13. Aftercare should have monitoring strategies (drug testing, case management, home visits, telephone calls, etc.)

With the goal in mind of helping the client to continue recovery by reducing relapse risk factors, it is important to understand first and foremost that clients in treatment face multiple problems in addition to drug dependence. These problems and unmet needs, if not addressed, will help place clients at a higher risk for drop out and/or relapse. Improved outcomes for an aftercare program will depend on the degree to which the program is able to match services to the clients' needs.

3. Improving case management for offenders.

An essential ingredient of aftercare services is case management. While the value of case management is well documented, it is also a time and labor intensive function. Historically, treatment staff has been challenged to provide more than minimal case management due to the fact that case

management was not a reimbursable activity. However, effective January of 2008 reimbursement will be available for case management activities.

Other states have also grappled with this issue of non existent or limited reimbursement for case management. Many have resorted to using third-party continuity programs as a means to fill this gap. Third-party continuity programs are ones where an agency, separate from corrections or treatment, takes primary responsibility for ensuring case management and service continuity. One of the most frequently used case management approaches to assisting recovering offenders transition into the community is the Treatment Accountability for Safer Communities (TASC). TASC programs, of which there are currently over 200 nationwide, serve as bridges between the separate systems of criminal justice and substance abuse treatment. TASC participates in justice system processing as early as possible, identifying, assessing, and referring nonviolent offenders to treatment as an alternative or supplement to justice system sanctions. TASC then monitors the offender's compliance with expectations set for abstinence, employment, and social functioning.

4. Improve job training/readiness services for offenders in the community.

A crucial aspect of case management for substance using offender is addressing issues related to employment. There is

a need to find jobs for people who have successfully completed prison rehabilitation programs and are being released into the community. Evaluation studies have consistently shown that employment is related to a decreased likelihood of relapse and recidivism (Platt, 1995). However not all employment is equal. A body of research (Berk, Leinihan, & Rossi, 1980; Comerford, 1999; Uggen, 1999; Bausch, Weber & Wolkstein, 2000) indicates that high-quality jobs, that provide a living wage, decreased the likelihood of criminal behavior independent of criminal history and substance use. Consequently, while attaining employment is important for many ex-offenders, job retention and upgrading to a higher quality job is also important. However, many offenders will need assistance to develop the skills to do so. The scope of programs conducted by the educational institutions in prisons has been limited mostly to basic literacy, GED and entry-level job training. In both prison and community treatment, when training is available, it is usually aimed at relatively low skill levels.

Unfortunately, most treatment programs provide few vocational and educational services. This is evidenced by the disparity between those who say they need employment services versus those who actually receive them (Comerford, 1999; Bausch, Weber & Wolkstein, 2000). Providers often cite lack of resources (both internally and in the community) to offer such services as a chief reason why this is often a

neglected area. Most programs do not have employment/vocational specialists on staff and, thus rely on community vocational programs to fill this void. These community programs (i.e. the Department of Vocational Rehabilitation) however are tasked with providing placement to large numbers of people, many of whom are considered a higher priority for placement than offenders.

5. Explore ways to improve access to safe, affordable housing for offenders.

The issue of safe, affordable housing was mentioned by criminal justice personnel, treatment staff and offenders alike. From the criminal justice perspective, appropriate housing is a large supervision issue. For treatment staff, safe housing (or lack of it) influences level of care decisions and the client's ability to attend treatment. For offenders, housing was an ongoing concern. Many reported significant concerns that they would either remain or end up homeless.

6. Place an increased emphasis on providing life skill development for offenders in the community.

Another challenge faced by both systems is the fact that there is often a loss of structure for offenders immediately after release that leaves them vulnerable to relapse and recidivism. Offenders who have been incarcerated for extended periods of time may lack many basic life skills and the ability to problem solve day-to-day problems. While some of these issues or

skills may be addressed in treatment and/or supervision, they typically fall into a more nebulous area of "life skills". The decisions about these new obligations can lead to serious consequences, yet often no individual or system is responsible for helping offenders prioritize and balance the challenges of life in the community.

7. Training for criminal justice personnel on the Patient Placement Criteria (developed by the American Society of Addiction Medicine, ASAM).

As there appeared to be a great deal of confusion within criminal justice as to how treatment providers arrived at level of care decisions, it would be useful to provide criminal justice personnel with an understanding of the ASAM and its role in the continuum of care.

8. Increase the availability of peer recovery/mentoring programs.

Peer recovery support services provide social support/mentoring for recovery. Along with case management, they are a valuable and arguably critical component to the continuum. They promote engagement in the recovery process and reduce relapse once recovery has been initiated. The key feature of these programs is that they are designed and delivered by peers. They effectively extend the reach of treatment beyond the clinical setting into the

everyday environment of those seeking to achieve or sustain recovery. Peer recovery/mentoring services encompass four kinds of social support identified in the literature (Cobb, 1976; Salzer, 2002).

- Emotional support geared to bolster a person's self esteem and confidence. This is done both on a 1:1 level as well as in a group format.
- Informational support through sharing knowledge and information or providing skill training. For example, peers can provide information on where to go for resources or teach specific skills, such as resume preparation.
- Instrumental support by providing concrete assistance to help others accomplish tasks. Examples include transportation to appointments and mutual aid group meetings and helping fill out applications.
- Affiliation support enables people to connect with others within the community of recovering people. These interpersonal connections can be important in helping the recovering person form a new personal identity structure around pro social behavior, health and wellness as opposed to criminality, alcohol and drugs.

While there are many national models of these types of programs, Oregon is fortunate to have three exemplary programs that are designed to provide a smooth transition process between prison and the community.

Bridgeway and Marion County Corrections have been partnering on mentors for high risk offenders since 2003. Bridgeway uses paid clinicians in recovery known as Community Integration Specialists to provide very hands on case management and other supports. The Community Integration Specialists are highly mobile and are available twenty-four hours a day, seven days a week. They meet with offenders before they are released from prison and develop a release plan specific to their needs. They also pick people up at the prison when they are released, so that no last minute glitches or crises occur. They help people with everything from getting connected to the recovering community to jobs, drug free housing, food, clothing, family reintegration, substance abuse and mental health services, medications, etc. This concept has been so successful that it now spilling over into other health and human service areas. For example, there is a Community Integration Specialist that works with Psychiatric Security Review Board (PSRB) folks being released from Oregon State Hospital with addiction problems.

The Recovery Association Project (RAP) has earned accolades on both a local and national level. The RAP Center functions as a drop-in center where people in recovery are available to help their peers' access resources and build relationships in a clean and sober environment. The Center has staff offices, a resource and referral center with computers, meeting rooms,

several large rooms used for classes and activities, a kitchen, and café.

Peer resource coaches staff the reception area, handle phone inquiries, and work with peers to find housing, employment assistance, and other resources. They also offer assistance with computers, Internet, phones, and fax. One popular service provided by the coaches is assistance with resume preparation.

Classes and Workshops

People in recovery design and teach all classes at the RAP Center, creating much variety. Classes and workshops include:

- Regular classes: Computer basics, RAP orientations, and Yoga classes
- Trainings: Conflict Resolution for 12 Steppers, Finding a Job with a Criminal Background, Prostitution Recovery, RAP Basics, and Turning Story Into Issue
- Workshops: Creative Writing, Returning to School, Men & Addiction, Communication, Advanced Leadership, Recovery Coach Training, Meditation, and Vision Quest.

Home for Good in Oregon: A Corrections, Community and Faith-Based Re-entry Partnership (HGO) is a statewide network of community and faith-based individuals and organizations committed to "*building strong communities for the*

successful reintegration of offenders." HGO has created a model re-entry program that is structured on three organizational and programmatic building blocks:

1. Transition Focused Prison Chapel Programs; Re-entry Coordinators work with institutional chaplains to assist offenders prepare for the challenges of returning to their family and community. Activities in the prison include spiritual-based transition classes, pre-release counseling and help to link inmates to community and faith-based supports and services that will compliment the inmate's approved release plan. This one-on-one work with inmates helps them prepare for and work on the issues they will face upon release. HGO also works with the faith-based volunteers who are conducting services in the prisons that are releasing inmates to help them focus some of their services around transition issues.
2. Volunteer Community Chaplains

The second foundation block is a statewide network of trained and experienced volunteer Community Chaplains committed to helping released offenders reconnect in healthy and supportive ways with families, community organizations and faith communities. This ever-growing network of 30-35 Community Chaplains works closely with and supports Community Correction's Probation and Parole Officers. Community Chaplains provide offenders with needed social support, guidance and direction and also hold them accountable for unhealthy, unsafe or illegal behaviors. The

Community Chaplains are divided into six statewide regions under the direction of Regional Community Chaplains. To date, HGO has recruited a Community Chaplain for most of the 36 counties.

3. Local and State Wide Community-Based Organizational Structure

HGO's foundation block number three is a leadership group that brings together government and correctional representatives, locally-based service providers and an ever-growing network of community and faith-based individuals and organizations. Functioning over the past year and one-half as a statewide Steering Committee, 30-35 individuals (*all volunteers*) from across Oregon have met together once a month via video and phone conferencing to build collaboration and cooperation among Oregon's community and faith-based re-entry and transitional resources.

This statewide Steering Committee is in the process of developing a network of county or area Local Community Re-entry Partnership Councils that will bring together local governmental, correctional, service providers and community and faith-based organizations to coordinate county level re-entry efforts. These Partnership Councils will be developed by a network of Community Coordinators and the many local councils will be represented on the state wide Steering Committee which will, in turn, be represented on a HGO Executive Committee composed of management level

representatives of correctional, community and governmental agencies and organizations and the HGO Steering Committee.

FUNDING CONSIDERATIONS

Full treatment of the funding issues involved in providing offenders with a continuum of care to maximize recovery are extensive and beyond the scope of this document. However, the funding issues identified as being very high priorities as a result of these interviews include:

1. There is a serious need for additional funds and resources to provide offenders with the ancillary services that are essential to successful recovery (i.e., housing, transportation, child-care, and vocational services).
2. Funding for treatment services in the beginning of the continuum (motivational enhancement interventions, outreach services) and at the end of the continuum (after-care, case management, vocational skills development) are very limited and create serious gaps in the continuum of care.
3. Most payers have not yet embraced the chronic care concept for addiction treatment. They resist funding post-acute care services or "aftercare" that may result in more costs. Funders should be encouraged to purchase "episodes of care," versus outpatient or inpatient treatment
4. Moving to a true model of individualized care requires treatment agencies to provide a menu of treatment intervention options to each recipient; under the current

funding system this type of model is cost-prohibitive, as many agencies struggle financially to provide even basic treatment services through heterogeneous groups.

5. To ensure a smooth transition through the continuum of care providers in both systems need to understand the models of treatment and supervision being used by their counterpart. Funds are needed to provide the necessary cross-training for both systems.

6. Case management services are one of the most effective means to facilitate the offender's movement through the continuum of care and these services are not usually covered under the current State and County contracts.

RESOURCES &ADDITIONAL CONTACTS

For information on TASC please see:
http://www.tasc-il.org/preview/index.html
http://www.dhss.delaware.gov/dhss/dsamh/bckgrnd.html
http://www.uab.edu/uabsap/tasc/

For more information on Bridgeway please consult:
Bridgeway (Cascadia Behavioral Healthcare)
3325 Harold Dr. NE
Salem, OR
(Mail to: P.O. Box 17818, Salem, OR 97305)
Ph (503) 363-2021

For more information on Home for Good please contact:
HGO Re-entry Office
ODOC
2575 Center Street NE
Salem, Oregon 97310-0470
503-945-0929

For more information on RAP please consult:
www.rap-nw.org/home.html
facesandvoicesofrecovery.org/pdf/Publications/2006-09_RCSP_Reportlevel job training. In both prison and community treatment, when training is available, it is usually aimed at relatively low skill levels.

EVIDENCE BASED PRACTICES

OVERVIEW

The original question proposed by the Collaboration Group in regards to evidence-based practices was how do we integrate Department of Correction's evidence-based practices with Addiction and Mental Health Division's evidence-based practices (EBPs). In order to explore this issue and the challenges related to implementing EBPs, it is important to identify how each system defines evidence-based services.

The Department of Corrections is using the Corrections Program Checklist (CPC) to determine whether a program is delivering evidence-based services for offenders that will result in a reduction in recidivism. The CPC evaluates the entire program and assesses how well the program is aligned with known principles of effective interventions for offenders. The CPC looks at five domains (1) Program Leadership and Development, (2) Staff, (3) Offender Assessment, (4) Treatment, and (5) Quality Assurance. To be considered an evidence-based program, an agency must score "satisfactory" on the CPC. The CPC does look at specific evidence-based

practices and models and how they are being implemented, however this is just one element of the assessment process.

The Addictions and Mental Health Division defines an evidence based practice as a specific intervention that has been determined to be evidence-based for facilitating recovery in people with addiction and/or mental health disorders. AMH maintains a list of specific practices and interventions which are considered approved EBPs. This list is continually being updated and practices that meet the approval criteria are added.

So when individuals are discussing EBPs it is important to specify what the evidence-based practice is related to; is it effective for reducing recidivism, decreasing alcohol & drug use, or improving mental health functioning? And secondly, one needs to acknowledge the contrast and potential for conflict: DOC is evaluating the entire program (i.e. agency) for adherence to evidence-based principles (which include the incorporation of specific evidence-based practices); whereas, AMH is looking at the implementation of specific interventions and practices. These two distinctions need to be kept in mind when discussing the challenges related to the use and implementation of EBPs.

CHALLENGES & BARRIERS

Over the last several years multiple documents have been produced that discuss the challenges and barriers related to the transference of evidence-based practices from the research world into community based treatment centers and community corrections. And while several state and national initiatives have succeeded in pushing the criminal justice and substance abuse treatment systems forward in moving towards the use of evidence-based practices, significant challenges and barriers remain. In an extensive review of the research literature on implementation of evidence-based practices, Fixsen and his colleagues (2005) identify seven "implementation drivers" that are key to the success of a practitioners' ability to implement an intervention and achieve positive client outcomes. These implementation drivers include: supervision & coaching, staff performance evaluation, decision support data systems, facilitative administrative supports, system interventions, recruitment and selection, pre-service and in-service training. The presence and/or absence of these core components of implementation determine the success of an agency or system in successfully adopting an evidence-based practice. Issues related to these "implementation drivers" did surface both in the interviews with criminal justice professionals and substance abuse providers. Specifically the issues of clinical

supervision, training and fidelity monitoring were frequently mentioned. In addition smaller programs, particularly rural programs, often cite the cost of implementing specific EBPs as being particularly onerous.

RECOMMENDATIONS

1. **Treatment providers should select AMH approved practices that have been shown to be effective with offenders.**

The table below matches the eight evidence-based principles supported by the National Institute of Corrections (which the CPC is based on) with AMH approved clinical techniques and treatment interventions that most closely align with these principles.

National Institute of Corrections Eight Evidence-Based Principles	DOC Evidence Based Practices	AMH Evidence Based Practices
1) Assess Actuarial Risk/Need (screening & assessment of offender's needs)	LSI-R	American Society of Addiction Medicine PPC-2
2) Enhance Intrinsic Motivation	Motivational Interviewing	Motivational Interviewing Motivational Enhancement Therapy
3) Target Interventions a) Risk Principle b) Criminogenic Need Principle c) Responsivity Principle d) Dosage e) Treatment Principle	Prioritize supervision and treatment resources for higher risk offenders Cognitive Restructuring Integrate treatment into the full sentence/ sanction requirements	Intensive Case Management Cognitive Behavioral Therapy Community Reinforcement Approach with Vouchers Relapse Prevention Dialectical Behavioral Therapy Methadone Treatment

	During the initial months post release, 40%-70% of free time should be occupied with routine and appropriate services	Drug Courts Functional Family Therapy Seeking Safety
4) Provide skills training with directed practice using cognitive-behavioral treatment methods	Cognitive Restructuring Skills emphasizing role-playing	Cognitive Behavioral Therapy Relapse Prevention Matrix
5) Increase Positive Reinforcement	Swift responses for negative & appropriate graduated consequences	Contingency Management
6) Engage On-going Support in Natural Communities	Supportive family/spouse Twelve step programs Religious activities, Restorative Justice initiatives	Community Reinforcement Approach Twelve Step Facilitation Therapy Supportive Housing
7) Measure Relevant Processes/Practices	CPC	Fidelity Monitoring
8) Provide Measurement Feedback	Clinical Supervision CPC	Clinical Supervision Outcomes Monitoring Fidelity Monitoring

2. Provide appropriate cross trainings between systems to assist treatment clinicians and probation officers in developing an understanding of each others concepts and/or practices.

While some practices may at first seem dissimilar, a great deal of overlap or common ground does in fact exist. For example, NIC Evidenced Based Principles calls for programs to screen and assess offenders for actuarial risk/need. The DOC uses the LSI-R to clearly achieve this goal. Treatment providers, on the other hand, use the American Society of Addiction Medicine Patient Placement Criteria, 2nd Edition to evaluate the severity of a patient's need for treatment along six

dimensions and then utilize a fixed combination rule to determine which of four levels of care a substance abusing patient will respond to with the greatest success (Turner et al, 1999). The hope is that by reducing mismatches involving over or under treatment, providers are able to allocate resources more efficiently and reduce the risk of adverse treatment outcomes.

The Level of Severity Index- Revised (LSI-R) is an assessment tool that results in a composite score indicating an offender's overall level of risk, and criminogenic need factors. The composite score is rendered via the assessment of ten domains. In theory, assessing an offender using the LSI-R allows for a valid classification (e.g., high, medium, or low-risk), as well as the identification of the most prevalent criminogenic need factors that may facilitate case planning and treatment intervention.

3. Follow the recommendations from the DOC and AMH EBP agreement.

The agreement states, "A corrections treatment program that scores well on the CPC and is using one or more of the AMH approved practices is in the best situation to be effective both at reducing recidivism and supporting recovery for those with addiction and/or mental illness. These are complementary outcomes and are those identified in the statute that resulted from the passage of SB267."

The purpose of the CPC is to identify the program strengths and areas needing improvement is to assist programs in becoming EBP. There are several advantages to the CPC. First, it is applicable to a wide range of programs (adult, juvenile, community, institutional, etc.). Second, all of the indicators included in the CPC have been found to be correlated with reductions in recidivism. Third, the process provides a measure of program integrity and quality; it provides insight into the "black box" of a program.

4. Successful implementation and adoption of evidence-based practices such as Motivational Interviewing and Cognitive Behavioral Therapy require on-going training, coaching and clinical supervision.

The key to counselor skill development in these practices is the availability of mentoring and supervision. Training and/or reading a manual alone does not result in any long-term implementation of these models (Fixsen et al., 2005, Miller et. at., 2004, Sholomskas et al. 2005,). Therefore it is essential that implementation of any evidence-based practice or principle includes a plan for on-going clinical supervision, training, and mentoring.

AMH's Evidence-Based Practices unit is piloting several new projects that are designed to provide agencies with the technical assistance necessary to facilitate the adoption of

evidence-based practices. These projects include resources and technical assistance for helping agencies learn how to use a change process to develop and implement a plan for the adoption of an evidence-based practice, as well as on-going coaching, mentoring, and training on clinical supervision to help staff learn the model and maintain fidelity. For more information on these pilot projects and possible opportunities to participate in similar projects please contact Shawn Clark with AMH at 503-945-9720.

5. When selecting an evidence-based practice use a change process that examines the needs of the agency and customers to determine the best fit for the program.

A couple of key characteristics for successful implementation include selecting a program/intervention that is consistent with the philosophy of the agency and meets the relevant needs of the providers and customers. It is essential to use a systematic process for selecting and implementing evidence-based practices. In order to achieve positive client outcomes it is essential that both an evidence-based practice be selected and an evidence-based process for implementation be utilized. A local model for facilitating this process is described below:

Service Improvement Projects

AMH and the Northwest Frontier Addiction Technology Transfer Center have collaborated on two service improvement projects designed to help treatment agencies in

the State of Oregon learn a process for improving services. Agencies receive training and technical assistance to: 1) help them use data to identify service areas needing improvement; 2) identify specific targets for improvement; 3) use an effective change process for identifying possible change strategies (these strategies may include pilot testing an evidence-based practice); 4) continually use data to determine if a change strategy results in an improvement. This model draws heavily from the Network for Improvement of Addiction Treatment model and the Addiction Technology Transfer Center *Change Book*. Many of the principles guiding this model are consistent with the recommendations for program development that are assessed by the CPC (e.g., pilot test changes/new models before full implementation, use data to evaluate services, assess customer satisfaction, implement quality assurance programs). A full description of the NIATx process improvement model and multiple tools and resources are available on the NIATx website at www.NIATx.net . For more information on this model please contact, Shawn Clark at AMH (503) 945-9720 and/or Denna Vandersloot at (503) 378-8516.

6. Successful implementation of evidence-based practices requires attending to three key areas 1) the evidence-based practice; 2) organizational development; and 3) collaboration.

The National Institute of Corrections (NIC) and the Crime and Justice Institute (CJI) have partnered to develop a model to guide implementation of evidence-based practices in the criminal justice system. Three separate papers are available on the NIC website describing these three components, along with suggestions and checklists to guide the implementation of EBPs. These documents can be downloaded from the NIC website at http://nicic.org/Library/020174 .

FUNDING CONSIDERATIONS

Funding is a major issue related to the utilization and implementation of evidence-based practices. Tracy Rieckmann and colleagues at Oregon Health and Science University through a grant funded by Robert Wood Johnson Foundation looked at the impact of Senate Bill 267 on substance abuse treatment services and the number one challenge identified by treatment providers in this study, around the implementation of EBPs, is the lack of financial resources to support the adoption and implementation of many EBPs (Rieckmann, T.,, Bergmann L., & Bergeson, B., (2006) *Presentation: Implementing evidence-based treatment in an era of state budget cuts: Using Oregon as a case study*).

The primary funding issues related to the adoption of EBPs identified by participants in this study can be categorized into four major areas:

1) Initial start-up costs (i.e. training, loss of staff time to attend trainings, materials, trainer manuals, participant manuals) limit the use of many of the approved EBPs.

2) On-going costs such as clinical supervision, coaching, mentoring, fidelity monitoring related to the implementation of evidence-based practices is very expensive and is an additional cost both systems do not have the resources to cover.

3) Access to substance abuse treatment is extremely limited in many counties. This is particularly true for male offenders who, despite comprising the largest segment of the criminal justice population, typically aren't considered a special or vulnerable population. There are a very limited number of treatment slots available and more funding is needed to truly provide services to the number of offenders who need substance abuse treatment.

4) There is a serious lack of funding for ancillary services such as housing, mental health, vocational training, and medical services.

As stated in the beginning of this chapter the general consensus of the individuals interviewed for this document is "evidence-based practices are extremely valuable and help to move both the criminal justice and substance abuse field

forward", however both the substance abuse treatment system and the criminal justice system need additional resources to effectively implement and utilize these practices.

RESOURCES &ADDITIONAL CONTACTS

1) For a complete list of the AMH approved evidence-based practices go to:
http://www.oregon.gov/DHS/mentalhealth/ebp/practices.shtml.

2) Washington EBP Database List
http://adai.washington.edu/ebp

3) Northwest Frontier Addiction Technology Transfer Center has a resource section on evidence-based practices:
www.nfattc.org

4) Texas Christian University has a Treatment Process Model for assessing agency needs and a Treatment Program Change model that can be helpful for thinking about the process of making treatment improvements. The website with multiple resources is www.ibr.tcu.edu

5) National Institute of Corrections (NIC), Community Corrections Division and Crime and Justice Institute (CJI) provide several documents on their website on the Integrated Model of Implementation. www.nici.org and www.cjinstitute.org

6) Fixsen, D. L., Naoom, S. f., Blasé, K.A., Friedman R. M., & Wallace, F (2005) *Implementation Research: A Synthesis of the Literature Research* University of South Florida, Tampa, Florida.

CONCLUSION

This report began by stating the premise put forth in the NIC Integrated Model for implementation of evidence-based principles in community corrections which states that the successful implementation of evidence based principles can only be achieved when integrated with corresponding organizational development and collaboration. This report highlights the importance of understanding and acknowledging the differences between the criminal justice and treatment systems with regard to several key issues and the impact of those differences on the development of future policies, practices and trainings for these two systems.

The goal of this document is to stimulate questions and discussion about the collaborative process and how it may be achieved within the different counties. Ultimately, commitment and willingness on the part of the Collaboration Group and other interested stakeholders will be needed to actualize the recommendations of this document and keep moving the conversation forward. Thus, ***the strongest recommendation that this document can make is to encourage members of the Collaboration Group to convene cross-system, collaborative brainstorming meetings and creative problem solving sessions designed to fully explore the issues and recommendations made in this document.*** The power of a

group of committed participants who give attention and set aside the time to collaborate and take on even one issue, challenge or barrier and attempt to find a solution that works for both systems has been demonstrated on many occasions.

GLOSSARY

American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R): The American Society of Addiction Medicine's (ASAM) Patient Placement Criteria (ASAM PPC-2R) are the most widely used and comprehensive national guidelines for placement, continued stay and discharge of patients with alcohol and other drug problems. The ASAM PPC-2R provides two sets of guidelines, one for adults and one for adolescents, and five broad levels of care for each group. The levels of care are: Level 0.5, Early Intervention; Level I, Outpatient Treatment; Level II, Intensive Outpatient/Partial Hospitalization; Level III, Residential/Inpatient Treatment; and Level IV, Medically-Managed Intensive Inpatient Treatment. Within these broad levels of service is a range of specific levels of care.

For each level of care, a brief overview of the services available for particular severities of addiction and related problems is presented as well as a structured description of the settings, staff and services, and admission criteria for the following six dimensions: acute intoxication/withdrawal potential; biomedical conditions and complications; emotional, behavioral or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and recovery environment.

Evidence-based practices (EBPs): Evidence-based practices are practices whose effectiveness has been confirmed by systematic research or expert consensus.

Clinical Supervision: Supervision is an intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to the clients she, he, or they see(s), and serving as a gatekeeper of those who are to enter the particular profession (Bernard and Goodyear (1998).

Cognitive Behavioral Therapy: Cognitive behavioral therapy (CBT) is an evidence based therapy based on modifying cognitions, assumptions, beliefs and behaviors, with the aim of influencing disturbed emotions. The term "cognitive-behavioral therapy" is a very general term for a classification of therapies with similarities. There are several approaches to cognitive-behavioral therapy, including Rational Emotive Behavior Therapy, Rational Behavior Therapy, Rational Living Therapy, Cognitive Therapy, and Dialectic Behavior Therapy.

Cognitive Restructuring: Cognitive Restructuring attempts to correct thought patterns that are characteristic of criminal

thinking. Cognitive restructuring concerns the content or substance of what offenders are thinking. Cognitive treatment addresses the process, or how they think.

Community Reinforcement Approach (CRA): CRA is a treatment approach that aims to achieve abstinence by eliminating positive reinforcement for substance use and enhancing positive reinforcement for sobriety. CRA integrates several treatment components, including building the client's motivation to quit using, helping the client initiate sobriety, analyzing the client's substance use pattern, increasing positive reinforcement, learning new coping behaviors, and involving significant others in the recovery process. These components can be adjusted to the individual client's needs to achieve optimal treatment outcome.

Community Reinforcement Approach with Vouchers: CRA is an intervention which uses an incentive program (Vouchers) wherein patients can earn points exchangeable for retail items by remaining in treatment and abstinent.

Contingency Management: Contingency management uses a system of incentives and disincentives to motivate patients to meet their treatment goals, and has successfully been implemented in community treatment clinics, drug courts, and other settings.

Corrections Program Checklist (CPC): The CPC is a tool developed to assess correctional intervention programs. It is used to ascertain how closely correctional programs meet known principles of effective intervention; evidence-based practice. The purpose of the CPC is to identify the program strengths and areas needing improvement as pertains to evidence based practice. There are five domains within the CPC, and the scores in all five domains are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the five domains are given equal weight, and some items may be considered "not applicable," in which case they are not included in the scoring.

Dialectical Behavior Therapy (DBT): DBT is an empirically-supported treatment designed specifically for individuals with self-harm behaviors, such as self-cutting, suicide thoughts, urges to suicide, and suicide attempts. DBT is a modification of cognitive behavioral therapy (CBT).

Drug Courts: Drug courts are specialized courts designed to handle cases involving offenders who abuse addictive substances. The judiciary, prosecution, defense bar, probation, law enforcement, social service, and treatment communities work together to break the cycle of addiction. Drug courts offer offenders charged with non violent drug crimes or even drug-using offenders charged with a non-drug related crime the option of entering the drug court system in lieu of serving

a jail sentence. Offenders will have to plead guilty to the charge, agree to take part in treatment, regular drug screenings, and regular reporting to the drug court judge for a minimum of one year. Should the offender fail to comply with one or more of the requirements they may be removed from the drug court and incarcerated at the judge's discretion. If they complete the drug court program the charges brought against them are dropped.

Fidelity Monitoring: A method for service providers to look at or measure their adherence to an EBP model they are implementing. The effectiveness of a particular EBP depends on how accurately the provider has followed or replicated the essential elements of the model defined in the research. Incomplete or ineffective adherence may result in outcomes not meeting expectations. Fidelity monitoring is often done by using research-based fidelity scales.

Functional Family Therapy (FFT): FFT is a family-based prevention and intervention program that has been applied successfully in a variety of contexts to treat a range of these high-risk youth and their families. It combines and integrates the following elements into a clear and comprehensive clinical model: established clinical theory, empirically supported principles, and extensive clinical experience.

42-CFR Part 2: A Federal regulation that protects "patient identifying information", which is information, recorded or unrecorded, that could potentially link an individual, by name or otherwise, to a substance abuse treatment program. 42-CFR Part 2 applies to alcohol and drug programs that are federally conducted, regulated or assisted in any way, directly or indirectly

Graduated Consequences: Criminal sanctions that escalate in intensity with each subsequent, more serious offense.

Health Insurance Portability and Accountability Act (HIPAA): A Federal regulation that gives patients greater access to their own medical records and more control over how their personally identifiable health information is used. The regulation also addresses the obligations of healthcare providers and health plans to protect health information.

Level of Service Inventory—Revised (LSI-R) : The LSI-R measures 54 risk and criminogenic need factors about 10 criminogenic domains that are designed to inform correctional decisions of custody, supervision, and service provision. The domains measured by the LSI-R include criminal history, education/employment, financial situation, family/marital relationships, accommodation, leisure and recreation, companions, alcohol or drug use, emotional/mental health, and attitudes and orientations (Andrews & Bonta).

Matrix: The Matrix Model (Rawson et al., 1995) of outpatient treatment was developed during the 1980s in response to an overwhelming demand for stimulant abuse treatment services. The intent was to create an outpatient model responsive to the needs of stimulant-abusing patients while constructing a replicable protocol that could be evaluated. Treatment materials draw heavily upon published literature pertaining to the areas of relapse prevention, family and group therapies, drug education, self help participation and drug abuse monitoring.

Methadone Maintenance Treatment (MMT): MMT is a program in which addicted individuals addicted to opioids take regular doses of methadone to decrease the withdrawal and cravings that are associated with opioids. It is one of the most successful treatments for heroin addiction.

Motivational Interviewing: Motivational interviewing is an evidenced based practice that which is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

Motivational Enhancement Therapy (MET): MET seeks to evoke from clients their own motivation for change and to consolidate a personal decision and plan for change. The approach is largely client centered, although planned and directed.

Outcomes Monitoring: The foundation of evidence-based practices is measurable client outcomes. Therefore, one key component of the implementation of an evidence-based practice is the careful monitoring of client outcome data. Outcome data may look at such things as health status, use of inpatient services, employment, psychological and social functioning, alcohol and other drug use, and criminal activity.

Relapse Prevention Therapy (RPT): RPT is a cognitive-behavioral approach to the treatment of addictive behaviors that specifically addresses the nature of the relapse process and suggests coping strategies useful in maintaining change.

Restorative Justice: Within the context of the Criminal Justice field, Restorative Justice views conflict and crime as harm done by one person to another. The consequences of such an action should be "making things right" (as much as possible) between these individuals. Restorative Justice involves the victim, the offender and the community in search for solutions, which promote repair and possibly reconciliation. Examples of restorative justice initiatives include: Victim Offender Mediation and Community Conferencing.

Seeking Safety (SS): SS is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. The treatment protocol is available as a book, providing both

client handouts and guidance for clinicians. The treatment was designed for flexible use. It has been conducted in group and individual format; for women, men, and mixed-gender; using all topics or fewer topics; in a variety of settings (outpatient, inpatient, residential); and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD.

Senate Bill 267 Evidence Based Crime Prevention Programs: SB 267 requires prevention, treatment or intervention programs which are intended to reduce future criminal behavior in adults and juveniles or to reduce the need for emergency mental health services to be evidence-based.
Supervision: Criminal justice personnel such as parole or probation officers who closely monitor the offender for compliance with the conditions of release set by the court.

Twelve-Step Facilitation (TSF): TSF consists of a brief, structured, and manual-driven approach to facilitating early recovery from alcohol abuse/alcoholism and other drug abuse/addiction. It is intended to be implemented on an individual basis in 12 to 15 sessions and is based in behavioral, spiritual, and cognitive principles that form the core of 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). It is suitable for problem drinkers and other drug users and for those who are alcohol or other drug dependent.

BIBLIOGRAPHY

American Probation and Parole Association and NASADAD. 1992. *Coordinated Interagency Drug Training Program*. Lexington, KY: APPA.

Berk, R.A., Leinihan, K.J. & Rossi, P.H. (1980). Crime and Poverty: Some experimental evidence from ex-offenders. *American Sociological Review*, 45, 766-86.

Bernard, J. & Goodyear, R. K. (1998). *Fundamentals of Clinical Supervision*. (2nd ed.). Boston: Allyn &Bacon.

Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic Medicine, 10*(5), 300-314.

Comerford, A.W. (1999). Work dysfunction and addiction: Common roots. *Journal of Substance Abuse Treatment*, 16(3), 247-253.

Duffee, D. and B. Carlson, (1996). "Competing Value Premises for the Provision of Drug Treatment to Probationers." *Crime and Delinquency 42(4):* 574-593.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Inciardi, J. A., Martin, S. S., Butzin, C. A., Hooper, R. M., & Harrison, L. D. (1997). An effective model of prison-based treatment for drug-involved offenders. *Journal of Drug Issues*, *27*, 261-278.

Knight, K., & Hiller, M. (1997). Community-based substance abuse treatment: A 1-Year outcome evaluation of the Dallas County Judicial Treatment Center. *Federal Probation*, *61*(2), 61-68.

Koehler, J. & Sisco, J. (1981). *Public Communication in Business and the Professions. West Publishing*. New York.

Lipton, D. S. 1995. "The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision." Presentation at the Conference on Criminal Justice Research and Evaluation. Washington, DC: National Institute of Justice

Maruna, S. (2001). *Making Good: How Ex-Convicts Reform and Rebuild Their Lives.* Washington, DC: American Psychological Association.

McKay, J.R., Lynch, K.G., Shepard, D.S., Morgenstern, J, Forman R.F., Pettinati, H.M. (2005). Do patient characteristics and initial progress in treatment moderate the effectiveness of telephone-based continuing care for substance use disorders*? Addiction* 100(2):216-226, 2005.

Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.R., Griffith, J.H., eds. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Miller, W.R., Yahne, C.E., Moyers, T.B., Martinez, J., Pirritano, M. (2004). A randomized trial of methods to help clinicians learn motivation interviewing. *Journal of Consulting and Clinical Psychology*. 72, 1050–1062.

National Institute of Corrections. (2004). *Implementing Effective Correctional Management of Offenders in the Community: An Integrated Model.* Accessed at http://nicic.org/Library/019341\

Pelissier, B.M., Gaes, G., Rhodes, W., Camp, S., O'Neil, J., Wallace, S., & Saylor, W. (1998). *TRIAD drug treatment evaluation project six-month interim report.* Federal Bureau of Prisons Office of Research and Evaluation. Washington, DC: US Government Press.

Platt, J.J. (1995). Vocational rehabilitation of drug abusers. *Psychological Bulletin*, 117(3), 416-433.

Rawson, R.A., Obert, J.L. McCann, M.J. and Mann. A.J. (1986) Cocaine treatment outcome: Cocaine use following inpatient, outpatient and no treatment. CPDD NIDA Research Monograph, 67, 271-277.

Rawson, R., Shoptaw, S., Obert, J.L., McCann, M, Hasson, A., Marinelli-Casey, P., Brethen, P. & Ling, W. (1995). An intensive outpatient approach for cocaine abuse: the Matrix model. *Journal of Substance Abuse Treatment*, 12 (2), 117-127.

Rieckmann, T., Bergmann, L., Fuller, B.E., Bergeson, B. (2005). *Implementing evidence-based treatment in an era of state budget cuts: Using Oregon as a case study.* Paper presented at the meeting of the American Public Health Association, Philadelphia PA.

Salzer, M. (2002). Consumer-delivered services as a best practice in mental health care delivery and the development of practice guidelines. *Psychiatric Rehabilitation Skills, 6*(3), 355-383.

Sholomskas, D.E., Syracuse-Siewert, G., Rounsaville, B. J., Ball, S. A., Nuro, K. F., & Carroll, K. M. (2005). We Don't Train in Vain: A Dissemination Trial of Three Strategies of Training Clinicians in Cognitive–Behavioral Therapy. *Journal of Consulting and Clinical Psychology*, 73 (1), 106–115.

Turner, W.M., Turner, K.H., Reif, S., Gutowski, W.E., & Gastfriend, D.R. (1999). Feasibility of Multi-Dimensional Substance Abuse Treatment Matching: Automating the ASAM Patient Placement Criteria. *Drug and Alcohol Dependence*, 55, 35-43.

Uggen, C. (1999). Ex-offenders and the conformist alternative: a job quality model of work and crime. *Social Problems*, 46, 127-151.

Wolkstein, E., Bausch, R., & Weber, G. (2000). Work as a critical component of recovery. Dayton, OH: Wright State University, RRTC on Drugs and Disability. Accessed at: http://www.med.wright.edu/citar/sardi/workandcovery.html

APPENDIX

Challenges/Barriers: Focus Group Results

TYPE OF INFORMATION THAT NEEDS TO BE SHARED	
Criminal Justice Perspective	**Treatment System Perspective**
Some officers want only the essential information, such as, is the offender attending treatment and providing clean UA's. Reasons cited for the benefit of having limited information include being too busy to sift through additional information and/or trust that "treatment providers know what they are doing; I just need to know if they are showing up." As such, information conveyed by treatment providers to criminal justice staff should be confined to matters of attendance, UA data, completion or early termination from treatment. Other officers are interested in much more specific information on clients. Reasons cited for the need for additional information include: a better understanding of the issues being faced by the offender and an increased ability to support the work being done in treatment by reinforcing the needs identified by the treatment provider and client in their own work with the offender. For example, one group of probation/parole officers who do receive monthly status reports from treatment providers, that include only how many treatment sessions were attended by the offender and the status of urine analysis results, stated they would like to receive information around "what the core issues are for the client, relapse prevention plans, and aftercare plans."	Treatment providers consistently indicated that they do not currently receive any type of status reports on offenders who are coming out of in-prison treatment programs. This makes it very difficult for community treatment providers to build on the treatment provided in prison and develop an effective continuum of care. Information identified as needed by treatment providers include: **1. LSCMI results**- The LSCMI is being done in some of the counties by probation and parole, however, the results are not yet being provided to the treatment providers. **2. ASAM reports completed by in-prison treatment personnel** - If treatment providers have a copy of the ASAM/Evaluation report they would not need to duplicate efforts and require the offender to receive another assessment/evaluation. This is important because treatment programs often charge offenders for a new assessment and due to a lack of ability to pay this can hold up the offender's entrance into treatment. **3. Basic information around the impetus for referring the offender to substance abuse treatment is often lacking**. - One treatment provider talked about the need to receive consistent information that would include: "Reason for the referral to substance abuse treatment, screening assessment results, previous treatment and any significant clinical and legal issues."

TIMELINESS OF INFORMATION	
Criminal Justice Perspective	**Treatment System Perspective**
Some probation officers report not receiving timely updates on status from treatment providers. As a result, some find themselves needing to call treatment agencies to get information which is often a time consuming, inefficient use of the probation officers time.	Treatment providers noted that it is often impossible to get probation officers on the phone to get or provide information about clients. Treatment providers acknowledge that the probation officers have large case loads and limited time in which to correspond with providers. Some treatment providers do use email, somewhat successfully, while others do not feel comfortable corresponding about clients through this medium.

DIFFERING PERSPECTIVES ON WHAT SHOULD BE CONFIDENTIAL INFORMATION	
Criminal Justice Perspective	**Treatment System Perspective**
A small number of probation officers interviewed indicated that having a more in depth understanding of the issues that offenders are facing is helpful for them in providing supervision. As one probation officer stated, "If I understand that their relapse was based on them confronting some unresolved issue, like dealing with an old abuser, I'm more likely to handle a positive UA differently than I would if I thought they were just not working their program." Others felt that getting more detailed psychosocial information also	Some treatment providers expressed concern about the nature of information disclosed to criminal justice staff. Reasons cited for this concern were respect for the offender's privacy around sensitive and personal issues such as sexual abuse and trauma. In addition to privacy of sensitive information, some provider's also questioned the utility of probation officers having such information "Why would they need to know, what would they do with it?" Still other providers felt that even the results of UA's should not

DIFFERING PERSPECTIVES ON WHAT SHOULD BE CONFIDENTIAL INFORMATION	
Criminal Justice Perspective	**Treatment System Perspective**
increased their overall understanding of addiction and actually made them more compassionate towards substance users It should be noted that some probation officers are aware of this reluctance to share information and feel that treatment providers are "enabling" or "too protective" of criminal justice offenders.	be disclosed, as the results might be used to "punish clients".

Cross-Discipline Trainings and Forums	
Criminal Justice Perspective	**Treatment System Perspective**
One consistent message voiced by both criminal justice and substance abuse treatment professionals, especially front line-staff, was the need for on-going opportunities to meet together to learn more about each system's processes, to network and build relationships, and to identify ways to work together more effectively. Several of the front-line staff talked about how the administrators from mental health, substance abuse, and criminal justice often have these cross-discipline forums; however they expressed frustration at not having the same opportunities to meet with the other discipline's front-line staff. One participant stated, "We're the ones doing the work and we need to be meeting with each other more often." A few participants talked about how occasionally (about once or so a year) these types of opportunities for meeting with each other happen and the conversation is started, but then there is no "follow-through." Counselors and probation and parole officers both identified this area as one of the priority areas that could help them improve the work they do with offenders.	

LENGTH OF STAY IN THE TREATMENT	
Criminal Justice Perspective	**Treatment System Perspective**
Probation/parole officers reported being frustrated that offenders were kept in treatment for lengthy outpatient stays that often delayed or interfered with their ability to get or retain a job. Compounding this frustration was the belief that the additional time spent in treatment was often "unhelpful" in that clients were getting the same type of treatment/information that they had already received in prison and were not realizing any additional benefit from it. While they did not generally question the efficacy of treatment, they did have concerns that treatment was not individualized enough to meet the needs of transitioning offenders. In the words of one probation officer, "It's like they all have to go through the same program, whether they need it or not." A similar sentiment was expressed by another probation officer who stated 'They (offenders) have so many things they have to accomplish once they are out, like getting a job. If all their time is spent going through yet another treatment program how can they get on their feet?" However, these same probation/parole officers would also question why some offenders were "so quickly moved through treatment when they obviously still needed more care" as evidenced by their perception that the offender was "still acting like an addict" or (in some cases) continually relapsing. Those who felt that length of treatment was insufficient often felt that offenders were being discharged from treatment "before they had the skills to go out there (the community)."	Many treatment providers feel that adherence to manualized evidence based practices (EBP) have created an additional pressure with regard to length of stay. Instead of determining length of stay based on ASAM criteria, there is a growing sentiment that clients "have to be kept in a specific number of weeks of treatment because the EBP is based on that amount of time." Many providers share the above stated concerns of criminal justice personnel about clients either being kept too long or too little, but are constrained by the demands of EBPs. Similarly, providers report being challenged with regards to the ASAM patient placement criteria with offenders who have been incarcerated for long periods of time. As ASAM takes into account time abstinent from substances as factor in placement, it is highly unlikely that offenders will be eligible for all but the lower levels of treatment. Treatment providers report that some criminal justice personnel become upset that offenders are not placed at a higher level of care. Additionally, the current continuum still revolves around agencies having levels of care (i.e. intensive outpatient) as opposed to also having services "unbundled" to allow for truly individualized care.

TREATMENT SERVICES OFFERED IN THE COMMUNITY DO NOT ALWAYS MATCH THE NEEDS OF CLIENTS	
Criminal Justice Perspective	**Treatment System Perspective**
Criminal justice personnel often questioned if clients were receiving the essential recovery and/or self management skills appropriate to their individual needs or simply being "run through the same program everyone gets because it all that they (treatment providers) offer?" It was often felt that treatment services did not provide or put enough emphasis on criminogenic thinking, other life skills and vocational issues. Instead some respondents felt that they "just kept getting the same relapse prevention education". Similarly several respondents wondered what was different between the services the clients received while incarcerated versus those in the community. It was felt that community based treatment did not "take them (clients) to the next level" and should be structured in a way to "help the client pick up where they left off after being released from prison". Criminal justice personnel also worry that offenders need a variety of services, in addition to substance abuse treatment, during their transition to life in the community. Many of these are considered "ancillary," although without them treatment success is unlikely. For example, an offender will not be able to participate in outpatient treatment if he or she doesn't have housing and transportation. Probation/parole officers stated that clients without housing appear to "struggle" despite being in treatment.	As mentioned previously, flow of information between the two systems is often problematic. Treatment providers find this particularly challenging when it comes to making level of care decisions and developing treatment plans in the absence of information about a client's previous treatment history while they were incarcerated. As a result clients may end up "doing the same stuff they were doing in prison" and not truly advancing through the continuum of care. As one provider put it "If we don't know what (treatment) they already have had, and based on their reported information they seem appropriate for a certain type of care, that's where they go." Another provider summed it up this way, "It's hard to provide a continuum of care when we don't always know what they have had before coming to us?" Treatment providers acknowledge that a range of services is necessary for effective treatment. However, providing these services is often cost prohibitive, thus treatment agencies often rely on other community organizations to fill this gap. While some treatment agencies may provide some of these services, there is a notable lack of ancillary services in the community available or easily accessible for offenders.

DIFFERING PERSPECTIVES ON RISK AND MOTIVATION FOR TREATMENT	
Criminal Justice Perspective	**Treatment System Perspective**
Several probation/parole officers felt that often they would work closely with a client over a period of time to help enhance the their readiness for treatment, only to have the treatment providers "shoot them down" during an assessment and deem them not sufficiently motivated for a treatment slot. These respondents also felt that this occurred because of a difference of perspective or opinion as to what constituted "motivation" as well as a lack of communication between the probation/parole officer and treatment staff prior to and immediately after an assessment occurred. One probation/parole officer indicated "I wish they (treatment provider) had called me before telling the client that. Maybe we could have come up with a better outcome. I now feel like all my work went down the drain. What happened there?" Interviewees in one county expressed concern around there being somewhat of a conflict between the two systems in regards to which offenders are given priority for treatment slots. The risk principle recommends high-risk offenders be given first priority for treatment resources; whereas the substance abuse treatment programs, having only limited slots, tend to give priority to clients who demonstrate motivation and a higher readiness for treatment. Probation officers talked about how some of their "high-risk" offenders, who do not want to enter treatment, use this to their advantage and simply avoid entering services by telling providers they do not want treatment. These interviewees thought this might be less of a problem if more publicly funded treatment slots were available.	Treatment providers further felt that in these cases they were put in a quandary as to whether they admit "someone who was highly motivated and had a chance of doing well in our program but not a criminal justice referral versus the offender who is defined as being high risk per the criminal justice system, but has low motivation." Many providers have a limited amount of available slots for treatment. As such, there is a sensitivity to making every effort to ensure that a prospective client's placement level is congruent with their stage of readiness for change or amenability to treatment. Several providers have reported that they often were referred clients from the criminal justice system who displayed a high degree of resistance or lower level of readiness for treatment. Treatment providers were frustrated by what they saw as "pressure to admit people (to a certain level of care) who clearly were not ready to be there."

IMPLEMENTATION AND FIDELITY MONITORING	
Criminal Justice Perspective	**Treatment System Perspective**
The degree to which the various evidence-based practices have been implemented varies considerably from system to system and agency to agency. For example, most of the probation and parole officers are just learning how to use the LSI/R and so full implementation of this instrument for effective treatment matching and case management is in the early stages of development. At the same time the Department of Corrections is evaluating substance abuse treatment programs using the CPC and are looking at how well substance abuse treatment programs are assessing for risk, need, and responsivity, and so for those programs not currently receiving the LSI/R assessment from the criminal justice system, this creates a problem for meeting the CPC criteria unless they have implemented their own risk assessment instrument. Another concern expressed by a few probation and parole officers was the lack of clinical supervision for practices such as motivational interviewing and cognitive behavioral therapy. They recognize these practices require clinical skills that they have not sufficiently developed and in most units there is not a system in place for the development and monitoring of these types of clinical skills. Criminal justice personnel who use the	As was mentioned in the communications chapter, very few of the treatment providers are actually receiving the results of the LSI/R. This creates a problem because one of the criteria on the CPC is evaluating whether programs are using proven assessment methods that assess the risk, need, and responsivity factors of offenders and then providing the appropriate services. Therefore, treatment programs need the results of the LSI/R to be able to effectively match the needs of offenders with treatment services. This is an area where many of the treatment providers assessed on the CPC score less than satisfactory (personal communication Bill Sawyer). One provider identified an emerging need related to the implementation of the LSI/R being training and technical assistance for understanding how to create effective individual treatment plans to address the identified needs and provide adequate case management. The lack of clinical supervision and on-the-job coaching and training also impacts the degree to which evidence-based practices are full implemented and fidelity maintained. Front line-staff often receive the primary training for an EBP and the clinical supervisors and/or program managers may not receive extensive training in the model (due to all the other demands on their time),

IMPLEMENTATION AND FIDELITY MONITORING	
Criminal Justice Perspective	**Treatment System Perspective**
CPC to monitor felt strongly that programs "who use the Matrix as it is designed will score well if they are consistently using the skill building, modeling, and practice and do not slip back into processing. Many programs that have great curriculum simply do not use it as designed and do not keep the majority of each group focused on teaching new skills and having offenders consistently practice new skills. The CPC will not only recommend they use EBP curriculum, like the Matrix, but that they consistently use it as it is designed and perhaps even be creative and add additional practice (role plays) that might not be a built in part of the curriculum. Those programs who do follow the skill building as the core and follow the Matrix normally score very well in that section and hopefully have the proper assessments, staffing, quality assurance, etc that will allow them to have an overall high score as well."	and so this also contributes to the difficulties agencies experience around sustaining specific evidence-based practices. When new staff are hired external trainers and consultants must be hired to provide the on-going training and clinical supervision necessary to that specific EBP. A significant concern for the administrators at AMH is the issue of fidelity. AMH along with its stakeholders, are in the process of developing a strategy for monitoring fidelity to EBPs. This is a high level priority at the state-level to ensure that the practices being reported are actually being used with enough fidelity to produce positive outcomes. One County Alcohol and Drug Provider talked about having some difficulties adapting some of the curriculums that were developed for use in in-prison or inpatient facilities to outpatient treatment. The number of sessions in some of the curriculums is significantly higher than the number of outpatient treatment sessions that are feasible for most clients. For example, the Milkman & Wanburg curriculum "*Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change, Pathways To Responsible Living*" has twenty-seven sessions which this provider found difficult to adapt to an outpatient setting. This same respondent also expressed a concern that some of the

IMPLEMENTATION AND FIDELITY MONITORING	
Criminal Justice Perspective	**Treatment System Perspective**
	EBPs do not fit well with the education level and responsivity needs of some of the clients they serve. Other respondents talked about needing to adapt EBPs for special populations. The issue then arises around maintaining fidelity when there is a need to make significant adaptations. Although the majority of the individuals interviewed in the field did not express concern around fidelity issues, this is a concern that was expressed by administrators at the State level. The Department of Corrections is seeking to address this issue through the use of the CPC. Three of the areas that providers tend to score the lowest in on the CPC at a national level, and a few reports indicate this is consistent in Oregon, are in the areas of assessment, treatment, and evaluation. The assessment and treatment area deficiencies can often be correlated directly to implementation and fidelity issues. Another issue identified by administrators is under the current plan only substance abuse treatment agencies providing services to offenders are being assessed using the CPC; however, general probation and parole programs are not being evaluated with the CPC to determine their own level of the incorporation of evidence-based principles.

CONFLICTS BETWEEN CRIMINAL JUSTICE AND ADDICTION AND MENTAL HEALTH EVIDENCE-BASED PRACTICES	
Criminal Justice Perspective	**Treatment System Perspective**
A conflict identified by providers is there are EBPs on the approved AMH list, that do not score high on the CPC. The Matrix Model of Treatment for Stimulant Abuse was one of the models identified as being on the approved AMH list, but failing to score high on the CPC. And on the other hand, there are programs that DOC is endorsing, that have not met the approval criteria to be on the AHM EBP list. For example the Milkman and Wanburg curriculum "*Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change*" is being used by DOC and this curriculum is not on the AMH approved list. However, it is a curriculum that is based on CBT and MI, which are both on the AMH approved list. This particular problem can be traced back to the fact that the Criminal Justice System relies more on evidence-based principles to guide its evaluation of effective interventions versus looking at specific evidence-based practices or interventions. The distinction is subtle, but it does create problems when evaluating the use of EBPs across the two systems.	