



the NATIONAL REENTRY
RESOURCE CENTER

— A project of the CSG Justice Center —

Recidivism Reduction, Substance Use and Co-occurring Disorders: What Does Evidence and Practice Tell Us?

Brought to you by the National Reentry Resource Center and the
Bureau of Justice Assistance, U.S. Department of Justice

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Foundation, Annie E. Casey Foundation, and Open Society Institute

Speakers

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Director of Health Systems and Services Policy
Council of State Governments Justice Center

Presentation Outline

- **Overview of the concept of Evidence Based Practices and their application to individuals with co-occurring substance use disorders and non-addiction mental illnesses**
- **What we know about what works for individuals with substance use dependence and mental illnesses that are not severe – Quadrant III**
- **What we know about what works for individuals with serious mental illnesses and substance use dependence – Quadrant IV**
- **Discussion**

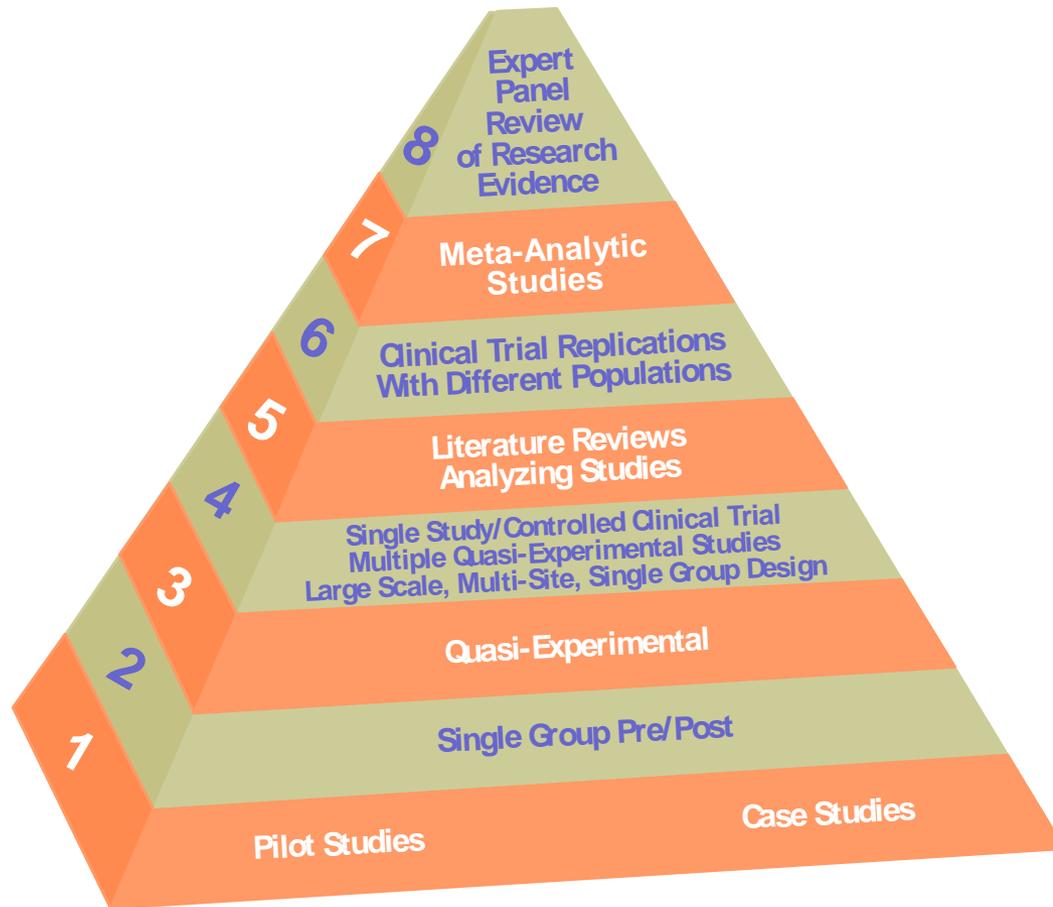
Evidence-Based Practice...

.... **“the integration of the best research evidence with clinical expertise and patient values.”**

Institute of Medicine, 2000

Pyramid of Research Evidence

(SAMHSA, 2005)



What is Fidelity?

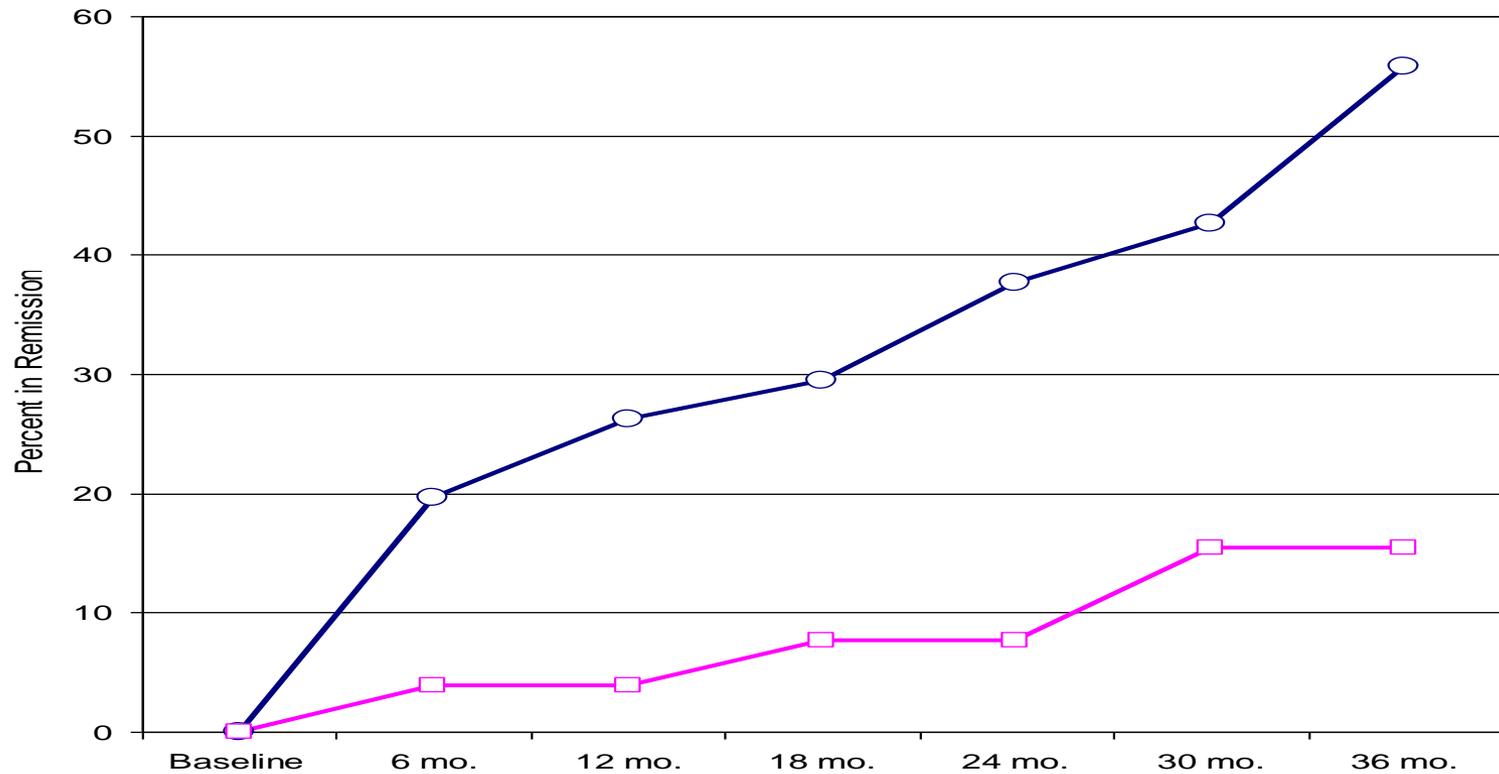
Fidelity is the degree of implementation of an evidence-based practice

Programs with high-fidelity are expected to have greater effectiveness

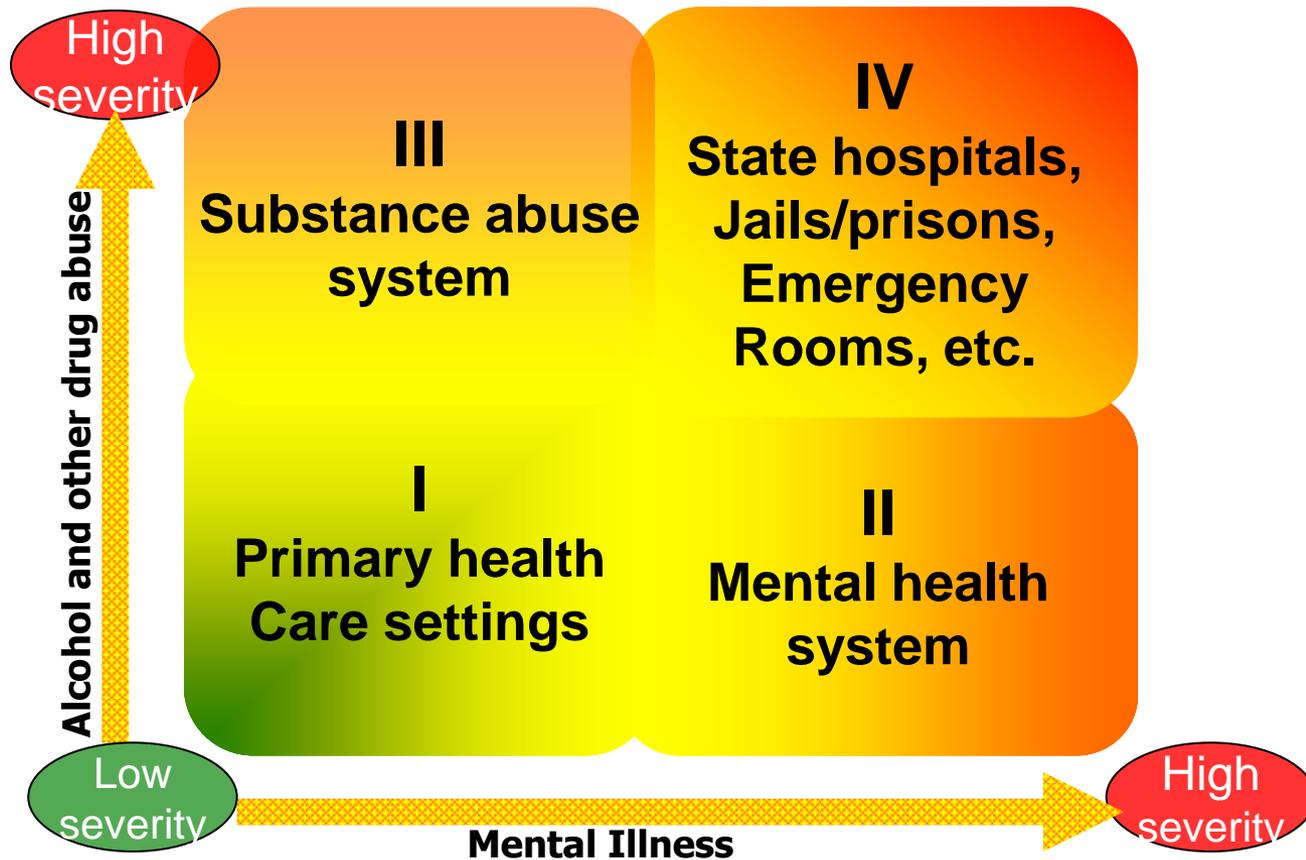
Fidelity scales assess the critical ingredients of an EBP

Why care about fidelity?

Figure 1. Percent of Participants in Stable Remission for High-Fidelity ACT Programs (E; n=61) vs. Low-Fidelity ACT Programs (G; n=26).



Heterogeneity of the Population with Co-occurring Disorders

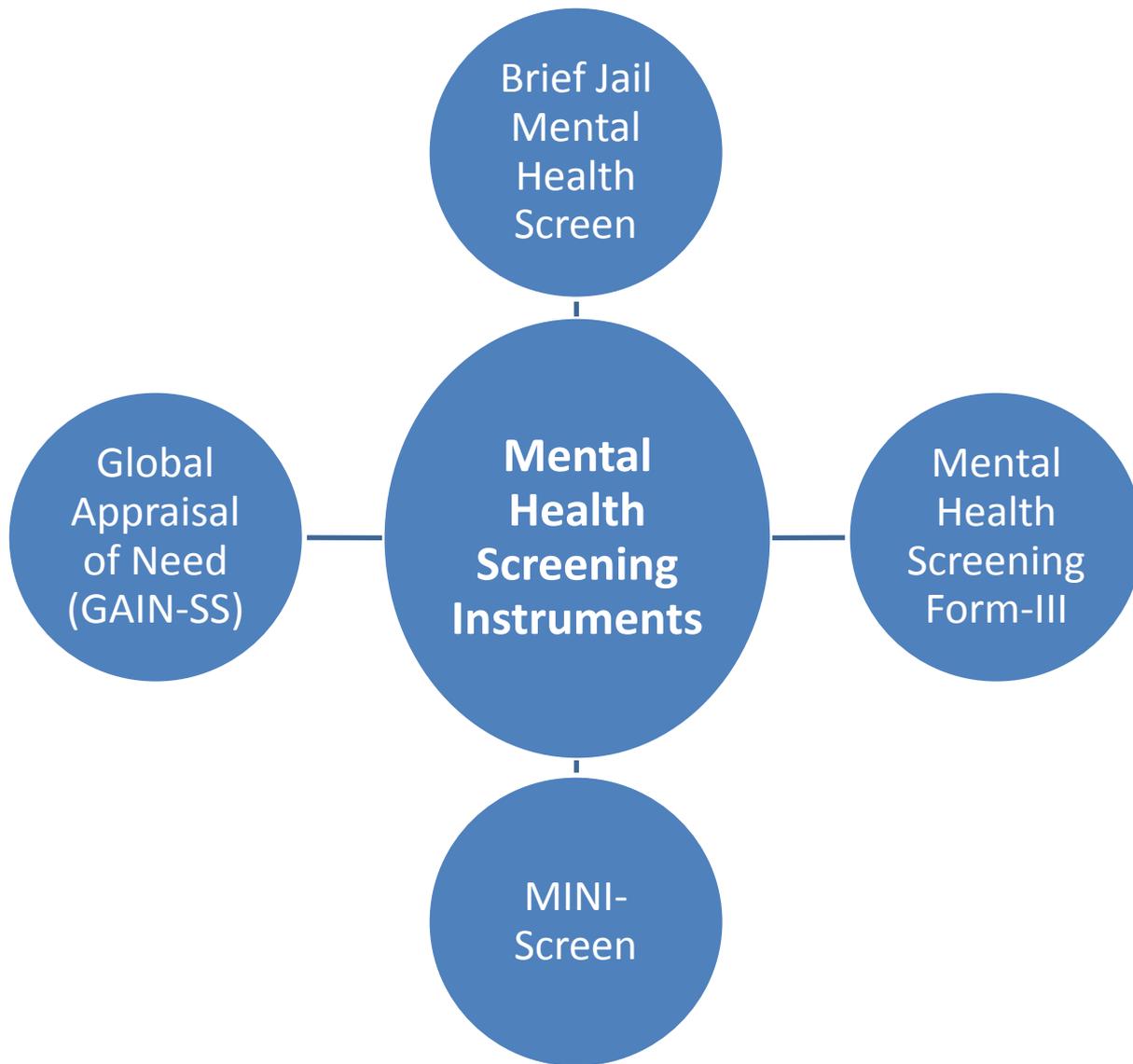


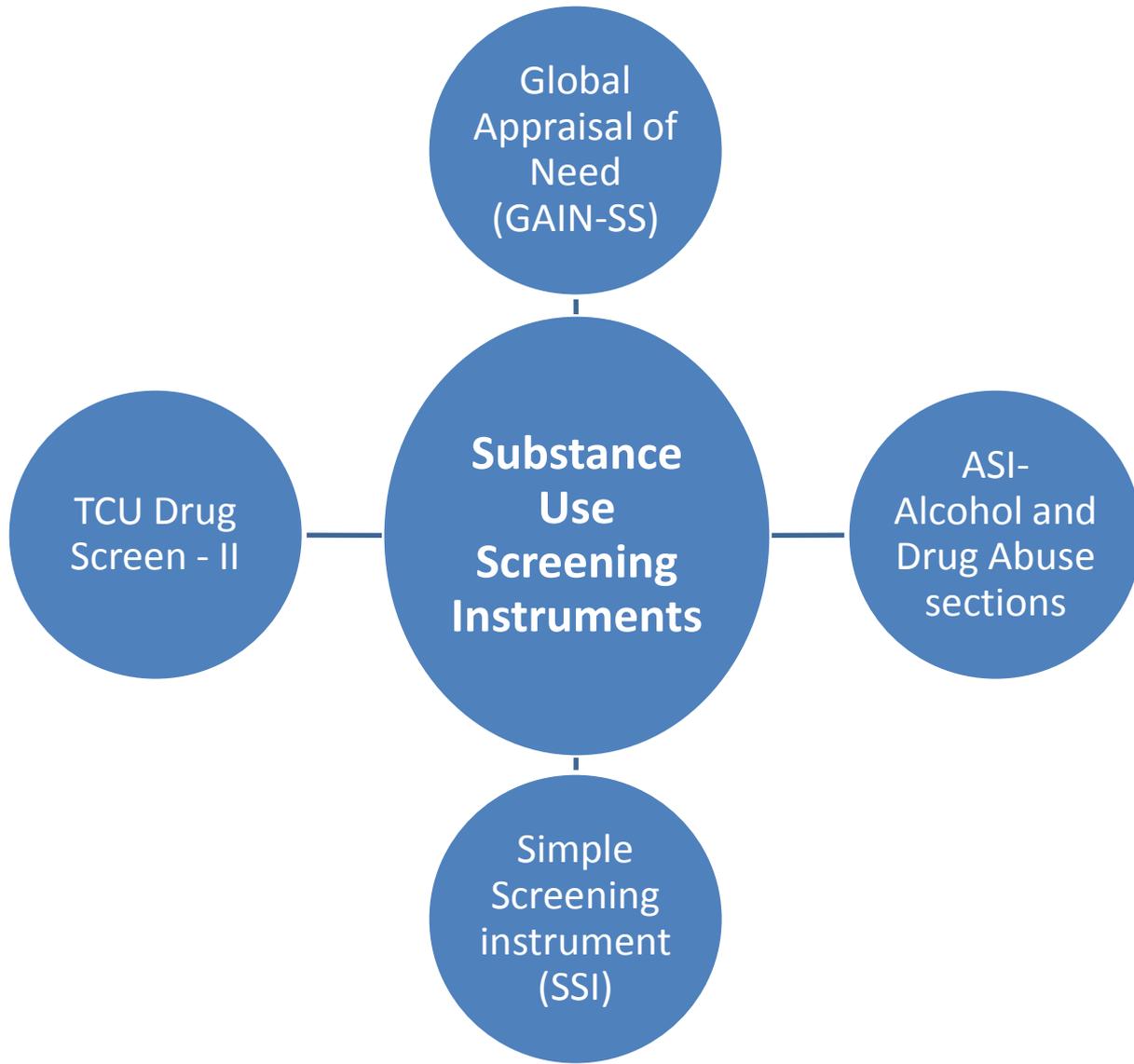
Importance of Screening and Assessment for CODs

- **High prevalence** rates of mental and substance use disorders in criminal justice settings
- Persons with undetected disorders are likely to **cycle back through** the criminal justice system
- Allows for **treatment planning** and linking to appropriate treatment services

Issues in Selecting COD Screening and Assessment Instruments

- **Wide number** of instruments available – not all created equal
- **Direct to consumer marketing**
- Use of **non-standardized instruments**
- Instruments **not validated in CJ settings**
- **Coverage** of mental and substance use disorders is uneven
- Absence of **comparative data**





Assessment Instruments for CODs

Addiction
Severity Index
(ASI)

Global Appraisal
of Needs (GAIN)

- *GAIN-Quick*
- *GAIN-Initial*

Texas Christian
University - IBR

- *Brief Intake Interview*
- *Comprehensive Intake*

Conceptual Model of Treatment Services

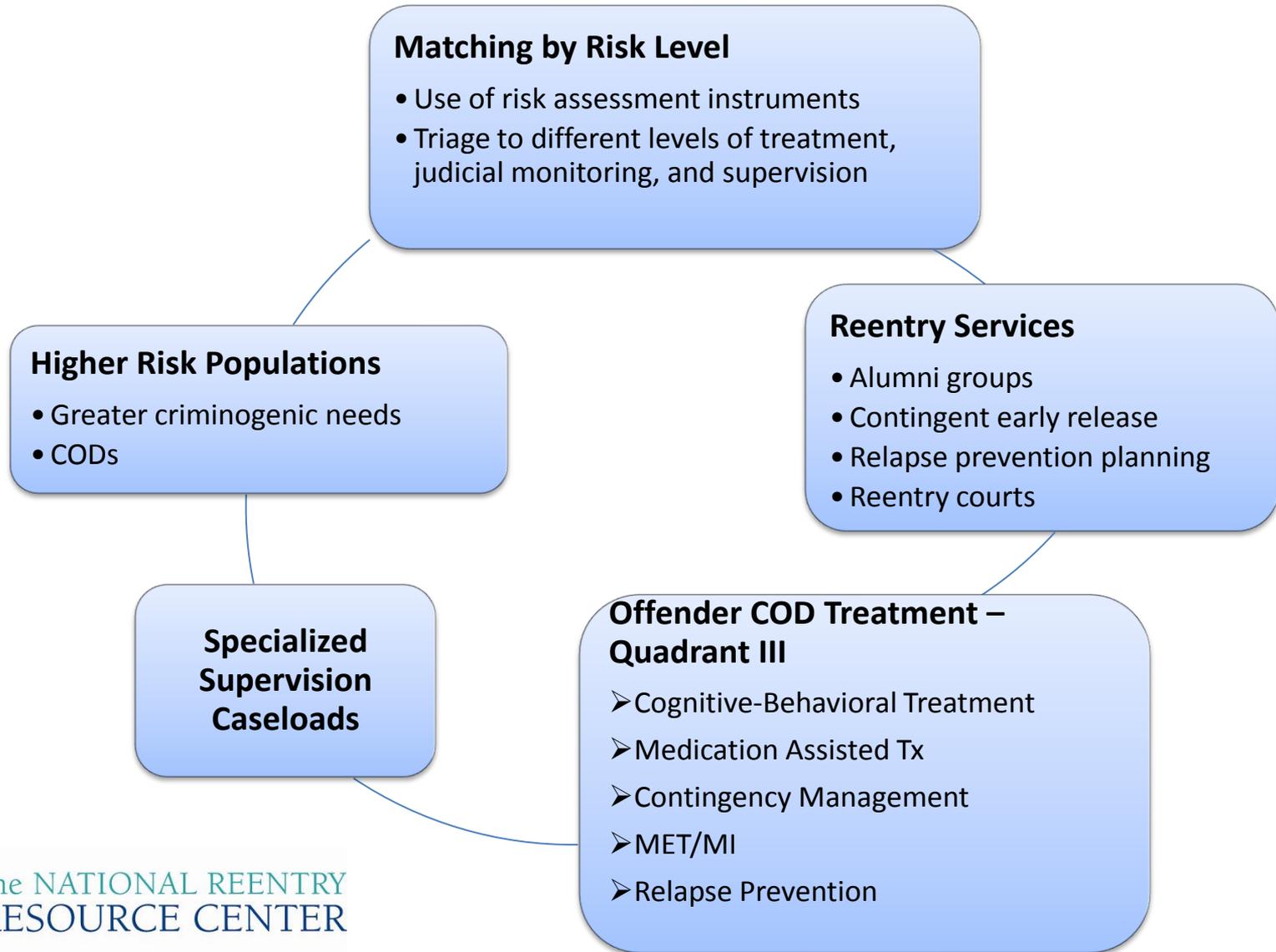


Table of Evidence-Based Practices for Justice Involved Persons with Co-occurring Disorders (Adapted from COCE, 2005)

Evidence-Based Practices	
For Persons with Substance Dependence and Mental Illness – Quadrant III	For Persons with Serious Mental Illnesses and Substance Dependence – Quadrant IV
Cognitive–Behavioral Therapeutic Techniques	Integrated Dual Disorder Treatment
Modified Therapeutic Communities	Supported Housing
Medication Assisted Therapies	Psychopharmacologic Interventions
Contingency Management Techniques	Forensic Assertive Community Treatment
Motivational Enhancement Therapy	Illness Management and Recovery Skills
Relapse Prevention	Supported Employment
Trauma-focused Treatment	Trauma-focused Treatment
Participation in Mutual Self-Help Groups	Cognitive Behavioral Therapeutic Techniques

Evidence-Based Practices – Quadrant III

- Cognitive-behavioral treatment
 - Focused on substance abuse
 - Focused on ‘criminal thinking’
- Modified Therapeutic Communities
- Medication-assisted treatment
- Contingency management
- Motivational enhancement
- Relapse prevention
- Trauma-focused treatment
- Participation in mutual self-help groups

Cognitive-Behavioral Interventions

- Focus on skill-building (e.g., coping strategies)
- Self-control and self-management
- Problem-solving approaches
- Use of role play, modeling, feedback
- Repetition of material, rehearsal of skills
- Curriculum-based

Reentry Planning for CODs

In-reach of
community
treatment
providers

Accessing and
restoring
benefits

Continuity of
medications

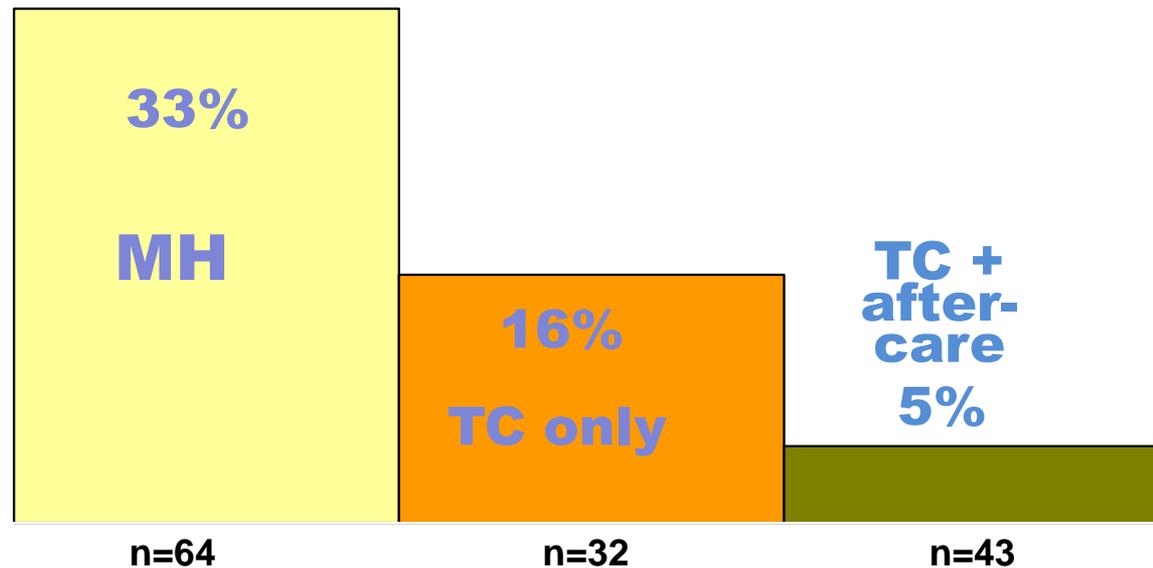
Dedicated staff
to coordinate
reentry

Develop reentry
or transition
plan (e.g., APIC
model)

Other Reentry/Transition Services

- Assistance to engage in **community-based MH and SA treatment**
- Engagement in **peer support and self-help networks** to assist in recovery
- **Stable housing**
- **Vocational training** and employment support
- **Case management** and community supervision

Effectiveness of Prison COD Treatment and Reentry – 1 Year Reincarceration



Total n=139

Community Supervision and CODs

- **Specialized caseloads (MH/COD)**
- **Smaller caseloads (e.g., < 45)**
- Sustained and specialized **officer training**
- Active engagement in **SA and MH treatment**
- **Dual focus** on treatment and surveillance

Community Supervision and CODs

- **Problem-solving approach**
 - Higher revocation threshold
 - Wide range of incentives and sanctions
 - Flexibly apply sanctions
 - Avoid sanctions that remove participants from treatment
- **Relationship quality important** (trust, caring-fairness, avoid punitive stance) – “firm but fair”

(See Skeem et al., 2006, 2009)

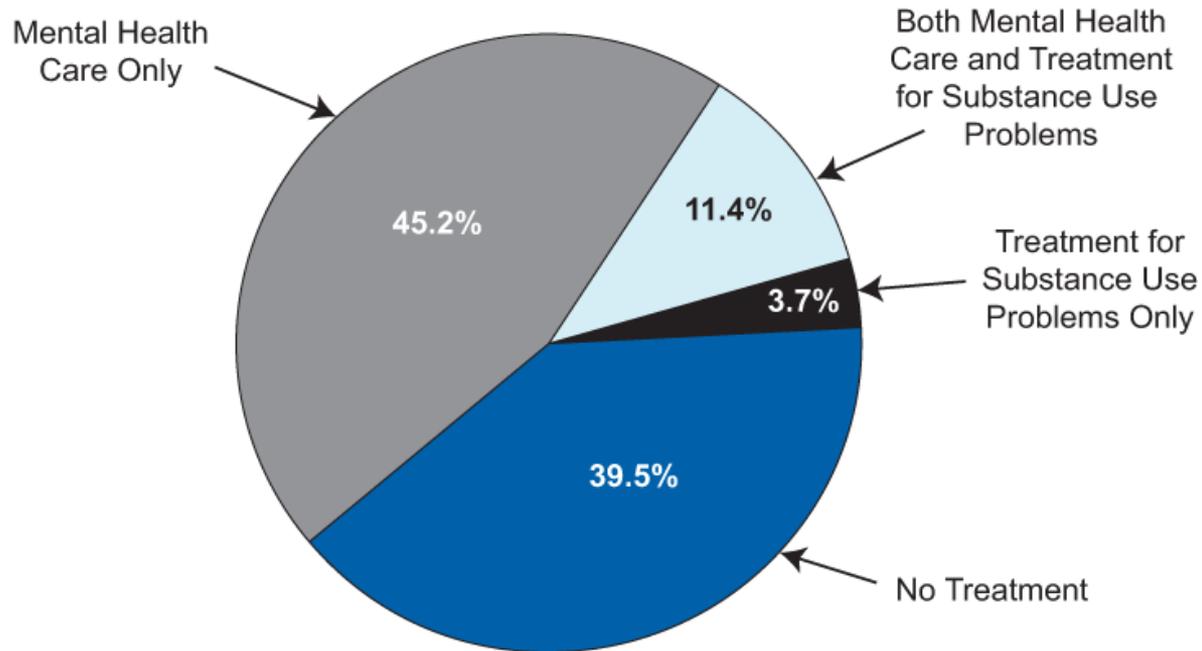
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CODs are Often Untreated

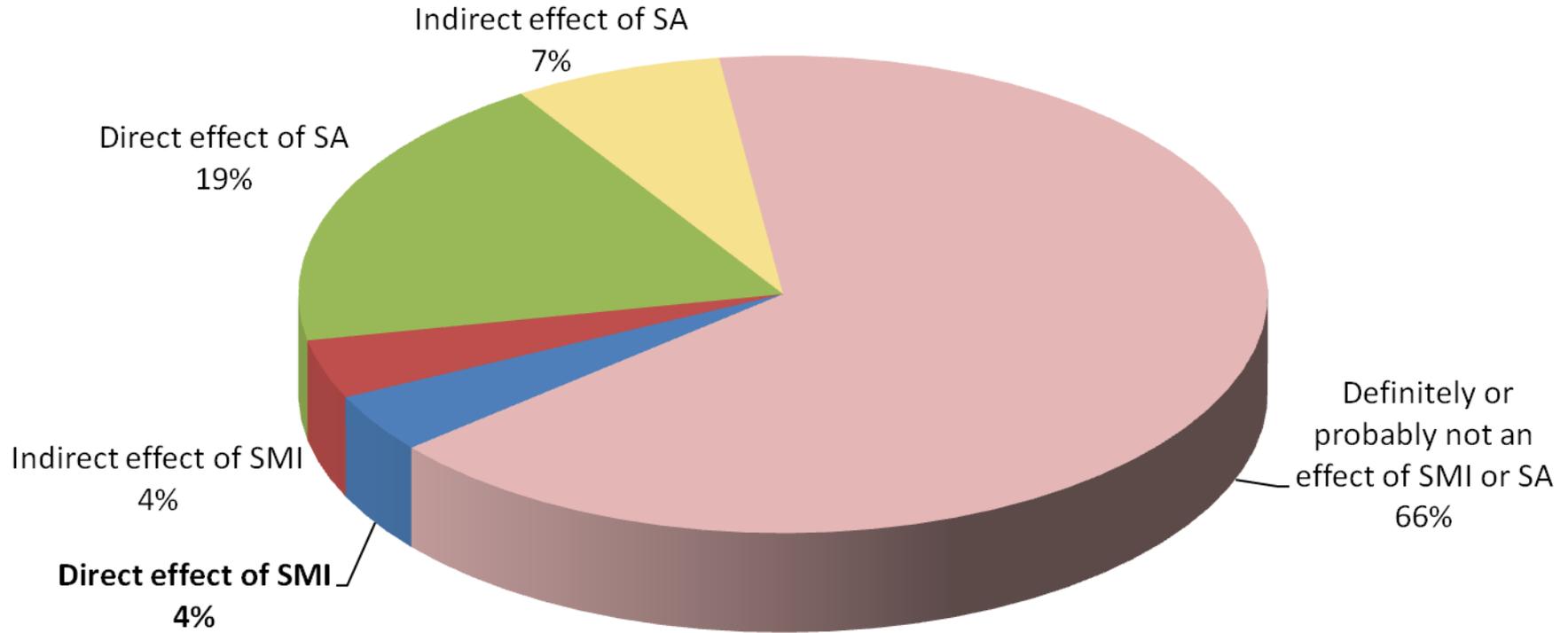
Past Year Mental Health Care and Treatment for Adults Aged 18 or Older with Both Serious Mental Illness and a Substance Use Disorder



Source: NSDUH, 2008

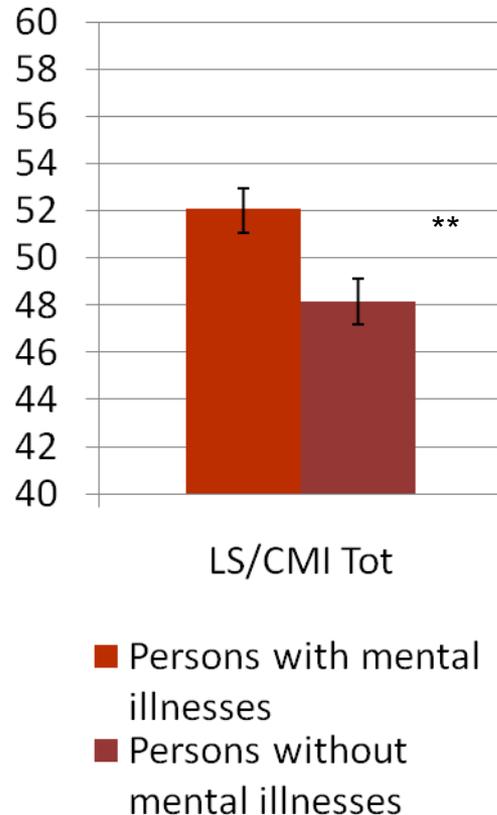
2.5 Million Adults with Co-Occurring SMI and Substance Use Disorder

Arrest is Not Always a “Direct” Product of Mental Illness



Source: Junginger, Claypoole, Laygo, & Cristina (2006)

Justice Involved Persons with MI Have Significantly *More* “Central 8” Risk Factors



Dynamic Criminogenic Risks

Antisocial Behavior
Antisocial Personality
Antisocial Peers
Antisocial Thinking
Family Discord
School or Work Problems
Few Leisure Activities
Substance Abuse

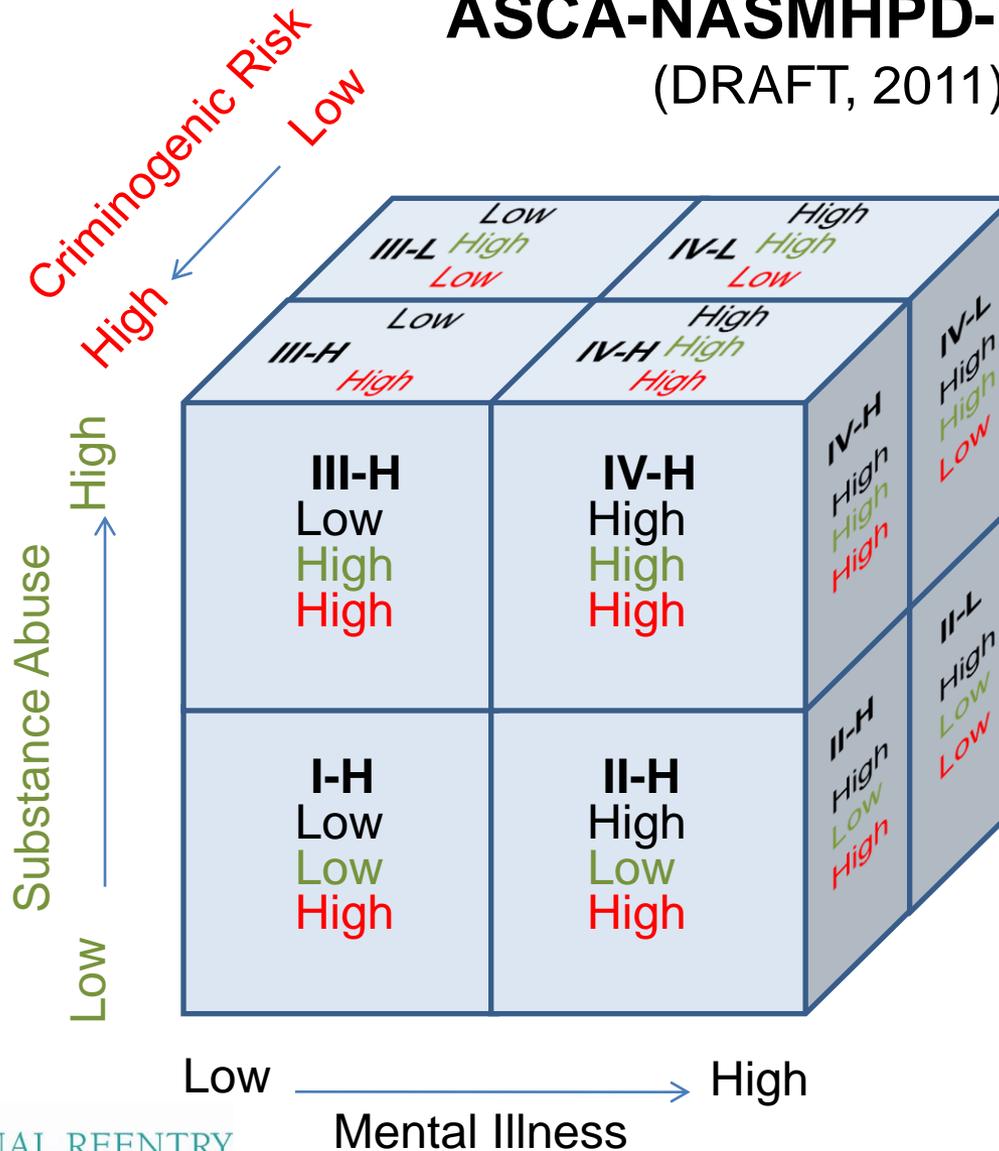
Source: Skeem, Nicholson, & Kregg (2008)

Risk-Need-Responsivity Principles as a guide to best practices

- Focus resources on high **RISK** cases
- Target criminogenic **NEEDS**: antisocial behavior, substance abuse, antisocial attitudes, and criminogenic peers
- **RESPONSIVITY** – Tailor the intervention to the learning style, motivation, culture, demographics, and abilities of the offender. Address the issues that affect responsivity (e.g. mental illnesses).

Evolving NIC Framework ASCA-NASMHPD-NASADAD

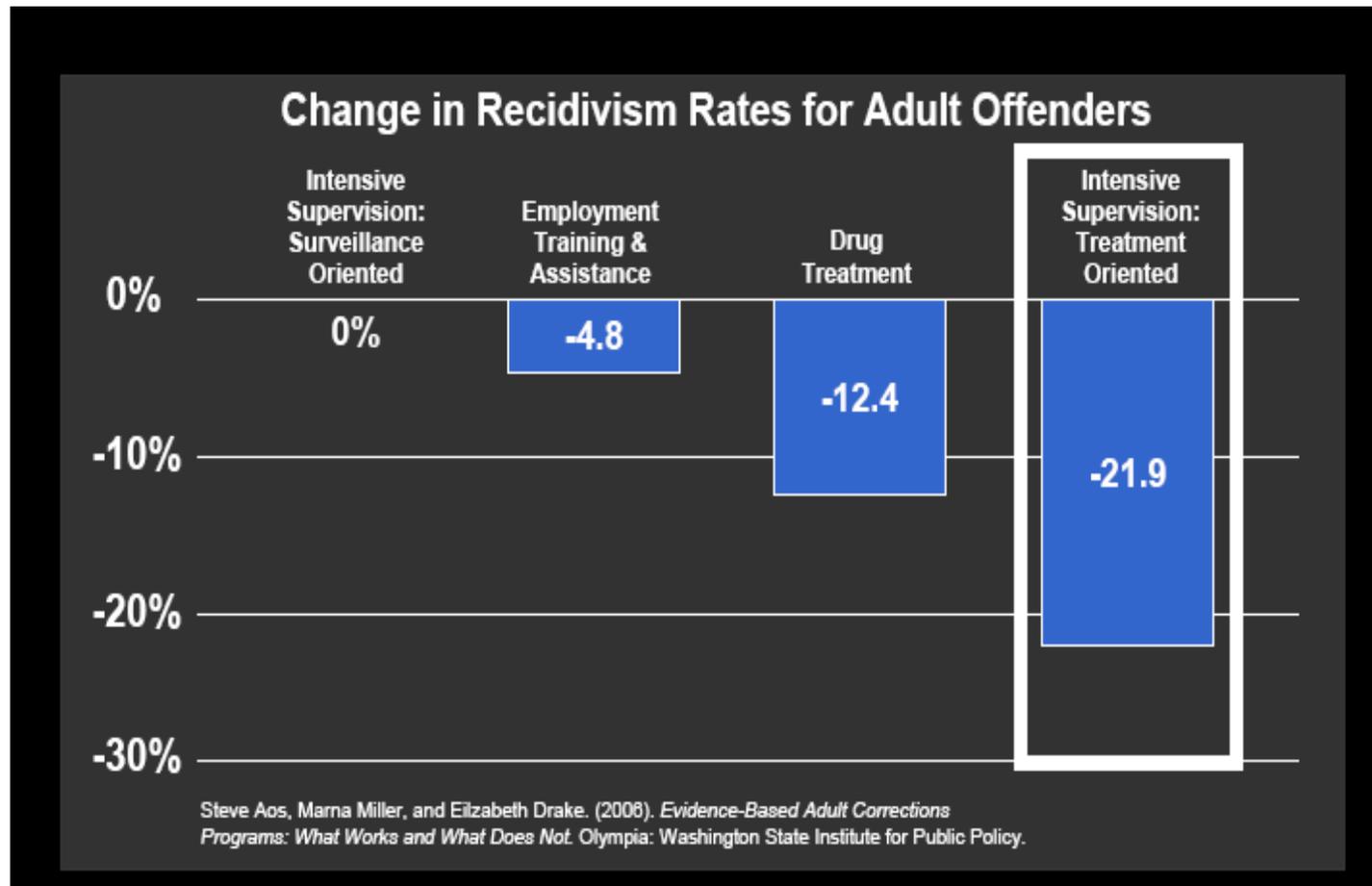
(DRAFT, 2011)



The Bottom Line

EBP	Data for Quadrant IV	Impact
Integrated Tx	+++++	+++++
Housing	++	+++++
Medications	+++++	+++++
FACT/FICM	+++	+++++
Illness Mgmt.	+	++
Supported Emp.	+	+++
Cognitive-Behavioral Tx	++	+++++

Integrating Treatment and Supervision Can Reduce Risk



Challenges to EBP Implementation

- **Target population characteristics**
- **Staff attitudes and skills**
- **Facilities/resources (Physical environment, staff and staffing patterns, funding resources, housing, transportation)**
- **Agency Policies/Administrative Practices**
- **Local/State/Federal regulation**
- **Interagency networks**
- **Reimbursement**

Too much emphasis on EBPs?

- There are not enough EBPs to cover the range of clinical circumstances
- Yet, if you only have a dime to spend....
- Hence, Evidence-Based Thinking
 - The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals.

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Questions and Answers

Contact Information

- Content questions about this webinar should be directed to:

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Dr. Fred Osher: fosher@csg.org



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