CREATING A STRONG FOUNDATION FOR EFFECTIVE CONNECTIONS TO COMMUNITY SUBSTANCE ABUSE TREATMENT

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Brought to you by the National Reentry Resource Center, Treatment Alternatives for Safe Communities, the Addition Technology Transfer Center Network, and the Bureau of Justice Assistance, U.S. Department of Justice

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The resource center is continually updating its website with materials relevant to the reentry field.

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Presenter

- Phillip Barbour
  Master Trainer- Center for Health and Justice at Treatment Alternatives for Safe Communities (TASC)
The ATTC Network is funded by the Substance Abuse and Mental Health Services Administration and serves a critical role in improving the health of our nation.

The mission of the ATTC Network is to:

- Accelerate the adoption and implementation of evidence-based and promising addiction treatment practices and recovery services;
- Heighten the awareness, knowledge, and skills of the workforce that addresses the needs of people with substance use or other behavioral health disorders; and
- Foster regional and national alliances among practitioners, researchers, policy makers, funders, and the recovery community.

Regional Centers

National Focus Area Centers

- National Frontier and Rural ATTC
- National American Indian and Alaska Native ATTC
- National Hispanic and Latino ATTC
- National SBIRT ATTC

ATTC Network Coordinating Office

ATTCCnetwork.org
TASC’s Work

• Over 30 years of experience integrating justice and health in Illinois

• TASC = bridge for people involved in both
  • criminal justice system
  • Behavioral Health treatment system
  • Recovery

• TASC case management
  • keeps people engaged in treatment = improves their chance of successful recovery
  • accountable to the criminal justice system
Presentation Outline

• Comprehensive reentry planning process
• Timing reentry with the completion of treatment (jail timing?)
• Clinical case management - starts at high intensity and steps down
• Access to community services and support
• Tighten the relationship between clinical and community corrections
Learning Objectives

• Illustrate what a Step-down process looks like
• Treatment phases and sentencing (timing)
• Demonstrate the importance of pre and post release service coordination
• How to engage the family in the recovery planning process
• The importance of Interdisciplinary staffing with clinical and community corrections
NIDA Principles

1. Drug addiction is a brain disease that affects behavior.
2. Recovery from drug addiction requires effective treatment, followed by management of the problem over time.
3. Treatment must last long enough to produce stable behavioral changes.
4. Assessment is the first step in treatment.
5. Tailoring services to fit the needs of the individual.
6. Drug use during treatment should be carefully monitored.
7. Treatment should target factors that are associated with criminal behavior.
NIDA Principles

8. Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.

9. Continuity of care is essential for drug abusers re-entering the community.

10. A balance of rewards and sanctions encourages pro-social behavior and treatment participation.

11. Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.

12. Medications are an important part of treatment for many drug abusing offenders.

13. Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions.
Reentry Planning Process

- Strengths-Based approach
- Engagement and outreach oriented
- Ideally designed for caseloads of 40:1
- Three phases of case management/recovery support
  - High Intensity
  - Case Management
  - Recovery Support Services
- Starts 60 days prior to release by staffing clients with stake holders (aftercare providers, parole agent, case manager, etc.)
- Ensures identified services are being delivered
High Intensity Case Management

- Ideally first 90 days post-release
- Also implemented at junctures of vulnerability
- Designed to stabilize the formerly incarcerated person in the community
- Formerly incarcerated person is stepped down once he achieves behavioral indicators
Behavioral Indicators for Step-down

- Stable housing (recovery home)
- Engaged with appropriate vocational program
- Stable in treatment
- Employed
- Engaged in Support Groups (12-step is emphasized)
- Complying with Parole
- Negative drug tests in the last 45 days (min. one test)
Regular Case Management

- Ideally 90-180 days post-release
- Implemented for formerly incarcerated persons who are stable in the community and working toward achieving goals
- Formerly incarcerated individual is stepped-down to recovery support services once behavioral indicators are achieved
Monthly Activities-Case Management

- Two client contacts per month/ one face-to-face
- One quarterly home visit
- One on-site contact with treatment/recovery support provider
- One interdisciplinary staffing

Total Minimum Contacts=4 per month
Step up at junctures of vulnerability and/or if no longer meet behavioral indicators for this level
Behavioral Indicators for Step-Down

- Completed all treatment
- Employed for 60 days
- Negative Drug tests for the last 60 days (min. two tests)
- Stable housing for 60 days
- Engaged in support groups
- Complying with Parole
Recovery Support Services

- Ideally begins 6 months post-release
- Support formerly incarcerated individual in on-going recovery
- Primary worker assigned is Recovery Support Specialist
- Continues ideally for six months
- Minimum six months in recovery support services
Monthly Activities for Recovery Support

- Monthly recovery check-in’s by phone
- Monthly contact with parole
- Share/coordinate pro-social recovery activities
- Continue monitoring support group attendance and getting a sponsor is encouraged
### Successful Completion Criteria

#### Example

- Completed all treatment
- Stable Employment for 60 days
- Stable Housing for 60 days
- No substance use in last six months as evidenced by negative drug tests and observation
- Positive Support System
- Six months case management and six months recovery support services
Timing of Treatment

- Consider “real time” of the sentence to ensure treatment completion
- Length of the treatment model (phases), is it appropriate for the client?
- Transfers from “gen pop” when the time is optimal
- Avoid sending inmates back to finish out time after treatment is done (forward progress)
- Should be near the back end of sentence if possible, making reentry planning and process more seamless
Access to Community Services and Support

- Increasingly across the country, corrections clients make up the majority of referrals to community treatment
- What types of community support is needed?
- What are the funding options or opportunities?
- Health Care Reform will make more clients eligible for services
How to Engage the Family in the Recovery Planning Process

• Education on SUD’s for the family
• Sharing the treatment planning process with family
• Contingency management (behavioral contracts with family)
• Understanding the different family therapy models
  • family disease model, family systems model, Cognitive–behavioral approaches, multidimensional family therapy (MDFT)
Family Models

The **family disease model** looks at substance abuse as a disease that affects the entire family. Family members of the people who abuse substances may develop codependence, which causes them to enable the IP’s substance abuse. Limited controlled research evidence is available to support the disease model, but it nonetheless is influential in the treatment community as well as in the general public ([McCrady and Epstein 1996](#)).
Family Models

The *family systems model* is based on the idea that families become organized by their interactions around substance abuse. In adapting to the substance abuse, it is possible for the family to maintain balance, or homeostasis ([Steinglass et al. 1987](#)).
Family Models

Cognitive–behavioral approaches are based on the idea that maladaptive behaviors, including substance use and abuse, are reinforced through family interactions. (O’Farrell and Fals-Stewart 1999).
Family Models

Most recently, *multidimensional family therapy* (MDFT) has integrated several different techniques with emphasis on the relationships among cognition, affect (emotionality), behavior, and environmental input (*Liddle et al. 1992*).
Tightening the Clinical and Community Corrections Relationship

- Activities that involve CC as part of the “clinical team”
- Pre–release staffing with CC
- Making compliance with CC an integral part of the treatment planning process
- Emersion training for both stakeholders
- Work in tandem, support each others’ mission
Thank You!

Questions and Answers
Contact Information

- Content questions about this webinar should be directed to:
  Kati Habert at khabert@csg.org
Selected ATTC Resources


> Improving Client Engagement and Retention in Treatment – Side presentation

> Outreach Competencies: Minimum Standards for Conducting Street Outreach for Hard-to-Reach Populations – Book

> Practice Guidelines for Recovery and Resilience Oriented Treatment – Book
   http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=819&rcID=8

> Novel Approaches To Engagement In Care – Video and companion booklet

> Recovery Oriented Systems of Care (ROSC) Framework the Criminal Justice System

> Criminal Justice-Substance Abuse Cross-Training: Working Together for Change – Curriculum
   http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=721&rcID=15
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