Research on Effective In-Custody Treatment

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Characteristics/Principles of Effective In-Custody Treatment Programs

1.	High program intensity; how much time a participant receives the program
2.	Interactive programing focused on skill building according to the needs of the offenders'
3.	Includes cognitive-behavioral therapy
4.	Includes structured curriculum
5.	Multiple treatment modalities
6.	Trained professionals administer treatment program
7.	Treatment is more successful among high-risk offenders (risk principle)
8.	Length of program is associated with effectiveness
a.	Aftercare in the community has been shown to significantly improve treatment program effectiveness

(Bahr, 2013; Cullen & Jonson, 2011; Landenberger & Lipsey, 2005; Lipsey & Cullen, 2007; Pendergast, 2009)

Assessment of FL Prison SUD Services

- Aftercare and transitional substance abuse programming were significant in increasing employment and reducing recidivism after release
- Completing in-prison substance abuse treatment programs closer to their release date were less likely to recidivate

CAUTION: Evaluation outcomes are dependent on the evaluation method used. Random assignment most promising.

An Assessment of Substance Abuse Treatment Programs in Florida's Prisons Using a Random Assignment Experimental Design by Samuel Scaggs; William D. Bales; Catie Clark; David Ensley; Philip Coltharp; Thomas G. Blomberg (April 2016)

Treatment for SUD

Most Effective: CBT, therapeutic communities, and interactive journaling

Promising: 4-week On-Unit Treatment (OUT) program (Andrews, Bonta, & Wormith, 2011, p. 738)

Inconclusive Evidence: 12-step programs (CAUTION: have been found to have harmful consequences if not fully completed)

Too few programs to evaluate: Faith-based programs that work with inmates to help grow their beliefs as part of the rehabilitation program (Sumter and Clear, n.d.)

Correctional Therapeutic Community for Substance Abusers

Phase 1	Assessment, evaluation, and orientation into a CTC. Primary counselor conducts a needs assessment.
Phase 2	Emphasizes the residents' active involvement in the CTC, including such activities as morning meetings, group therapy, one-on-one interaction, confrontation of other residents who are not motivated toward substance abuse recovery, and nurturing of newer residents. Residents begin to address their own issues related to substance abuse and criminal activity in group sessions and during one-on-one interactions.
Phase 3	Stresses role modeling and overseeing the working of the CTC on a daily basis (with the support and supervision of the clinical staff). So residents develop a strong sense of community, they are organized into a hierarchical structure by roles and job functions, which are associated with strict behavioral expectations and corresponding rewards or sanctions. The rewards or sanctions are applied jointly by staff (many of whom are former offenders or recovering adults who formerly abused substances and act as role models) and residents who act as role models for newer residents.

Medication Assisted Treatment in a Correctional Setting

- The induction and maintenance of Medication Assisted Treatment (MAT) has been shown through research to increase retention in treatment after the period of incarceration (Belenko, Hiller, & Hamilton, 2013).
- Agonist medications (e.g. Methadone) have proven to have a significant positive effect on post-release drug use when combined with counseling (Kinlock, et al., 2009). The effects of methadone on recidivism are mixed.
- Antagonist medications (e.g. buprenorphine and naltrexone) have also shown statistically positive results on treatment retention and recidivism.

Best Practices for Jail-Based MAT Programs

- The National Sheriffs' Association and the National Commission on Correctional Health Care released a document entitled "Jail-Based Medication-Assisted Treatment: Promising practices, guidelines, and resources for the field" in 2018. This booklet outlines both evidence based and promising practices for establishing and maintaining a functional jail-based MAT program and includes important protocols that provide a foundation for success.

Important Practice Guidelines

- Systematic clinical screenings should be conducted to determine eligibility for the programs.
- The client must be an active participant in decision making regarding both participation as well as treatment preference.
- Clients should be routinely and consistently tested to ensure proper dosage.
- MAT must be complimented with appropriate substance abuse counseling and other support services.
- Training of staff, including supervision personnel, is critical to program success.

The Denver Model

- IN 2016 Denver Adult Probation, The Mental Health Center for Denver, Denver Health, The University of Colorado, and the Denver Sheriff's Department undertook to create a jail-based MAT program. The program initially focused on methadone treatment. The program centered around a short induction phase followed a warm handoff to a community-based treatment provider. The clients were provided with extensive support upon release including paid treatment and other social support services. As the program matured the team added antagonist medications with support from both manufacturers and a jail-based physician who monitored sobriety and provided injections for clients.

Lessons from Denver

- Timing in the jail was critical as the speed of justice system processing did not always comport with the time frames needed to safely introduce the medications to the clients.
- One of the keys to success with clients was the warm handoff. Clients were initially transported by Sheriff's Deputies upon release to the treatment facility which was effective increasing retention.
- It was particularly difficult to keep clients engaged if there were extended periods of time between interactions with clients.
- Counseling was a critical and necessary adjunct to MAT treatment and those that fully engaged with counseling had significantly better outcomes including abstinence and reduced violations on probation.

SMI, SUD and Co-Occurring Disorders

	General Public	State Prisons	Jails
Serious Mental Disorders	5.4%	16%	**17%**
Substance Use Disorders – Abuse and/or Dependence	16%	53%	**68%**
A Co-occurring Substance Use Disorder when Serious Mental Disorder is Diagnosed	25%	59%	**72%**
A Co-occurring Serious Mental Disorder when Substance Abuse Disorder is Diagnosed	14%	60%	**33%**

FACTORS IN SCREENING & ASSESSMENT

Balance of risk and resources

- **Who will conduct? Custody or medical staff**
- **How? Standardized tools or agency-specific**
- **When? Prior to accepting custody, at booking, some other point while in custody?**

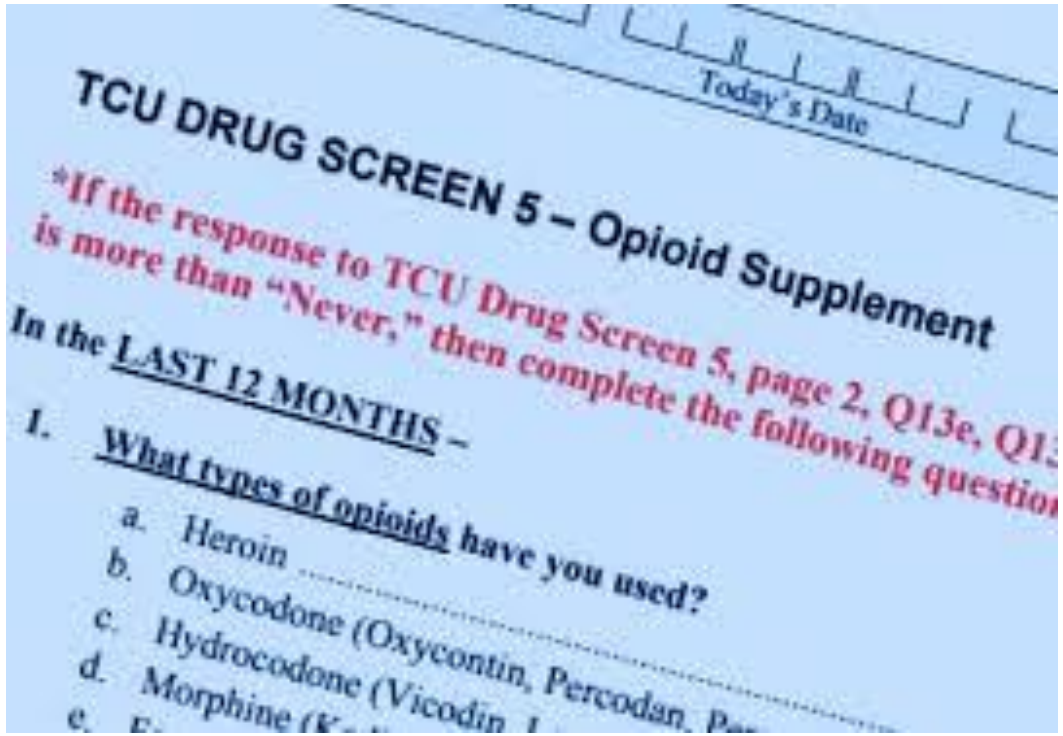
What resources are currently available?

- **Internal/agency**
- **Public sector**
- **Contracted services**

How will you handle suicidal/self-injurious arrestees

Validated SUD Screening Tools

- **Texas Christian University Drug Screen 5 (SCUDS-5)**
- **Adult Substance Abuse Subtle Screening Inventory – 4 (SASSI-4)**
- **Addiction Severity Index (ASI)**



TCU Drug Screen 5

Client ID#	Today's Date	Facility ID#	Zip Code	Administration

TCU DRUG SCREEN 5

During the last 12 months (before being locked up, if applicable) –

		Yes	No
1.	Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	O	O
2.	Did you try to control or cut down on your drug use but were unable to do it?	O	O
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	O	O
4.	Did you have a strong desire or urge to use drugs?	O	O
5.	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	O	O
6.	Did you continue using drugs even when it led to social or interpersonal problems?	O	O
7.	Did you spend less time at work, school, or with friends because of your drug use?	O	O
8.	Did you use drugs that put you or others in physical danger?	O	O
9.	Did you continue using drugs even when it was causing you physical or psychological problems?	O	O
10a.	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	O	O
10b.	Did using the same amount of a drug lead to it having less of an effect as it did before?	O	O
11a.	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	O	O
11b.	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	O	O

12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

- O None
- O Alcohol
- O Cannaboids – Marijuana *(weed)*
- O Cannaboids – Hashish *(hash)*
- O Synthetic Marijuana *(K2/Spice)*
- O Opioids – Heroin *(smack)*
- O Opioids – Opium *(tar)*
- O Stimulants – Powder Cocaine *(coke)*
- O Stimulants – Crack Cocaine *(rock)*
- O Stimulants – Amphetamines *(speed)*
- O Stimulants – Methamphetamine *(meth)*
- O Synthetic Cathinones *(Bath Salts)*
- O Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*
- O Dissociative Drugs – Ketamine/PCP *(Special K)*
- O Hallucinogens – LSD/Mushrooms *(acid)*
- O Inhalants – Solvents *(paint thinner)*
- O Prescription Medications – Depressants
- O Prescription Medications – Stimulants
- O Prescription Medications – Opioid Pain Relievers
- O Other (specify) _____

Many Mental Health Screening Tools

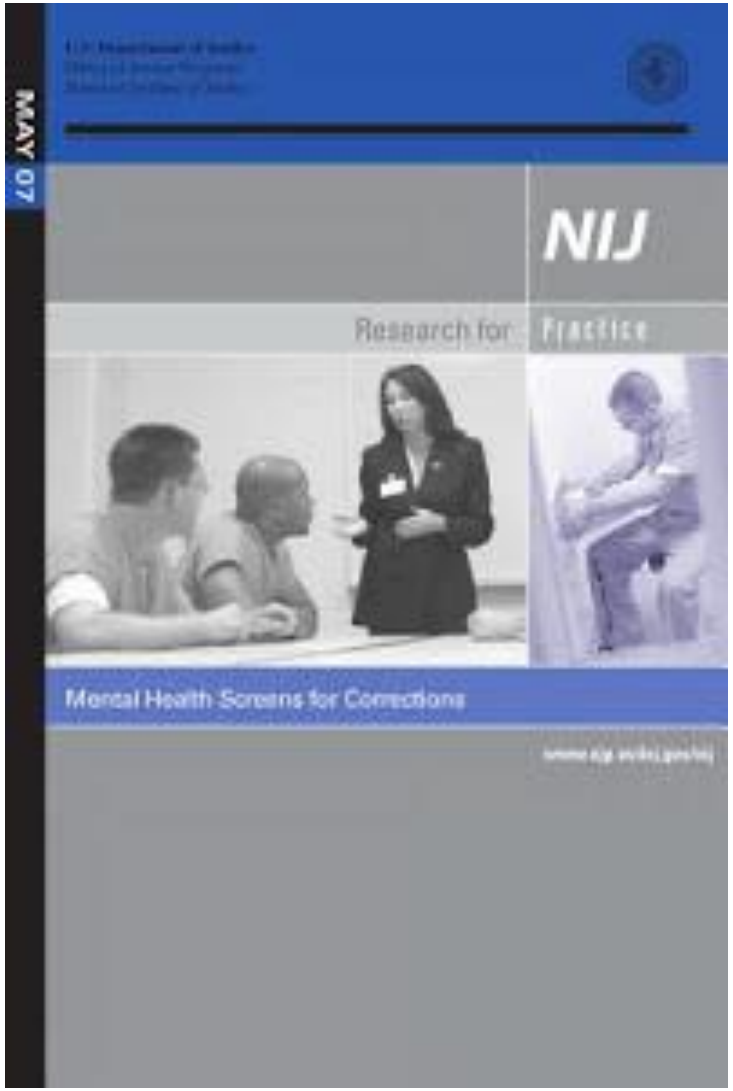
Colman, I, Simpson, AIF & McKenzie, K (2013)

BEST

- Brief Jail Mental Health Screen (BJMHS)
- Correctional Mental Health Screen for Men (CMHS-M)
- Correctional Mental Health Screen for Women (CMHS-W)
- England Mental Health Screen (EMHS)
- Jail Screening Assessment Tool (JSAT)
- Referral Decision Scale (RDS

PROMISING

- Kessler Screening Scale for Psychological Distress (K6)
- General Health Questionnaire (GHQ-28)
- New York State Brief Screening Tool (NYS BST)

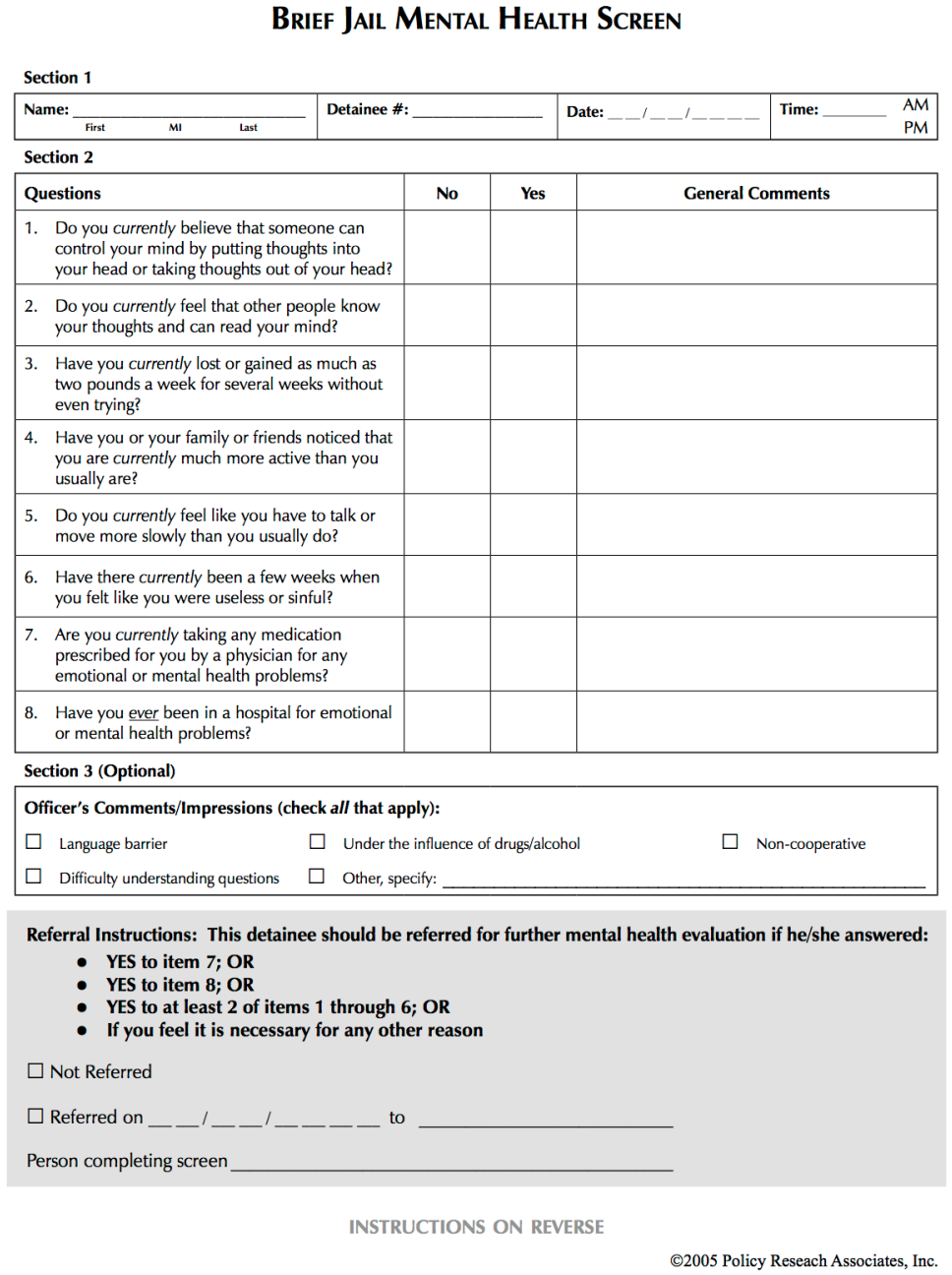


Brief Jail Mental Health Screen (BJMHS)

Correctional Mental Health Screen (CMHS), ha

https://www.prainc.com/wp-content/uploads/2015/10/bjmhsform.pdf

- Easy to administer
- Quick to score
- Free/low cost
- Officers with training/supervision can administer



Brief Jail Mental Health Screen

Section 1

Name: _____ (First MI Last)	Detainee #: _____	Date: __ __/__ __/__ __ __ __	Time: _____ AM PM

Section 2

Questions	No	Yes	General Comments
1. Do you *currently* believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2. Do you *currently* feel that other people know your thoughts and can read your mind?			
3. Have you *currently* lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are *currently* much more active than you usually are?			
5. Do you *currently* feel like you have to talk or move more slowly than you usually do?			
6. Have there *currently* been a few weeks when you felt like you were useless or sinful?			
7. Are you *currently* taking any medication prescribed for you by a physician for any emotional or mental health problems?			
8. Have you *ever* been in a hospital for emotional or mental health problems?			

Section 3 (Optional)

Officer's Comments/Impressions (check *all* that apply):

☐ Language barrier ☐ Under the influence of drugs/alcohol ☐ Non-cooperative

☐ Difficulty understanding questions ☐ Other, specify: _____

Referral Instructions: This detainee should be referred for further mental health evaluation if he/she answered:

- **YES to item 7; OR**
- **YES to item 8; OR**
- **YES to at least 2 of items 1 through 6; OR**
- **If you feel it is necessary for any other reason**

☐ Not Referred

☐ Referred on __ __/__ __/__ __ __ __ to _____

Person completing screen _____

INSTRUCTIONS ON REVERSE

Measuring Effectiveness of In-Custody Treatment Programs

- What does it mean for In-Custody Treatment programs to “work?”
- Preferred research designs include “random assignment” of test subjects and uniformity of related variables between treatment and control groups.
- Defining the Target Population
  - Assessments conducted to determine the extent of substance abuse dependence.
  - Other relevant factors should be considered when constructing pool of eligible participants (independent variables).

Examples of Independent Variables that might bear consideration

- Age
- Gender
- Client Diagnosis
- Age at first arrest
- Length of substance abuse history
- Criminal associations
- Risk/Need variables

Dependent Variables

- Dependent variables are the research variables. They attempt to operationalize the purposes of the programming. For example, treatment programs focused primarily on substance use, such as MAT programs, are often designed to impact the client's ongoing use, continued participation in treatment, and recidivism (although this variable is sometimes a bit of a stretch). There should be a fairly direct link between the intervention and the measured outcome.
- Difficulty of measurement.
  - Jurisdictional Issues
  - Frequency of testing

Other Evaluation and Research Options

- Process Evaluations are tools for program managers use to determine the extent to which the program or intervention is being applied in a manner consistent with program design.
- Comparison Group designs lack the rigor of randomization but if carefully applied can provide useful information to support programming and to guide decision-making and policy. Comparison groups should be matched on the important independent variables to the extent possible to ensure more dependable results.
- Time series analysis considers trends over time. Data are collected on the same variables and compared before and after interventions.

Conclusion

- In-Custody Treatment models have been proven in multiple environments to improve outcomes for participants.
- In-custody assessment provides an excellent means for information gathering that supports further risk/need responsivity.
- In many of the studies the primary effect of these programs is to enhance participation and retention in post-custody treatment programming.
- In-custody treatment provides an important opportunity for treatment linkages for clients in need of services who may resist community based interventions (Belenko, Hiller and Hamilton, 2013).

Andrews, D., Bonta, J., & Wormith, J. (2011). The risk-need-responsivity (rnr) model: Does adding the good lives model contribute to effective crime prevention?. *Criminal Justice and Behavior*, *38*(7), 735-755.

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