Practice Guidelines

As part of the 2019 New York City Risk Need Responsivity Gap Analysis Research Project in coordination with the Mayor's Office of Criminal Justice (MOCJ), the Center for Advancing Correctional Excellence (ACE!) developed a series of Practice Guidelines for responding to particular needs identified through this study. The guidelines are intended to act as primers on the importance of each topic and how to address the issues through best practices, and to provide additional resources on each topic. These practice guidelines focus on strength-based approaches to promoting desistance and on using developmentally appropriate treatment strategies that promote individuals' healthy physical, emotional, and behavioral development.

These Practice Guidelines cover the following topics:

- Motivation and Treatment Readiness Techniques
- Promoting Healthy Living
- Healthy Relationships
- Using Incentives to Engage People and Sustain Behavior Change
- Medication Management
- Assertive Case Management

The Center for Advancing Correctional Excellence (ACE!) is housed within the department of **Criminology, Law and Society** at **George Mason University** in Fairfax, VA.
ACE! is a dynamic center that aims to bridge disciplines and bring researchers, practitioners, and policymakers together to grapple with issues that affect criminal justice and health systems and to promote evidence-informed/based approaches.

ACE!'s mission is three-pronged to create:
IMPACT through conducting high quality research,
REACH through forming lasting partnerships with agencies and the community, and
SCHOLARSHIP through developing the next generation of researchers.

Table of Contents

Practice Guideline: Motivation and Treatment Readiness Techniques 3

Practice Guideline: Promoting Healthy Living 7

Practice Guideline: Healthy Relationships 10

Practice Guideline: Using Incentives to Engage People and Sustain Behavior Change 13

Practice Guideline: Medication Management 15

Practice Guideline: Assertive Case Management 18

PRACTICE GUIDELINE: MOTIVATION AND TREATMENT READINESS TECHNIQUES

An important part of the treatment engagement process is identifying and addressing individuals' ambivalence to change. Many people are not prepared to make substantial life changes when they are recommended to participate in a treatment program or services. It is, therefore, incumbent upon treatment providers to appropriately craft motivation to build individuals' self-confidence in the possibility and potential benefits of change. Individuals' ambivalence to change can manifest itself in many different ways including (1) not understanding why they engage in certain behaviors; (2) uncertainty that their life will be better if they change; and (3) uncertainty that they can do anything differently. This ambivalence often underlies individuals' hesitance to engage in treatment or to make changes. Service providers should work collaboratively with individuals to help them understand how to address and move past these roadblocks. For example, service providers can use reframing techniques to guide individuals to reframe their thoughts, behaviors, and emotions to help them start believing in the possibility of change. For individuals who are mandated to relatively short diversion programs and have more extensive needs than can be addressed during the program mandate, motivation and treatment readiness is particularly important to build the intrinsic motivation to continue in programming past the mandated period of time.

Diversion programs, such as Alternatives to Incarceration (ATI), should use a clinical orientation in their motivation and treatment readiness approach, which should focus on individuals' willingness, readiness, and interest in engaging in services. Programs should create a structured approach to address ambivalence so that individuals understand issues that contribute to their involvement in the criminal justice system and factors that make it difficult for them to change their behavior. The goal during the short ATI program mandate is to help individuals see the value in continuing to engage in services after the mandated program has been completed.

Motivation is a dynamic process that can be developed by extrinsic factors (e.g. work, family, friends, significant others) and/or intrinsic factors (e.g. one's own drive, will, personal preferences). Treatment providers should identify how both factors can be best used to facilitate individuals' behavior change process, since moving through the stages of change varies by individual. Typically, many providers focus on extrinsic factors as an initial "push" to help individuals begin moving from pre-contemplation to contemplation in the stages of change (described below). This is because providers can help individuals recognize that the people they care about (e.g. family, peers, children, employers) also care about them and want them to make positive change. Intrinsic factors are useful when moving from contemplation to action because moving through these stages requires an internal commitment to self-improvement. Employing motivational and treatment readiness techniques can be especially useful when engaging individuals who may not be initially motivated to change their behavior, which may include individuals mandated to services by the court.

Stages of Change:

Evidence shows that motivational strategies, including motivational interviewing and other strong engagement practices, help individuals who otherwise would not have likely engaged in behavior change to be more inclined to participate in treatment and make progress toward their goals (e.g. Miller & Rollnick, 2002). Research identifies five principle stages of change. Progression through the stages is not always linear, so it is important that treatment providers continuously pay attention to where an individual is on the continuum (DiClemente & Velasquez, 2002).

- **Pre-contemplation**: Individuals are not aware, concerned, or considering changing their behavior. Essentially, they do not understand the issues that affect criminal behavior.
- **Contemplation**: Individuals begin to recognize problematic behaviors and consider making changes in the foreseeable future (i.e. within the next 6 months). At this point, individuals do not know how to change their behavior and/or do not understand the benefit of changing their behavior.
- **Preparation**: Individuals believe that behavior change is necessary and begin making small steps to prepare for the action phase. Individuals are trying to understand how to get started.
- **Action**: Individuals provide signals to indicate they are ready to change their behavior. The readiness to act phase provides a small window of opportunity to engage individuals in services because individuals may retreat to a prior stage to avoid dealing with a problem as they become aware of it. Clinicians and treatment providers should recognize cues and "change talk" and initiate the action process. When individuals are in the action stage, they often struggle with appropriate actions to make and sustain change. The action stage is a long period of time that requires individuals learn new skills and develop new habits and routines.
- **Maintenance**: Individuals have developed skills to sustain their new healthy, positive behaviors. However, they still need continuous support to sustain change, maintain progress, and prepare to address potential relapses.

Approaches to Effective Motivational Interventions: Motivational techniques are used to assist clients as they move through the change process (CSAT, 1999).

- Motivational Interviewing: a counseling style used as a way to interact with ambivalent and/or resistant clients. The goal is to be directive while eliciting self-motivational "change talk." Click here for resources and information on Motivational Interviewing.
  - The FRAMES approach: a motivational interviewing guide towards change which stands for Feedback, Responsibility, Advice, Menu Options, Empathy, and Self-Efficacy. For resources and information on FRAMES:
    - o https://www.ncbi.nlm.nih.gov/books/NBK64963/
    - o http://tiny.cc/fcmc3y
  - OARS (Open Questions, Affirmation, Reflective Listening, and Summary Reflections) is a skills-based and client-centered approach that utilizes verbal and non-verbal responses and behaviors. These are good ways to work with individuals on how to open up for change.
- Decisional balance exercises: used by clinicians or treatment staff to assist clients in weighing the pros and cons of a behavior. For resources and information on decisional balance exercises:
  - o http://www.midss.org/content/decisional-balance-scale-exercise
  - o http://www.ncbi.nlm.nih.gov/books/NBK64958/#A61942
  - o http://www.ncbi.nlm.nih.gov/books/NBK64976/table/A62221/?report=objectonly
- Developing discrepancy: clinicians help individuals recognize gaps between future goals and current behavior. For resources and information on developing discrepancy: http://www.therapistaid.com/therapy-worksheet/building-discrepancy
- Flexible pacing: clinicians must assess individuals' past experiences with treatment, current treatment readiness, and progress toward goals in order to appropriately tailor different treatment responses to the individual. Use past successful experiences with treatment to guide individual through the change process. For resources and information on flexible pacing: https://www.ncbi.nlm.nih.gov/books/ NBK64963/

- Personal contact with clients, such as phone calls and emails, as well as home visits, can be effective encouragement for individuals to continue in treatment or return to treatment.

Motivation and Treatment Readiness Assessments and Scales:

There are a variety of assessment instruments and tools that can be used to evaluated clients' motivation, which can produce findings that may be included in the treatment process. The way the clinician or treatment provider discusses the results can also enhance motivation. Therefore, it is necessary to establish rapport with clients before conducting assessments. The treatment provider should make sure that assessment findings are individualized, and use them to engage clients in discussion. In addition to using assessments, treatment providers should listen for "change talk" and pay attention to shifts in clients' attitudes toward treatment.

- TCU Treatment Motivation Scales
  https://ibr.tcu.edu/forms/treatment-motivation-scales/
- SAMHSA/CSAT
  https://www.ncbi.nlm.nih.gov/books/NBK64976/#A62297
  - Readiness to Change Questionnaire
  - Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)
  - What I Want from Treatment
- University of Rhode Island Change Assessment (URICA)
  https://www.guilford.com/add/miller11/urica.pdf?t

Brief Motivation/Treatment Readiness Interventions

- TCU Getting Motivated to Change
  https://ibr.tcu.edu/manuals/description-getting-motivated-to-change/
- TCU Treatment Readiness and Induction Program (TRIP)
  https://ibr.tcu.edu/manuals/treatment-readiness-and-induction-program-trip/
- Your Own Reintegration System (YOURS) in which change is driven through developing supports.
  www.yours.gmuace.org/tools

Structuring the Assessment and Feedback Session:

- Express appreciation to clients for providing information.
- Ask clients if they have any questions or comments about the assessment.
- Encourage clients to ask questions throughout the feedback of the results.
- Provide clients with background about the assessment, how it is standardized, how widely used it is (provide written copy).
- Present all information to clients in written form and accompany with verbal explanation.
- Use motivational style when presenting information.
- At the end of the feedback session, summarize the results and the overall risks or problems that were discovered. Ask for the client's reactions and any self-motivational feelings that the feedback prompted.

Special consideration for individuals with intellectual disabilities and/or mental illness requires treatment providers to pace programming appropriately for their capacity. Programming should be more frequent, include more frequent workgroups or role playing sessions, and sessions should be repeated.

Additional Resources:

- DiClemente, C. C., & Velasquez, M. M. (2002). Motivational interviewing and the stages of change. *Motivational interviewing: Preparing people for change*, *2*, 201-216.
- Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1999. (Treatment Improvement Protocol (TIP) Series, No. 35.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK64967/
- Miller, W. R., & Rollnick, S. (2002). Motivational interviewing: Preparing people for change (2nd ed.). New York, NY, US: Guilford Press.

PRACTICE GUIDELINE: PROMOTING HEALTHY LIVING

Strategies for helping clients succeed while in treatment should take into consideration the whole person, not just clients' convictions or criminogenic needs. Healthy living encompasses a broad range of daily functioning, habits and activities including engaging in healthy and productive activities, maintaining positive relationships, taking medication, and exercising. Many individuals would benefit from help and encouragement in this area from treatment providers, criminal justice actors, and non-profit organizations that work in the criminal justice system.

Why Promote Healthy Living:

- Most providers, whether employed by the courts or treatment/service agencies, tend to focus on long-term goals that may be hard to achieve. Helping the individual focus on shorter-term healthy living behaviors will allow them to have "wins" along the way.
- Compared to the general population, individuals with criminal justice involvement have high rates of both physical and behavioral health problems, many of which require medication management, regular physician visits, and practicing healthy living habits. Left untreated or under-treated, these health concerns can be very disruptive to a person's daily functioning (Gideon, 2013).
- Many individuals who are criminal justice-involved or engaged in treatment have limited access to nutritious foods, and many have limited knowledge of how to cook or have trouble finding the time to cook among work, treatment, and other obligations (Heller, 2016). Healthy eating habits are also important, since food insecurity can hinder positive decision-making (Frech, 2013).
- Individuals in the criminal justice system and individuals with substance use disorders are frequently homeless or unstably housed, including stays at homeless shelters or moving frequently from various friends' and relatives' homes. The conditions of homelessness can lead to poor health, and many health issues may also lead some individuals to become homeless. Common health concerns related to homelessness include mental health problems, substance abuse, bronchitis and pneumonia, problems caused by being outdoors, and wound and skin infections (National Library of Medicine, 2018).
- Housing instability has a negative collateral impact on sleep habits, which in turn impact many aspects of life, including energy level, productivity, safety, and appetite (Cordeiro, 2014), as well as decisions that are made about daily activities.
- Social connectedness matters—having people to rely on for emotional support can be an important stabilizing factor in individuals' lives (Warland et al., 2013).
- Finding new hobbies and ways to spend leisure time is important to making healthy choices. For example, exercising, can be a fun way for individuals to connect with new people and to develop healthier habits.
- An estimated 70-80% of criminal justice-involved individuals smoke cigarettes, which is associated with numerous, long-term health conditions (Cropsey et al., 2015).

Assessment:

Many biopsychosocial assessments that treatment providers use include measures of healthy living. In addition, agencies can use standardized instruments like the Short Form-12 (SF-12) and the Patient Health Questionnaire (PHQ-9) to assess for overall health.

How to Help Promote Healthy Living:

- Healthy living starts with individuals' housing situation. Service providers (including non-profit agencies) should check in frequently with their clients about where they are living, who they are living with, and how they feel about their living situation. Is it stable? Are they getting along with the other people in the home? Do they feel safe?
- Individuals may need help accessing physical healthcare. This may include obtaining identification, enrolling in health insurance, finding healthcare providers and following up with medications, appointments, and recommendations.
- Individuals may need assistance managing their medications, symptoms, and appointments. Some helpful tools may include calendars, phone alarms, and daily pill boxes.
- Social media is no substitute for real social interaction and communicating with friends and family one-on-one.
- Healthy living practices can be fun. Many people use fitness trackers or smart phones that track physical activity. Individuals can set their own goals and even compete with friends.
- Individuals have the option of using SNAP benefits at many farmers' markets to acquire fresh produce.
- Service providers can help individuals understand how their eating patterns can impact both their bodies and their emotions, and demonstrate the numerous benefits to improving eating habits. Learning how to cook can be an activity that increases bonds with family or friends.
- Discussions on healthy eating may also address limiting consumption of sugary drinks and alcohol.
- There are numerous medications, apps, and strategies to help individuals quit smoking. Service providers may make individuals aware of the different options that are available and encourage them to try new ones when the first attempt does not work where appropriate.
- The first step to developing healthy sleep habits is understanding what they are and what can negatively affect them. Individuals should understand the positive impacts of keeping a consistent schedule, avoiding electronics and alcohol that can negatively affect sleep habits, and having a bedtime routine.
- Promoting healthy living allows individuals to learn to regulate their own behaviors and make decisions to improve their awareness of how lifestyle factors (e.g. food, sleep, safety, loneliness, support systems, etc.) affect their well-being (Frech, 2013).

Special consideration for individuals with intellectual disabilities and/or mental illness requires treatment providers to pace programming appropriately for their capacity. Programming should be offered more frequent, include more frequently in terms workgroups or role playing sessions, and sessions should be repeated.

Sources and Additional Resources:

- Cordeiro, Brittany (2014). 8 Healthy Sleep Habits. Accessed from: https://www.mdanderson.org/publications/focused-on-health/april-2014/healthy-sleep-habits.html
- Cropsey KL, Clark CB, Zhang X, Hendricks PS, Jardin BF, Lahti AC. (2015). Race and medication adherence moderate cessation outcomes in criminal justice smokers. American Journal of Preventive Medicine 49(3):335-44.
- Frech A. (2013). Pathways to adulthood and changes in health-promoting behaviors. Advances in life course research, 19, 40-9.

- Gideon, L. (2013). Bridging the gap between health and justice. Health & Justice, 1, 4. http://doi.org/10.1186/2194-7899-1-4.
- Heller, J. (2016). A Framework Connecting Criminal Justice and Public Health. Accessed from: https://humanimpact.org/a-framework-connecting-criminal-justice-and-public-health/
- Liu Y, Wheaton AG, Chapman DP, Cunningham TJ, Lu H, Croft JB. Prevalence of healthy sleep duration among adults – United States, 2014. MMWR Morbidity and Mortality Weekly Report. 2016;65(6):137–141.
- National Library of Medicine, Homeless Health Concerns (see http://www.nlm.nih.gov/medlineplus/homelesshealthconcerns.html)
- SAMHSA Tip 55: Behavioral Health Services for People Who Are Homeless (see http://store.samhsa.gov/product/TIP-55-Behavioral-Health-Services-for-People-Who-Are-Homeless/SMA13-4734)
- Warland, C, Jones, J., Phlipp, J., Schnur, C., & Young, M. (2013). Healthy relationships, employment, and reentry (Policy Brief). Washington, DC: National Resource Center for Healthy Marriage and Families.
- Online versions of assessment tools are available at https://www.phqscreeners.com/sites/g/files/g10049256/f/201412/PHQ-9_English.pdf and https://www.hss.edu/physician-files/huang/SF12-RCH.pdf

PRACTICE GUIDELINE: HEALTHY RELATIONSHIPS

Strategies for helping clients stabilize in the community and reduce the likelihood of future criminal justice involvement must take into consideration the whole person, not just clients' convictions or criminogenic needs. Working with individuals to develop and maintain positive relationships with family and friends can help create a network that supports individuals as they make progress on their goals.

Why Address Healthy Relationships:

- The majority of individuals who have been involved in the criminal justice system have friends and/or family who have also been involved in the criminal justice system (Esiri, 2016).
- Incarceration has a negative impact on both the individual and their family. It can strain family relationships and create barriers in healthy parent-child relationships (Wildeman & Western, 2010).
- Individuals re-entering the community from incarceration cite family support as the most important factor in helping them build stability and avoid repeat involvement in the criminal justice system (LaVigne, Shollenberger, & Debus, 2009).
- Having healthy relationships often positively impact employment, substance use, earnings, and recidivism (Warland et al., 2013).
- Family involvement in re-entry programming is associated with lower rates of substance use and recidivism, and fewer mental, physical, and emotional problems (Warland et al., 2013).
- Individuals who have close friends or family who actively use drugs are also more likely to use drugs frequently following release from incarceration (LaVigne, Shollenberger, & Debus, 2009).
- Building and maintaining healthy relationships may look different for men and women as well as for younger and older people. For example, women are more likely to be the custodial parent if they have children, and marriage tends to be less of a stabilizing influence on younger people than it is on older people (Laub, Nagin, & Sampson, 1998).
- Individuals are often focused on "tangible" actions to demarcate progress, such as completing substance use disorder treatment or finding a job, so they may not immediately see the positive impact that healthy relationships can have.

Assessment:

Many risk-need assessment instruments include one or more subscales that measure the degree to which an individual has friends or family who have active criminal justice involvement and/or have substance use disorder problems. Some instruments also assess the impact that these friends and family may have on the individual and the decisions that they make. Besides risk-need assessment instruments, there are instruments that specifically assess the influence of maintaining relationships with friends who abuse substances, such as the Global Appraisal of Individual Needs (GAIN), Orientation for Social Support, and the Texas Christian University Social Functioning assessment.

Curriculum to Address Healthy Relationships:

While there are a number of curricula that address healthy relationships for youth, there are few available for adults. SAMHSA developed Relationships Matter!, a webinar series for practitioners who work with women experiencing mental health and substance use issues, which explores the role of relationships. Topics include: Being Real: The Power of Authentic Therapeutic Relationships in Women's Services; #RelationshipGoals: Significant Others in Women's Recovery; Finding Her Tribe: Women's Relationships with Peers and Community; Motherhood: What It Means for Women's Recovery; Complex

Connections: Intimate Partner Violence (IPV) and Women's Substance Use and Recovery. These materials and webinars can be found at https://www.samhsa.gov/women-children-families/trainings/relationships-matter.

Tips for Helping People Build and Maintain Healthy Relationships:

- Many individuals could increase their exposure to models of healthy relationships; mentors, especially those with lived experience, can help provide those models.
- Addressing healthy relationships involves developing skills around effective communication, anger management, self-esteem, and conflict resolution (Ooms et al., 2006).
- Working with individuals on healthy relationships may involve working with their families and significant others as well.
- Interventions that help people build healthy relationships should not be limited to only those with young children.
- Building healthy relationships does not need to be a standalone project; it can be integrated into other types of programming including substance use treatment and employment services (Warland et al., 2013).
- Developing a positive relationship with an older mentor is often more beneficial than a romantic relationship (Laub, Nagin, & Sampson, 1998).
- Service providers can help individuals develop healthy relationships by acting as a reliable, stabilizing, positive, healthy relationship in the person's life.
- Service providers should actively listen when individuals discuss their relationships with friends and family members, particularly regarding engaging in substance use or criminal behavior. The goal is to help individuals identify positive healthy behaviors and distinguish which relationships may help them move toward their goals and which may not. Service providers should ask questions both about the friend or family member themselves and about the individual's relationship with them.
- Service providers should help individuals identify healthy relationships in their lives as positive examples, particularly individuals that are engaged in positive, healthy behaviors.
- Service providers can help individuals identify people who could potentially be negative influences (e.g., those who pressure the individual or encourage them to do things they should not). These conversations can help individuals examine their relationships with these individuals and practice how to make positive decisions.
- Making new friends can be hard. Service providers can identify opportunities for meeting new people, such as adult sports leagues, gyms, volunteering, or getting involved with a religious organization.
- Service providers can help the individual think through low-cost activities they can do to build relationships with peers who are involved in positive, healthy activities, such as hosting a family movie or game night or going to a church potluck.
- Individuals who have close relationships with others who are actively involved in the criminal justice system, including family members, could benefit from developing coping strategies for how to deal with these challenging relationships, or strategies for minimizing contact with those individuals if necessary and/or beneficial.
- Part of healthy, supportive relationships is being aware of and sensitive to the needs of others. Service providers can help individuals develop perspective-taking so they recognize that relationships are "two-way streets" that require consideration of multiple perspectives (Warland, et. al, 2013).

Special consideration for individuals with intellectual disabilities and/or mental illness requires treatment providers to pace programming appropriately for their capacity. Programming should be offered more frequent, include more frequently in terms workgroups or role playing sessions, and sessions should be repeated.

Sources and Additional Resources:

- Arditti, J. A., & Few, A. L. (2006). Mothers' reentry into family life after incarceration. Criminal Justice Policy Review, 17, 103-123.
- Bayse, D., Allgood, S., & Van Wyk, P. (1991). Family life education: An effective tool for prisoner rehabilitation. Family Relations, 40(3), 254–257.
- Braman, D., & Wood, J. (2003). From one generation to the next: How criminal sanctions are reshaping family life in urban America. In J. Travis & M. Waul (Eds.), Prisoners once removed. Washington, DC: The Urban Institute Press, 157-188.
- Esiri, M. (2016). The Influence of Peer Pressure on Criminal Behavior. Journal of Humanities and Social Sciences, 21(1), 8014.
- Laub, J., Nagin, D.S., & Sampson, R. J. (1998). Trajectories of change in criminal offending: Good marriages and the desistance process. American Sociological Review, 63(2), 225–238.
- La Vigne, N.G., Shollenberger, T.L., & Debus, S. (2009). One year out: The experiences of male returning prisoners in Houston, Texas (Policy Brief). Washington, DC: The Urban Institute.
- Ooms, T., Boggess, J., Menard, A., Myrick, M., Roberts, P., Tweedie, J., & Wilson, P. (2006). Building bridges between healthy marriage, responsible fatherhood, and domestic violence programs. Retrieved from https://www.clasp.org/sites/default/files/public/resources-and-publications/archive/0208.pdf
- Warland, C, Jones, J., Phlipp, J., Schnur, C., & Young, M. (2013). Healthy relationships, employment, and reentry (Policy Brief). Washington, DC: National Resource Center for Healthy Marriage and Families.
- Wildeman, C., & Western, B. (2010). Incarceration in fragile families. Future of Children, 20(2), 157–177.

PRACTICE GUIDELINE: USING INCENTIVES TO ENGAGE PEOPLE AND SUSTAIN BEHAVIOR CHANGE

Incentives, both material and social, can be a powerful tool to initiate and sustain behavior change. Incentives are widely used in substance use disorder treatment programs and housing programs. Incentives have gained traction in the criminal justice system, particularly in problem-solving courts, such as drug courts, and in probation settings.

Why Use Incentives:

- Service providers programming largely have been deficit-based, focusing on developing and providing sanctions to discourage non-compliance. Conversely, incentives, which focus on "catching people doing things right" and rewarding them for engaging in positive behaviors, have been found to be more effective in increasing compliance (Friedman et al., 2010).
- People learn how to behave by reacting to the positive and negative consequences of their behavior. Frequently, these are natural consequences, such as feeling hungover after binge drinking, but these reinforcements can come from the outside as well (Taxman et al., 2010).
- Receiving positive consequences from engaging in positive behaviors (e.g., treatment attendance) shifts the focus from failure to success and has the potential to influence improved client morale and self-efficacy (Taxman et al., 2010).
- Contingency Management (CM) is an evidence-based practice where treatment providers attempt to increase positive behavior among individuals with substance use issues through a transparent system of incentives. It involves three basic principles:
    1. Monitor for change in the target behavior
    2. Reinforce the desired behavior whenever it occurs
    3. Withhold positive reinforcements when the desired behavior does not occur (Petry, 2000); the use of sanctions should be minimized and only used for serious criminal behavior. Incentives should drive the responses by justice and treatment actors.
- Incentive systems can include both "social" and "material" rewards. "Social rewards" refers to intangible rewards including verbal or written praise or early completion of supervision. "Material incentives" refers to tangible items such as gift cards or transit passes (Rudes et al., 2011).

Tips for Using Incentives:

- Transparency with incentives is key—service providers should ensure that they make individuals aware of how they can earn rewards (i.e., what behaviors they are rewarding), and the system should treat all individuals equitably (Rudes et al., 2011).
- Incentives should be tied to the desired target behavior and the client's treatment or case plan. For example, substance use treatment programs should tie incentives to treatment engagement and/or drug tests that show up negative (Petry, 2000).
- Incentives are most useful in the early stages of programming or relationship building, when clients are more likely to engage in unhealthy activities and routines. Using incentives early in programming can help change behavior patterns because it provides individuals with an early taste of success, and providers with the opportunity to engage individuals in the treatment process and build internal motivation (Taxman et al., 2010).
- The incentive system should incorporate both social and material rewards, and should be meaningful to the person (Taxman et al., 2010). For example, if an individual enjoys sports, incentives developed around sporting events or activities may be more meaningful than incentives involving work activities.

- Incentives are most effective when they are delivered immediately (as soon as the supervision officer or treatment provider observes the behavior), consistently, and frequently (Petry, 2000).
- Service providers should not underestimate the power of kind words and verbal or written reinforcement of desired behaviors.
- "Fishbowls" can help to ensure that rewarding individuals remains cost effective. This is a process where individuals who are engaging in the desired behavior are eligible to draw from a fishbowl or hat with the incentive items written on slips of paper. Most of the items will have minimal monetary value (Petry & Bohn, 2003).

Special consideration for individuals with intellectual disabilities and/or mental illness requires treatment providers to pace programming appropriately for their capacity. Programming should be more frequent, include more frequent workgroups or role playing sessions, and sessions should be repeated.

Sources and Additional Resources:

- Festinger, D. S., Marlowe, D. B., Croft, J. R., Dugosh, K. L., Mastro, N. K., & Lee, P. A. (2005). Do research payments precipitate drug use or coerce participation? Drug and Alcohol Dependence, 78(3), 275-281.
- Friedmann PD, Green T, Rhodes A, Harrington M, Taxman FS. Collaborative behavioral management reduces drug-related crime, substance use among drug-involved parolees. Washington DC: Association for Medical Education and Research in Substance Abuse; 2010.
- Ghitza, U. E., Epstein, D. H., Schmittner, J., Vahabzadeh, M., Lin, J., & Preston, K. (2008). Effect of reinforcement probability and prize size on cocaine and heroin abstinence in prize- based contingency management. Journal of Applied Behavior Analysis, 41(4), 539-549.
- Lewis, M. W., & Petry, N. M. (2005). Contingency management treatments that reinforce completion of goal-related activities: Participation in family activities and its association with outcomes. Drug and Alcohol Dependence, 79(2), 267-271.
- Marlowe, D. B., Festinger, D. S., Dugosh, K. L., Arabia, P. L., & Kirby, K. C. (2008). An effectiveness trial of contingency management in a felony preadjudication drug court. Journal of Applied Behavior Analysis, 41(4), 565-577.
- Murphy A., Rhodes A.G., & Taxman F.S. (2012). Adaptability of Contingency Management in Justice Settings: Survey Findings on Attitudes toward Using Rewards. Journal of Substance Abuse Treatment, 43(2):168-77.
- Petry N.M. & Bohn MJ. (2003). Fishbowls and candy bars: Using low-cost incentives to increase treatment retention. Science & Practice Perspectives 2(1):55–61.
- Petry, N.M. (2000). A comprehensive guide for the application of contingency management procedures in standard clinic settings. Drug and Alcohol Dependence, 58, 9-25.
- Roll, J. M., Huber, A., Sodano, R., Chudzynski, J. E., Moynier, E., & Shoptaw, S. (2006). A comparison of five reinforcement schedules for use in contingency management-based treatment of methamphetamine abuse. Psychological Record, 56(1), 67-81.
- Rudes, D.S., Portillo, S., Murphy, A., Rhodes, A., Stitzer, M,. Loungo, P., & Taxman, F.S. (2011). Adding Positive Reinforcements in a Criminal Justice Setting: Acceptability and Feasibility. Journal of Substance Abuse Treatment, 42(3):260-70.
- Taxman F.S., Rhodes A., Rudes D., Portillo S., Murphy A., & Jordan N. JSTEPS: Using structured rewards and sanctions in justice supervision programs. Manual. Bethesda, MD: National Institute on Drug Abuse; 2010.

PRACTICE GUIDELINE: MEDICATION MANAGEMENT

Many individuals may present with a variety of both physical and behavioral health issues, some of which may require management of medications. Medication management can be challenging—working with multiple treatment providers, managing insurance and copays, ensuring compatibility with other medications, regularly visiting the pharmacy to obtain medications, and remembering when to take them. This practice guideline will focus primarily on medication that addresses behavioral health issues, including medication-assisted treatment (MAT) for individuals with opioid or alcohol use disorder. Medication non-adherence among individuals with MAT and/or mental illnesses has been associated with poorer treatment outcomes.

Talking to Clients about Medication Management:

- When working with clients who have multiple, complex needs, it is helpful to get a full inventory of all health issues. Many providers use bio-psychosocial instruments and measures of daily living that collect some of this information.
- Service providers may want to talk to the client about diagnoses; symptoms and severity; illness history (age of onset, hospitalizations); past and current medications, how effective the client perceives their current treatment to be; medication adherence; frequency of physician contact; current side effects; client preference and goals; and contact information for providers (SAMHSA, 2011).
- Medical information should not be collected only once at intake—it is important to continually check in with clients regarding medications, access to medications, medication adherence, and side effects they are experiencing.
- Treatment providers will want to have a release of information (ROI) that allows clients' past and current treatment providers to share information. If the client does not wish to sign such a release, providers may want to request that clients compile a list of the medications they are taking, dosage, and frequency.
- For clients who are using multiple medications, providers should discuss what time of day they take each medication. For emergency medications, such as Narcan, Epi-pens or asthma inhalers, providers will want to ensure clients know and remember to carry these medications at all times.
- Many medications (including over-the-counter) can have moderate to serious side effects when used in combination with alcohol or illicit drugs, and clients should be aware of these risks. See https://pubs.niaaa.nih.gov/publications/Medicine/medicine.htm.
- Service providers use reminders to take their medications, such as using pill boxes, writing a schedule, setting alarms and putting signs around the home.
- Service providers can use different strategies to ensure that clients are taking their medications including pill counts, observing clients taking medications, reviewing medication schedules, and/or drug testing to monitor levels of medications in the body.

Medication Assisted Treatment for Individuals with Opioid or Alcohol Use Disorder:

- Severe substance use disorder is often characterized by withdrawal symptoms (e.g. anxiety, agitation, insomnia, nausea, vomiting, etc.) when drug/alcohol use has ceased or been significantly reduced after heavy or long-term use. Detoxification, or detox, is often the first step of treatment. Detox from opioids often involves controlled and medically supervised withdrawal from the substance.
- Prescription drug abuse occurs when medications are abused or taken for reasons or ways that

are not intended by a doctor, or taken by someone other than the person for whom the drug was prescribed. Prescription opioid pain medications may have similar effects to heroin. OxyContin and Vicodin are currently among the most commonly abused drugs in the United States, and some research suggests that prescription drug abuse may be a gateway to heroin use, especially given the relatively low street price of heroin compared to prescription pain medications. Opioid prescription drugs include:
    - Fentanyl (Duragesic®)
    - Hydrocodone (Vicodin®)
    - Oxycodone (OxyContin®)
    - Oxymorphone (Opana®)
    - Propoxyphene (Darvon®)
    - Hydromorphone (Dilaudid®)
    - Meperidine (Demerol®)
    - Diphenoxylate (Lomotil®)
- Pharmacological treatment often increases retention in treatment programs and decreases opioid use, infectious disease, and involvement in the criminal justice system.
- Medication and behavioral therapy should be combined and used as part of a therapeutic process that encompasses detoxification (if needed), followed by treatment and relapse prevention.
- Many interventions for opioid use disorder include pharmacological approaches coupled with behavioral therapy (see below for information on Naltrexone, Buprenorphine, and Methadone).
- While treatment for alcohol use disorder has traditionally focused on behavioral therapies and support groups, there is growing use of medications coupled with therapy.
- Disulfiam (Antabuse®) impacts the way the body breaks down alcohol, often causing the user to get sick with nausea and/or flu-like systems if they use alcohol.
- Naltrexone (also used for opioid use disorder) can decrease individuals' craving for alcohol and change the way their bodies experience alcohol.
- Acamprosate (Campral®) can reduce some of the brain's hyperexcitability associated with alcohol withdrawal (NIDA, 2017).

Special consideration for individuals with intellectual disabilities and/or mental illness requires treatment providers to pace programming appropriately for their capacity. Programming should be more frequent, include more frequent workgroups or role playing sessions, and sessions should be repeated. Regarding medication management for this population, there is a need to ensure that clients take their medication and understand the importance of the medication.

Sources and Additional Resources:

- NIDA website: http://www.drugabuse.gov/publications/drugfacts/heroin
- Principles of Drug Addiction Treatment: Criminal Justice Populations – A Research-Based Guide: NIDA publication on research-based principles of addiction treatment in the criminal justice setting. http://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations
- Opiate Withdrawal: National Library of Medicine guide. http://www.nlm.nih.gov/medlineplus/ency/article/000949.htm
- Treating Opiate Addiction: Detoxification and Maintenance: Harvard Medical School primer on opiate treatment.

http://www.health.harvard.edu/newsweek/Treating_opiate_addiction_Detoxification_and_maintenance.htm
- Medication-Assisted Treatment and Opioid Treatment Programs, including Buprenorphine, Methadone, and Naltrxone: https://www.samhsa.gov/medication-assisted-treatment
- Marlatt, G. A., & Gordon, J. R. (Eds.). (2005). Relapse prevention: Maintenance strategies in addictive behavior change (2nd Ed). New York: Guilford.
- Knowing When to Say When: Transitioning Patients from Opioid Therapy. https://www.drugabuse.gov/sites/default/files/knowing_when_to_say_when_3-31-14_ln_sd_508.pdf
- Minimizing the Misuse of Prescription Opioids in Patients With Chronic Nonmalignant Pain. https://www.drugabuse.gov/sites/default/files/minimizingmisuse_part1.pdf
- Prescription Drug Abuse: An Introduction. https://www.drugabuse.gov/nidamed/centers-excellence/resources/prescription-drug-abuse-introduction
- Fareed, A., Vayalapalli, S., Casarella, J, & Drexler, K. (2012). Effect of Buprenorphine Dose on Treatment Outcome, Journal of Addictive Diseases, 31:1, 818, DOI: 10.1080/10550887.2011.642758

PRACTICE GUIDELINE: ASSERTIVE CASE MANAGEMENT

Assertive Case Management, sometimes referred to as Assertive Community Treatment (ACT), is a comprehensive approach to developing community capacity and services for individuals with severe mental health disorders who are most at-risk for psychiatric crisis and hospitalization and involvement in the criminal justice system. (Bond & Drake, 2015; Phillips et al., 2001). Assertive Case Management is used for both adults and adolescents. These clients present with many mental health needs and require a collaborative approach to stabilize them in the community and improve their quality of life. Most clients who are appropriate for assertive case management frequently receive hospital inpatient treatment services; however, from a holistic rehabilitative perspective, this kind of treatment does not address daily crises individuals may face while living in the community (Wilson, Tien, & Eaves, 1995).

Assertive Case Management is a proactive, assertive, and continuous care approach that promotes client engagement using an interdisciplinary team. The team must be large enough to contain all of the necessary disciplines for service delivery, while remaining small enough for familiarity and accessible communication. Case managers develop treatment goals with the client and the team to create a unified, continuous care approach. Since Assertive Case Management involves a team of several case managers working with each individual, it has been found to reduce burnout among case managers who work with seriously mentally ill clients (Boyer & Bond, 1999).

Why Use Assertive Case Management

- Case managers help navigate medical, behavioral, and social services and the criminal justice system with clients.
- Families are more satisfied with the care received in assertive case management and feel more included in the process than traditional case management (Phillips et al., 2001).
- Assertive Case Management was found to increase client retention and engagement (Tasmania Dept of Health and Human Services, 2008; Bond & Drake, 2015).
- Assertive Case Management improves quality of life among individuals with a persistent and serious mental health disorder (Phillips, et al., 2001).
- There are many variations of Assertive Case Management programs. Target populations should be clearly defined, such as individuals who are homeless, veterans with severe mental illness, individuals with co-occurring mental health and substance use disorders, etc.
- Assertive Case Management has proven to be cost effective for individuals who have had extensive hospitalization (Wilson, Test, & Eaves, 1995).
    - Assertive case management was found to reduce homelessness, recidivism, and hospital utilization (Bond & Drake, 2015).
    - An evaluation of a Vancouver-based Assertive Case Management system (Wilson, Test, & Eaves, 1995) found that individuals who were in the Assertive Case Management group spent an average of 271 days in the community before being re-arrested, compared to individuals in the comparison group, who spent an average of 120 days in the community before being re-arrested.
- Assertive Case Management has been implemented in 35 states and in Canada, England, Sweden, and Australia.

Note: The assertive principle in Assertive Case Management may conflict with other evidence-based practices such as dialectical behavior therapy, which promotes autonomy and responsibility. The assertive principle is most useful for clients that need more direction, such as individuals with serious mental illness.

Assessment

- Programs should have clearly defined target populations and explicit admission criteria, with measurable and operationally defined criteria to appropriately screen clients.
    - Assertive Case Management should target individuals who are high-need.
- Individuals should be formally assessed to determine their type and level of needs. At a minimum, staff should assess for mental health disorders, future involvement in justice system, and family and social supports. All assessment information should be shared with the multidisciplinary treatment team.
- Additional items to assess include general health, family needs, social skills, daily living activities, safety, vocational and educational needs (Tasmania Dept of Health and Human Services, 2008), and frequency and duration of hospital admissions (Vijverberg et al., 2017).
- Some examples of assessment instruments used by Assertive Case Management teams include the Clinical Global Impression Scale, the Global Appraisal of Individual Needs, the Timeline Follow Back, and DSM interviews (Vijverberg et al., 2017).
- Appropriate standardized assessments should also be used to monitor progress.

Principles of Assertive Case Management (Summarized from Phillips et al., 2001)

Staffing and Capacity

- An Assertive Case Management or Assertive Community Treatment team consists of about 10 to 12 staff members from the fields of psychiatry, nursing, and social work, as well as professionals with other types of expertise, such as substance use disorder treatment and vocational assistance (Phillips et al., 2001; Bond & Drake, 2015).
    - Caseload size and staffing structure and size may depend on the complexity of clients' needs, local demographics, and the existence of supplementary mental health services (Tasmania Dept of Health and Human Services, 2008).
- Team members are cross-trained in each other's areas of expertise in order to readily assist and consult with each other.
- Teams meet frequently to plan and review service plans (at least four program meetings per week).

Program Components

- Assertive Case Management has nine core elements: (1) treatment in the field (not in an office setting); (2) small caseloads; (3) working with difficult-to-reach clients; (4) focused on transitions; (5) early interventions; (6) conducting psychiatric assessments in the community; (7) developing family support; (8) reintegration/vocational and educational therapy; and (9) pharmacology (Vijverberg et al., 2017).
- Case managers and clients develop individualized service plans and relapse plans with the multidisciplinary team, family members, and service providers.
    - Should focus on no more than 3 areas of need at one time.
- Assertive Case Management team members pick up individuals and bring them to court to help ensure attendance at all court appearances during the period of legally mandated services.
- Assertive Case Management team will continue working with clients despite disengagement; program engages and retains 95% or more of a caseload over 12 months.
- Assertive Case Management develops community living skills in the client's environment, as opposed to in office settings.
- Assertive Case Management provides individualized substance abuse treatment and is based on dual-disorders treatment principles.

- Once clients are stable and their needs can be met through routine monthly mental health services in the community, a standardized discharge plan should be developed to ease transition to self-management and gradually reduce contact with the Assertive Case Management team.

Program Dosage

- Service time should be provided as needed, on average 2+ hours per week per client.
- Frequency of contact should be provided as needed, on average 4+ contacts per week per client.
- Program should work directly with the client's support system, such as family members, employers, etc. at least 4 times a month.
- Program should provide 24-hour coverage given that most clients do not have support services that are stable and available. Flexibility and long-term stability are necessary for Assertive Case Management.

Special consideration for individuals with intellectual disabilities and/or mental illness requires treatment providers to pace programming appropriately for their capacity. Programming should be more frequent, include more frequent workgroups or role playing sessions, and sessions should be repeated.

Sources and Additional Resources:

- Bond, G. R., & Drake, R. E. (2015). The critical ingredients of assertive community treatment. World Psychiatry, 14(2), 240–242. http://doi.org/10.1002/wps.20234
- Boyer, S., & Bond, G. (1999). Does Assertive Community Treatment Reduce Burnout? A Comparison with Traditional Case Management. Mental Health Services Research, 1(1), 31–45. doi:10.1023/A:1021931201738
- Phillips, S., Burns, B., Edgar, E., Mueser, K., Linkins, K., Rosenheck, R., Drake, R., et al. (2001). Moving assertive community treatment into standard practice. Psychiatric services (Washington, D.C.), 52(6), 771–9. doi:10.1176/appi.ps.52.6.771
- Wilson, D., Tien, G., & Eaves, D. (1995). Increasing the community tenure of mentally disordered offenders: An assertive case management program. International Journal of Law and Psychiatry, 18(1), 61–69. doi:10.1016/0160-2527(94)00027-1
- Resource Manual, Assertive Case Management: A Proactive Approach. Mental Health Services Department of Health and Human Services. January, 2008. Tasmania, Australia. Retrieved from https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0007/38509/Assertive_Case_Management_Resource_Manual__version_1_.pdf